

Texas Medicaid

Provider Procedures Manual

November 2026

Volumes 1 & 2

TEXAS
Health and Human
Services

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

PRELIMINARY INFORMATION

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Welcome—Texas Medicaid Provider Procedures Manual

This manual is a comprehensive guide for Texas Medicaid providers. It contains information about Texas Medicaid fee-for-service benefits, policies, and procedures including medical, dental, and children's services benefits.

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for information about the Medicaid Managed Care, which is administered by Texas Health and Human Services Commission (HHSC)-contracted managed care organizations (MCOs), dental managed care organizations, and behavioral health organizations (BHOs) across the state.

The *Texas Medicaid Provider Procedures Manual* is updated monthly on the TMHP website at www.tmhp.com to include revisions to policies and procedures that went into effect in the prior month. The manual is available in portable document format (PDF) as a complete book and as individual sections and handbooks. A hypertext markup language (HTML) version is also be available.

The current version of the manual always appears prominently on the Texas Medicaid Provider Procedures Manual web page. All previously published annual editions of the *Texas Medicaid Provider Procedures Manual* have been archived. Users can access the archives through links on the Texas Medicaid Provider Procedures Manual web page.

Providers can determine what has changed each month by following the Release Notes link on the Texas Medicaid Provider Procedures Manual web page. The release notes include the sections and handbooks that have changed for the current month and the nature of the changes. Most changes have been previously announced in news articles on the TMHP website, and, where appropriate, the release notes link to prior website articles.

Publishing the manual monthly has eliminated the need for the *Texas Medicaid Bulletin*, which was discontinued following the publication of the September/October 2012 *Texas Medicaid Bulletin*, No. 243. Special bulletins, such as the annual Healthcare Common Procedure Coding System (HCPCS) bulletin, which is published in January of each year, will continue to be published on an as-needed basis.

The *Texas Medicaid Provider Procedures Manual* is divided into two volumes as follows:

- Volume 1: General Information

  Volume 1 applies to all health-care providers who are enrolled in Texas Medicaid and provide services to Texas Medicaid fee-for-service clients. The sections in Volume 1 include general information for enrolling in the program, receiving appropriate reimbursement, prior authorizations, claim submissions and appeals for services rendered.

- Volume 2: Provider Handbooks

  Each handbook in Volume 2 covers Medicaid policies, procedures, and claims filing requirements for specific products or services. Volume 2 includes the following handbooks:

  - *Ambulance Services Handbook*
  - *Behavioral Health, Rehabilitation, and Case Management Services Handbook*
  - *Certified Respiratory Care Practitioners (CRCP) Services Handbook*
  - *Children's Services Handbook*
  - *Clinics and Other Outpatient Facility Services Handbook*
  - *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook*
  - *Gynecological, Obstetrics, and Family Planning Title XIX Services*
  - *Health and Human Services Commission Family Planning Program Services Handbook*
  - *Healthy Texas Women Program Handbook*

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- *Home Health Nursing and Private Duty Nursing Services Handbook*
- *Inpatient and Outpatient Hospital Services Handbook*
- *Medicaid Managed Care Handbook*
- *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*
- *Medical Transportation Program Handbook*
- *Outpatient Drug Services Handbook*
- *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook*
- *Radiology and Laboratory Services Handbook*
- *School Health and Related Services Handbook*
- *Telecommunications Services Handbook*
- *Vision and Hearing Services Handbook*

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Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook

Medical Transportation Program Handbook

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Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook

Radiology and Laboratory Services Handbook

School Health and Related Services (SHARS) Handbook

Telecommunication Services Handbook

Vision and Hearing Services Handbook

Introduction

Texas Medicaid Administration

The Texas Medical Assistance (Medicaid) Program was implemented on September 1, 1967, under the provisions of Title XIX of the federal *Social Security Act* and Chapter 32 of the *Texas Human Resources Code*.

The state of Texas and the federal government share the cost of funding Texas Medicaid. The Health and Human Services Commission (HHSC), the single state Medicaid agency, is responsible for the Title XIX Program. The administration of the program is accomplished through contracts and agreements with the following:

- Medical providers
- Texas Medicaid & Healthcare Partnership (TMHP), the fee-for-service claims administrator

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- MAXIMUS, the enrollment broker
- Various managed care organizations (MCOs) and dental managed care organization (dental plans), that administer Medicaid Managed Care benefits.
- The Institute for Child Health Policy (ICHP), the quality monitor
- State agencies

Texas Medicaid providers are reimbursed for services through contracts with health-insuring contractors, fiscal agents, or direct vendor payments.

By signing an HHSC Medicaid Provider Agreement (through the enrollment process) and submitting Medicaid claims, each enrolled provider agrees to abide by the policies and procedures of Medicaid, published regulations, and the information and instructions in manuals, bulletins, and other instructional material furnished to the provider.

Refer to: "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*) for addresses and telephone numbers of HHSC and Department of State Health Services (DSHS) regional offices.

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Section 1: Provider Enrollment and Responsibilities

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1.1 Provider Enrollment

To be eligible for Texas Medicaid reimbursement, a provider of health-care services (including an out-of-state provider) must:

- Meet all applicable eligibility criteria.
- Be approved by the Texas Health and Human Services Commission (HHSC) for enrollment and enter into a written provider agreement with HHSC.
- Obtain a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES).

Refer to: Subsection 1.1.2, "NPI and Taxonomy Codes" in this section.

- File with the Texas Medicaid & Healthcare Partnership (TMHP) the required Texas Medicaid enrollment application ensuring that the application is correct, complete, and includes all required attachments and additional information.
- Provide any additional information requested by TMHP, HHSC, or the HHSC Office of Inspector General (OIG) in connection with the processing of the application.

Providers can use the online Provider Enrollment and Management System (PEMS) tool to enroll electronically through the TMHP website at www.tmhp.com.

Refer to: Subsection 1.1.3, "Online Enrollment" in this section.

After receipt of all information necessary to process the application, the entire application process can typically take up to 60 days. This may be extended in special circumstances. Requests for exceptions to the enrollment process, risk category, and provider types that require additional state approval may extend the length of the application process.

All providers must be enrolled in Texas Medicaid before enrollment can be approved for any other service or program, including, but not limited to, Medicaid managed care.

Certain provider types are required to enroll in Medicare as a prerequisite for enrolling in Texas Medicaid. During the Texas Medicaid enrollment process, with HHSC approval, the Claims Administrator may waive the mandatory prerequisite for Medicare enrollment for certain providers whose type of practice will never serve Medicare-eligible individuals (e.g., pediatrics, obstetrician/gynecologist [OB/GYN]).

Providers must maintain a valid, current license or certification to be entitled to Texas Medicaid reimbursement. Providers cannot enroll in Texas Medicaid if their license or certification is due to expire within 30 days of application. A current license or certification must be submitted, if applicable.

Refer to: Subsection 1.1.9.7, "Copy of License, Temporary License, or Certification" in this section.

Providers will receive an approval email once the application is completed.

Refer to: Subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in this section for additional criteria that out-of-state providers must meet to enroll in Texas Medicaid.

1.1.1 Provider Enrollment Revalidation Requirements

To stay compliant with federal requirements (Title 42 Code of Federal Regulations §455.414), providers must complete the revalidation process before the end of their enrollment period, also called the "revalidation due date." If a provider's enrollment period ends before the revalidation process is completed, TMHP will automatically disenroll the provider on that date.

Providers can view and confirm their revalidation due date and enrollment information by logging into the Provider Enrollment and Management System (PEMS). Most providers have a five-year enrollment period, although some providers may have shorter enrollment periods based on risk level or other factors.

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Revalidation applications can only be submitted online through PEMS. Revalidation becomes available up to 180 days before the revalidation due date. Providers are encouraged to submit their application as soon as it is available to allow enough time for reviews and processing to be completed.

Revalidation is not complete until all deficiencies have been corrected, all required reviews have been completed, and the application has reached Closed–Enrolled status on the Requests page in PEMS.

Revalidation requests submitted before the revalidation due date that reach Closed–Enrolled status within the 45 day grace period after the revalidation due date are considered completed and will not experience a gap in enrollment.

Providers who do not submit a revalidation application before their revalidation due date or whose revalidation request does not reach Closed–Enrolled status within the grace period will be disenrolled from all Texas state health care programs, including Medicaid managed care organizations (MCOs) and dental maintenance organizations (DMOs). Disenrolled providers will have claims and prior authorization requests denied and must submit a reenrollment application to regain participation.

1.1.2 NPI and Taxonomy Codes

The NPI final rule, Federal Register 45, Code of Federal Regulations (CFR) Part 162, established the NPI as the standard unique identifier for health-care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in Health Insurance Portability and Accountability Act (HIPAA)-covered transactions. An NPI is a 10-digit number assigned randomly by the NPPES. An NPI must be obtained before a provider can enroll as a Texas Medicaid provider.

PEMS will display the provider types that are eligible to enroll without an NPI.

The Health Care Provider Taxonomy Code Set is an external, non-medical collection of alphanumeric codes designed to classify health-care providers by provider type and specialty. Providers may have more than one taxonomy code. (Taxonomy codes can be obtained from the Washington Publishing Company website at x12.org/codes.

During the enrollment process, providers must select a primary taxonomy code associated with their provider type. Providers will attest with National Plan and Provider Enumeration System (NPPES) the approved Texas taxonomy codes to choose from that correspond to the services rendered by the type of provider they wish to enroll as. Only the code will be displayed. Due to copyright laws, TMHP is unable to publish the taxonomy description. Therefore, providers must verify the taxonomy code associated with their provider type and specialty before beginning the online attestation process.

1.1.3 Online Enrollment

Providers can begin the enrollment process on the Provider Enrollment page of the TMHP website.

> ***Note:*** *All providers must be enrolled in Texas Medicaid before enrollment can be approved for Medicaid Managed Care.*

Online enrollment has the following advantages:

- NPI-based enrollment
- A single application for all programs
- A single revalidation date, and/or enrollment period
- Flexible application completion
- The effective date aligns with the approval date
- Paperless
- Consolidated provider agreement
- Email and online communication

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- Online help features available
- Enhanced data validation
- 165 cumulative business days will be provided to correct all deficiencies
- Providers are able to edit submitted applications to correct identified deficiencies.

Enrolling online promotes accurate submissions, decreases processing time, and enables immediate feedback on the status of the application.

1.1.4 Provider Enrollment Identification

PEMS bases each enrollment application on the applying provider's NPI or API. Provider's who would like to enroll in Texas health-care programs must do so under one of two categories, individual or organization, determined by their NPI or API.

Individual providers, performing providers, and sole proprietors will enroll in PEMS with an NPI type of Individual.

Facility and group health-care providers who have a single employee or thousands of employees will enroll in PEMS with an NPI type of Organization.

- *Individual.* This type of enrollment applies to an individual healthcare professional who is licensed or certified in Texas and who is seeking enrollment under the name and social security or tax identification number of the individual. An individual may also enroll as an employee, using the tax identification number of the employer. Certain provider types must enroll as individuals, including:
  - Dietitians
  - Licensed vocational nurses (LVNs)
  - Respiratory care practitioners
  - Registered nurses—Comprehensive Care Program (CCP)
  - Physical and occupational therapists—CCP
  - Speech language pathologists—CCP
- *Performing provider.* This type of enrollment applies to an individual health care professional who is licensed or certified in Texas, and who is seeking enrollment under a group. The enrollment is under the federal tax identification number of the group, and payment is made to the group. If a health-care professional is required to enroll as an individual, as explained above, but the person is an employee and payment is to be made to the employer, the health-care professional does not enroll as a performing provider. Instead, the health-care professional enrolls as an individual provider under the federal tax identification number of their employer. Providers are encouraged to submit performing provider applications through a Group Initiated request.
- *Group*. This type of enrollment applies to healthcare items or services provided under the auspices of a legal entity, such as a partnership, corporation, limited liability company, or professional association, and the individuals providing healthcare items or services are required to be certified or licensed in Texas. The enrollment is under the name and tax identification number of the legal entity.

  During the enrollment process, the available taxonomy code list is populated with either taxonomy code 193200000X or 193400000X for a clinic/group practice, depending on which specialty is chosen. Case Management for Children and Pregnant Women (CPW) providers enrolling as a group should use taxonomy code 251B00000X. The taxonomy codes for clinic/group practice providers are accurate and have been approved by HHSC. The most appropriate taxonomy codes should be selected for any performing providers that will be enrolled according to their specific performing provider type and specialty.

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- *Facility*. This type of enrollment applies to situations in which licensure or certification applies to the entity. Although individuals working for or with the entity may be licensed or certified in their individual capacity, the enrollment is based on the licensure or certification of the entity. For this reason, facility enrollment does not require enrollment of performing providers. The following facility enrollment types require the disclosure of a Supervising Licensed Practitioner (SLP):
  - Family Planning Enrollment
  - Hearing Aid Enrollment
  - Independent Lab Enrollment
  - Texas Health Steps Medical (THSteps Medical) Enrollment
- The following provider types must enroll as facilities:
  - Ambulance and air ambulance
  - Ambulatory surgical center (ASC) and hospital-based ambulatory surgical center (HASC)
  - Birthing center
  - Catheterization lab
  - Chemical dependency treatment facility (licensed by the Texas Commission on Alcohol and Drug Abuse)
  - Consumer Directed Services Agency
  - County Indigent Health Care Program
  - Community mental health center
  - Comprehensive health center
  - Comprehensive outpatient rehabilitation facility/outpatient rehabilitation facility
  - Durable medical equipment (DME)
  - Early Childhood Intervention
  - Federally Qualified Health Center (FQHC)
  - Freestanding psychiatric facility
  - Freestanding rehabilitation facility
  - Home and Community Based Services – Adult Mental Health (HCBS-AMH) providers
  - Home Health/Home and community support services agency
  - Hospital/critical access hospital/out-of-state hospital
  - Military hospital
  - Hyperalimentation
  - Independent diagnostic testing facility/physiological lab
  - Indian Health Services
  - Independent laboratory
  - Intellectual or developmental disability (IDD) case management
  - Local health department
  - Maternity services clinic
  - Mental health targeted case management and mental health rehabilitative services

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- Milk bank donor
- Personal care services
- Pharmacy
- Portable X-ray
- Prescribed Pediatric Extended Care Centers (PPECC)
- Radiation treatment center
- Radiological laboratory
- Renal dialysis facility
- Rural health clinic (RHC)
- School health and related services (SHARS)/non-school SHARS
- Service responsibility option
- Skilled nursing facility
- State Supported Living Center (SSLC)
- Vision medical supplier
- Women, Infant and Children

Providers can submit one request to enroll several different provider types and specialty combinations. A unique provider identifier will not be assigned. Providers are encouraged to submit performing provider applications through a Group Initiated request.

Refer to: Subsection 1.10, "Medicaid Fraud, Waste, and Abuse Policy" in this section for additional information.

1.1.4.1 Medicare-Only Providers

The Medicare-only provider type can be used by providers that only render Medicare services not covered by Texas Medicaid (Medicare-only services) or that have a provider type not recognized by Texas Medicaid. Providers that are currently enrolled in Texas Medicaid or providers that render, refer, or prescribe Medicaid services are not eligible to enroll as Medicare-only providers.

1.1.4.2 Ordering- or Referring-Only Providers

Individual providers who are not currently enrolled in Texas Medicaid and whose only relationship with Texas Medicaid is to order or refer for supplies or services for Texas Medicaid-eligible clients must enroll in Texas Medicaid as participating providers. This requirement is in accordance with provisions of the Affordable Care Act of 2010 (ACA), 42 CFR §455.410(b), which requires all fee-for-service (FFS) and managed care network ordering or referring physicians or other professionals who order or refer for supplies or services under the Medicaid State plan, or under a waiver of the plan, to enroll in Medicaid as participating providers.

Providers who are out of network for Medicaid managed care organizations (MCOs) do not need to enroll as ordering or referring-only providers. The enrollment requirement includes providers who order or refer for supplies or services for dually eligible clients (i.e., clients who are enrolled in both Medicare and Medicaid), as the client's claims would be considered Medicaid claims. These providers can enroll online using PEMS.

Important: *Individual providers who are currently enrolled in Texas Medicaid or the CSHCN Services Program and who currently have an active Texas Medicaid or CSHCN Services Program enrollment can use their current enrollment for ordering or referring services and do not need*

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to obtain a separate ordering and referring enrollment. An acute care billing provider's practice location will be deactivated if the provider enrolls as an ordering-only or referring-only provider.

Providers who enroll in Texas Medicaid as ordering or referring-only providers are not required to submit a separate enrollment to order and refer for both Texas Medicaid clients and CSHCN Services Program clients. Although ordering or referring-only providers do not submit claims to TMHP for rendered services, the ordering or referring-only provider's NPI is required on claims that are submitted by the billing providers that render the services or provide the supplies or services.

Refer to: Subsection 6.4.2.4, "Ordering or Referring Provider NPI" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about filing claims that require an ordering- and referring-only provider NPI.

1.1.4.3 Ordering or Referring-Only Providers Participating in Other State Health-Care Programs

Providers who order or refer for supplies or services for Children's Health Insurance Program (CHIP) clients must enroll as a participating providers with TMHP. Providers who are out of network for CHIP MCOs do not need to enroll as ordering or referring-only providers. Providers who order or refer for supplies or services for Healthy Texas Women (HTW) and CSHCN clients must also enroll as participating providers with TMHP.

1.1.4.4 Interns and Medical Residents Who Order, Prescribe, or Refer

Interns and medical residents with only Physician-In-Training (PIT) permits issued by the Texas Medical Board cannot enroll in Texas Medicaid. An intern or resident's licensed supervising physician must be reported as the ordering or referring provider on claims that are generated from the order or referral of the intern or resident. The NPI of the supervising physician must be listed on orders or referrals written by the interns or residents they supervise. The licensed supervising physician must be enrolled in Texas Medicaid as a billing provider or as an ordering or referring-only provider.

1.1.5 Affordable Care Act of 2010 (ACA) Enrollment Requirements

Providers are required to fulfill certain requirements for enrollment in order to comply with the provisions of ACA. Providers that are enrolled in Texas Medicaid and have fulfilled the ACA requirements through their Texas Medicaid enrollment are considered ACA-compliant for all programs in which they are enrolled.

Refer to: TMHP website at www.tmhp.com for additional information about ACA requirements.

In accordance with Section 6401 of ACA, the following requirements apply:

- Upon initial enrollment, revalidation, and re-enrollment, all participating providers are screened based on their categorical risk level. (complies with 42 CFR §§455.410 and 455.450)
- All providers are required to revalidate at least every three to five years based on provider type.
- Institutional providers who are enrolling, revalidating, or reenrolling are required to pay an application fee if one has not already been paid to Medicare or another state's Medicaid program or CHIP.
- Ordering and referring-only providers are required to enroll in Texas Medicaid as participating providers.

Refer to: Subsection 1.1.4.2, "Ordering- or Referring-Only Providers" in this section.

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1.1.5.1 Provider Screening Requirement

In compliance with ACA, all providers must be screened, which includes:

- Providers who submit a provider enrollment application for new enrollment or other type of enrollment or reenrollment.
- Providers who are currently enrolled in Texas Medicaid and are required to revalidate their enrollment in Texas Medicaid.

1.1.5.2 Provider Revalidation

In compliance with the 42 CFR §455.414, all providers are required to revalidate at least every three to five years:

- DME providers are required to revalidate enrollment information at least once every five years.
- All other provider types must revalidate their enrollment information at least once every five years.

Group administrators may submit enrollment revalidations for performing providers in a group. During revalidation, the provider screening will be repeated.

1.1.5.3 Application Fee

Under ACA, institutional providers are subject to an application fee for applications, including initial applications, applications for new practice locations, revalidation, and reenrollment applications. Upon completion of the PEMS online application, providers will be notified whether they are required to pay an application fee. The amount of the application fee is subject to change every calendar year.

Providers can refer to the TMHP website for the list of provider types that are required to pay the application fee.

Note: *Providers that are required to pay the application fee but have already paid the fee to Medicare or another state's Medicaid program or CHIP have fulfilled the fee requirement and do not have to submit the fee to Texas Medicaid. Proof of payment must be submitted with the application. Providers who are enrolled in Medicare must provide documentation that specifies whether or not they have completed the ACA rescreening process with Medicare.*

1.1.5.4 Ordering- or Referring-Only Providers Search on the Online Provider Lookup (OPL)

Providers can verify that an ordering- or referring-only provider is enrolled in Medicaid by using either the basic or advanced provider search function of the OPL.

1.1.6 Surety Bond Enrollment Requirement

All newly enrolling and re-enrolling DME and nongovernment-operated ambulance providers must obtain a surety bond that complies with 1TAC §352.15 as a condition of enrollment and continued participation in Texas Medicaid.

DME providers can refer to subsection 2.1.2, "Surety Bond Requirements" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*).

Ambulance providers can refer to subsection 1.1.6.1, "Ambulance Providers" in this handbook.

Important: *Surety bonds obtained for the purpose of accreditation in the Medicare program, which lists the Centers for Medicare & Medicaid Services (CMS) as obligee, do not fulfill the surety bond requirement for Texas Medicaid.*

The surety bond submitted to Texas Medicaid must meet the following requirements:

- A bond in an amount of no less than $50,000 must be provided for each enrolled location.

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- The bond must be submitted on the State of Texas Medicaid Provider Surety Bond Form. No other form will be accepted. The use of this form designates HHSC as the sole obligee of the bond. Instructions are included with the form.
- The bond must be issued for a term of 12 months. Bonds for longer or shorter terms are not acceptable.
- The bond must be in effect on the date that the provider enrollment application is submitted to TMHP for consideration. The effective date stated on the bond must be:
  - No later than the date that the provider enrollment application is submitted.
  - No earlier than 12 months before the date that the provider enrollment application is submitted.
- The bond must be a continuous bond. A continuous bond remains in full force and effect from term to term unless the bond is canceled.

Important: *An annual bond that specifies effective and expiration dates for the bond is not acceptable.*

At the time of enrollment, revalidation, or reenrollment, providers must submit a copy of the surety bond form with signatures and a copy of the Power of Attorney document from the surety company that issued the bond.

Note: *Surety companies may refer to Texas Department of Insurance (TDI) file #9212562912 or TDI link #132456 when filing the bond.*

DME and non-government-operated ambulance providers must maintain a current surety bond to continue participation in Texas Medicaid. To avoid losing Medicaid enrollment status, providers must submit proof of continuation to TMHP Provider Enrollment before the expiration date of the bond currently on file. The completed proof of continuation document must include the bond number, original signatures of the authorized corporate representative of the DME or ambulance provider (principal), the attorney-in-fact of the surety company, date of the original bond, and new "good through" date. Providers may upload a proof of continuation by initiating a Maintenance - Practice Location - Surety Bond Request in PEMS.

Refer to: The State of Texas Medicaid Provider Surety Bond Form in the Forms section of the TMHP website at www.tmhp.com.

1.1.6.1 Ambulance Providers

Ambulance providers that participate in Texas Medicaid fee-for-service, managed care programs, or the CHIP must, as a condition of emergency medical services (EMS) provider license renewal, obtain a surety bond that complies with Title 1 Texas Administrative Code (TAC) §352.15 and submit the bond to TMHP according to the requirements listed above. A copy of the bond must be included with their application to the Department of State Health Services (DSHS) to renew their emergency services provider license.

Providers can refer to the DSHS website for additional information.

Ambulance providers that are directly operated by a governmental entity are exempt from the surety bond requirement.

1.1.7 * Provider Enrollment Application Determinations

An application for provider enrollment may be approved with conditions, or denied. The provider applicant is issued a notice of the enrollment determination.

Refer to: Subsection 1.1.5, "Affordable Care Act of 2010 (ACA) Enrollment Requirements" in this section for additional information about the ACA 3- to 5-year revalidation requirement.

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When an application for enrollment is approved with conditions, the applicant has no right of appeal or administrative review of the enrollment determination. The types of conditional enrollment include, among other things:

- An application may be approved for time-limited enrollment, meaning the provider is approved to participate in Medicaid for a specific period of time. In this case, the provider is sent a notice that includes the enrollment period for which they are approved. If the provider wants to continue Medicaid participation beyond their approved enrollment period, they must complete the revalidation process before their enrollment period ends.
- An application may be approved subject to restricted reimbursement, meaning the provider is eligible to have only certain types of claims paid. This includes, among other things, reimbursement of only Medicare crossover claims (i.e., claims with respect to "dual eligible" recipients who are covered by both Medicare and Medicaid).

An application might be denied. If an application is denied, TMHP will send the provider a denial notice that explains the basis for the denial. The notice also explains the provider's right to make a request for an informal desk review of the denial decision and the procedures for filing such a request. The administrative rules governing a request for an informal desk review of the denial decision are found in the following TAC rules:

- 1 TAC § 371.1015(b). If the application is denied based upon the OIG's recommendation, an informal desk review request must be in writing (through PEMS), received within 20 business days of the date on the letter, and filed in accordance with the instructions provided in the denial notice.
- 1 TAC § 352.11(d)(2)(A). If the application is denied for any other reason, an informal desk review request must be in writing (through PEMS), received within 30 calendar days of the date on the letter, and filed in accordance with the instructions provided in the denial notice.

HHSC will conduct the informal desk review and render a final enrollment determination. HHSC's final determination is not subject to further administrative review or reconsideration.

The enrollment date is the day on which a new NPI was enrolled. This date impacts claims filing deadlines.

Refer to: Subsection 6.1.4.2, "Claims for Newly Enrolled Providers" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for timely-filing guidelines for newly enrolled providers.

[Revised] HHSC determines the enrollment effective dates for providers that choose to enroll in Medicaid and other Texas state healthcare services. Enrollment effective dates are determined based on the following criteria:

- [Revised] If enrolling in the Vendor Drug Program, the enrollment effective date is the date the application was approved.
- [Revised] If enrolling in Medicaid or other Texas state healthcare services and the provider is also enrolled in Medicare, the Medicare screen risk equals the Medicaid screen risk, and the Medicare effective date is not a future date. The enrollment effective date is the latest of the following dates:
  - [Revised] Medicare effective date (if there are multiple Medicare effective dates, then the earliest Medicare effective date will be used)
  - [Revised] License issue date (if there are multiple license issue dates, then the latest license issue date will be used)
  - [Revised] Change of Ownership (CHOW) effective date
  - [Revised] One year prior to the application submission date

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- [Revised] If enrolling in Medicaid or other Texas state healthcare services and the provider is also enrolled in Medicare, and the Medicare screen risk is lower than the Medicaid screen risk, the enrollment effective date is the date the application was approved.
- [Revised] If enrolling in Medicaid or other Texas state healthcare services and the provider is enrolled in Medicare, the Medicare screen risk equals the Medicaid screen risk, and the Medicare effective date is a future date, the enrollment effective date is equal to the Medicare effective date (which is a future date).
- [Revised] If enrolling in Medicaid or other Texas state healthcare services and the provider is not enrolled in Medicare, and the risk category is limited, the enrollment effective date is equal to the date the application was submitted.
- [Revised] If enrolling in Medicaid or other Texas state healthcare services and the provider is not enrolled in Medicare, and the risk category is moderate or high, the enrollment effective date is equal to the date that the application was approved.

Enrollment notification letters that contain the enrollment information for newly enrolling providers are emailed the following day. Revalidation notifications that contain the updated revalidation due date are sent by email and posted to the provider's My Account dashboard.

1.1.8 Enrollment in Medicaid Managed Care Programs

To be reimbursed for services rendered to Medicaid managed care clients, providers must be enrolled in Texas Medicaid and then must enroll with the client's health plan to be eligible for reimbursement for services rendered.

Refer to: Subsection 2.2, "Provider Enrollment and Responsibilities" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

1.1.9 Required Enrollment Forms

To enroll in Texas Medicaid, providers must complete all sections of the Texas Medicaid Enrollment Application through PEMS.

Providers can refer to the TMHP Provider Enrollment and Management System instructional website for information about required forms and other documentation. This website explains, by provider type, the documents and information that must be provided with the application.

Refer to: https://www.tmhp.com/topics/provider-enrollment/pems/start-application

When prompted to enter a tax identification number (tax ID) on the electronic copy of an enrollment application, the applicant should list the entity's nine-digit federal tax identification number.

Providers can call the TMHP Contact Center at 1-800-925-9126 for help with completing the application.

Providers will be notified of incomplete applications and will have 30 business days to provide the requested missing information. If the information is not provided within 30 business days, TMHP will terminate the enrollment process. If the provider wants to enroll at a later date, a new enrollment application must be submitted. Providers are required to review their enrollment application for correctness and completeness before submitting it to TMHP.

By e-signing the HHSC Medicaid Provider Agreement, a provider is certifying that all information submitted in connection with the application for enrollment is complete and correct. Any false, misleading, or incomplete information submitted in connection with an enrollment application constitutes a Medicaid program violation, and may result in administrative, civil, or criminal liability.

Refer to: Subsection 1.10, "Medicaid Fraud, Waste, and Abuse Policy" in this section.

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1.1.9.1 Application Payment Form

All providers who are required to pay an application fee to participate in the Medicaid program must fill out the Application Fee page during enrollment. The application cannot be processed if the application fee is required and is not submitted with the application.

Refer to: Subsection 1.1.5.3, "Application Fee" in this section.

1.1.9.2 HHSC Medicaid Provider Agreement

The HHSC Medicaid Provider Agreement must be submitted by all providers who enroll in Texas Medicaid and must be signed by the provider who is applying for enrollment. If the applicant is an entity, a principal of the entity who has the authority to bind the entity to the requirements of the HHSC Provider Agreement must sign the agreement. "Principal" is defined in the following section.

If the provider is city- or government-owned, the agreement must be signed by a person who is authorized under the city or government charter. This form is an agreement between HHSC and the provider performing services under the State Plan wherein the provider agrees to certain provisions as a condition of participation.

Note: *The person who signs the HHSC Enrollment Agreement is certifying that all of the information in the application packet, including every completed Owner/Creditor/Principal entry, is complete and correct. This includes a certification that every person who is required to complete an Owner/Creditor/Principal entry has done so, and all required Owner/Creditor/Principal entries are included with the application.*

1.1.9.3 Owner/Creditor/Principal Entry

An Owner/Creditor/Principal entry must be completed by each principal/creditor, subcontractor, and creditor of the provider that is applying for enrollment with the following exceptions:

- Performing providers who are applying to join a group that is already enrolled
- Individuals who enrolled using their own Social Security number and an entity type of Individual/Sole Proprietorship

Principals of the provider include all of the following:

- An owner with a direct or indirect ownership or control interest of 5 percent or more
- Corporate officers and directors
- Managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations
- Limited or nonlimited partners
- Shareholders of a professional corporation, professional association, limited liability company, or other legally designated entity
- Any employee of the provider who exercises operational or managerial control over the entity or who directly or indirectly conducts the day-to-day operations of the entity
- All individuals, companies, firms, corporations, employees, independent contractors, entities, or associations that have been expressly granted the authority to act for or on behalf of the provider
- All individuals who are able to act on behalf of the provider because their authority is apparent
- An individual or entity with a security interest in a debt that is owed by the provider if the creditor's security interest is protected by at least 5 percent of property listed in Section III(c) of the Disclosure of Ownership

Note: *A Taxpayer Identification Number (TIN) or Social Security number (SSN) is required. An Individual Taxpayer Identification Number (ITIN) can be submitted in place of an SSN.*

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A subcontractor of the provider is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

Note: *This includes the on-site manager, supervising licensed practitioner, or medical director for each physical location of the provider in Texas.*

1.1.9.4 Disclosure of Ownership and Control Interest Statement

All providers must submit the Disclosure of Ownership and Control Interest Statement as part of the enrollment application, with the following exceptions:

- Performing providers who are applying to join a group that is already enrolled
- ECI, MHMR, MHR, Blind Children's Vocational Discovery & Development Program, YES Waiver, TB Clinic, Military Hospital, State Hospital or SHARS providers

This form also contains questions that must be answered under federal law. Failure to provide complete and accurate information as instructed on this form will constitute an incomplete application, which may result in denial of enrollment. Incomplete or inaccurate information on this form constitutes a violation of the rules of Medicaid and may also result in administrative, civil, or criminal liability. Providers that dually participate in Medicare and Medicaid, are expected to make accurate and consistent disclosures of ownership and managing staff to each program pursuant to federal regulations at §§ 420.202 through 420.206.

Refer to: Subsection 1.10, "Medicaid Fraud, Waste, and Abuse Policy" in this section.

Note: *Providers are required to submit any change in ownership, corporate officers, or directors to TMHP Provider Enrollment within 30 calendar days of the change.*

Refer to: Subsection 1.7.3, "Maintenance of Provider Information" in this section.

1.1.9.5 Franchise Tax Account Status Page

When enrolling as a "Corporation" type of entity, providers must submit a Franchise Tax Account Status Page. This information can be obtained from the Texas State Comptroller's Office website at: https://mycpa.cpa.state.tx.us/coa/

Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit the Franchise Tax Account Status Page, but they must submit the IRS exemption letter.

1.1.9.6 Certificate of Formation or Certificate of Filing/Articles or Certificate of Incorporation/Certificate of Fact

When enrolling as a "Corporation" type of entity, providers must submit the Certificate of Formation or Certificate of Filing form. Obtain the form from the Office of the Secretary of State of Texas. The name on this form must exactly match the legal name shown on the W-9 form.

The following certificates also apply for corporations:

- For corporations formed prior to January 1, 2006, Articles or Certificate of Incorporation/Certificate of Authority/Certificate of Fact
- For corporations formed on or after January 1, 2006, Certificates of Formation or Certificate of Filing
- For corporations registered in a state other than Texas, Certificate of Authority or Certificate of Filing

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The Certificate and any required certifications to provide certain services in Texas must be submitted when a corporation is registered in a state other than Texas. The form identifies the legal name of the corporation and is proof that the corporation is registered to do business in Texas.

Note: *Out-of-state providers that do not provide services in the state of Texas are exempt from submitting this form.*

1.1.9.7 Copy of License, Temporary License, or Certification

Providers cannot enroll in Texas Medicaid if their license is due to expire within 30 days. During the enrollment process, TMHP verifies licensure using available resources. If TMHP cannot verify a license at the time of enrollment, it is the providers' responsibility to provide a copy of the active license to TMHP.

TMHP will notify the provider by letter if a copy has not been submitted and the license cannot be verified.

Once a provider is enrolled in Texas Medicaid,the license or certification must be kept current. A reminder email for renewal will be sent to the provider 60 days before the provider's license expires.

TMHP directly obtains licensure information from the following licensing boards:

- Texas Medical Board (TMB) (for physicians only)
- Texas Board of Nursing (BON)
- Texas State Board of Dental Examiners (TSBDE)
- National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA)
- The Executive Council of Physical Therapy and Occupational Therapy Examiners (ECPTOTE) (Physical Therapist only)
- Texas Optometry Board (TOB)

If a license cannot be verified due to a delay in obtaining the board licensing information, providers must request a letter from the licensing board for their individual provider information and submit it to TMHP by the deadline indicated in the reminder letter. The letter must contain the provider's specific identification information, license number, and licensure period.

All other licenses and certifications that are not issued by TMB, BON, or TSBDE must be submitted to TMHP upon renewal.

Important: *Providers are also required to submit to TMHP, within 10 days of occurrence, notice that the provider's license or certification has been partially or completely suspended, revoked, or retired. Not abiding by this license and certification update requirement may impact a provider's qualification to continued participation in Texas Medicaid. Providers must upload the document through a PEMS Maintenance request for License Transactions.*

Refer to: Subsection 1.1.9.9, "Licensure Renewal" in this section.

1.1.9.8 Physician's Letter of Agreement

Upon initial enrollment and upon revalidation, Certified Nurse Midwife (CNM) or Licensed Midwife (LM) providers must complete and submit to TMHP with the Medicaid provider enrollment application the Physician's Letter of Agreement affirming the CNM's supervising physician arrangement or the LM's referring or consulting physician arrangement.

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- According to HHSC rules, 1 TAC §354.1253(c), and 1 TAC §354.1252(3), CNM providers and LM providers are required to inform HHSC in writing of the identity of a licensed physician or group of physicians with whom the CNM or LM has arranged for referral and consultation in the event of medical complications. For purposes of this rule, "consultation" means discussion of patient status, care, and management.
- A separate agreement must be submitted for each physician with whom an arrangement is made. This agreement must be signed by the CNM or LM and the physician. When changes to an arrangement are made, providers must submit a PEMS Existing Enrollment request to update the agreement.

Refer to: Subsection 1.4.2, "Provider Status (Individual, Group, Performing Provider, or Facility)" in this section.

1.1.9.9 Licensure Renewal

Not abiding by the license and certification update requirement may impact a provider's qualification for continued participation in Texas Medicaid. If a provider's license has expired, a deactivation letter will be sent to the provider, and all claims filed on and after the expiration date will be denied.

To have claims payments resumed, updated information must be sent to the applicable licensing board to renew the license. Payment will be considered for dates of service on or after the date of license renewal. Claims denied due to an inactive license may be appealed, and payment will be considered for dates of service on or after the date of return to active license status. Payment deadline rules for the fiscal agent arrangement must be met.

Refer to: Subsection 6.1.5, "HHSC Payment Deadline" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

1.1.9.10 Medicare Participation

Under federal law, Medicaid is the payor of last resort. When Medicare is the client's primary insurance, the provider must bill Medicare first for services covered by Medicare. To comply with this requirement, under 1 TAC §352.13, Medicaid providers that perform Medicare-covered services must be enrolled in or certified by Medicare, unless HHSC waives the requirement or grants an exception.

Providers that do not qualify for the Medicare enrollment requirement waiver must include a valid, current Medicare number when they submit their Texas Medicaid Provider Enrollment application.

1.1.9.10.1 Medicare-Enrolled Groups

When enrolling in Texas Medicaid as a group, each provider in the group must have a valid Medicare number unless the performing provider has an exception in place.

The group's enrollment application must include the current Medicare numbers for the group and each provider.

1.1.9.10.2 * Providers Eligible for a Waiver

HHSC may waive the Medicare enrollment requirement for providers that exclusively deliver services not covered by Medicare or meet one of the other approved waiver criteria.

[Revised] HHSC also may waive the Medicare enrollment requirement for Federally Qualified Health Center (FQHC) parents and satellites at the time of initial enrollment in Texas Medicaid, with the expectation that FQHC parents and satellites will obtain a Medicare enrollment and subsequently report their valid Medicare number through a Maintenance request in PEMS. This waiver does not apply to FQHC parents and satellites when completing revalidation or re-enrollment in Texas Medicaid.

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Examples of Texas Medicaid benefits that are not covered by Medicare include services like eye exams for prescription eyeglasses, and hearing aid fitting examinations, as well as hearing aids themselves.

Note: *If Medicare adds coverage for a service offered by the provider, or if the provider begins offering services that are covered by Medicare, the Medicare enrollment requirement waiver is no longer valid. The provider must then enroll in Medicare within 90 days.*

Texas Medicaid also enrolls clients who are not eligible for Medicare. Providers who only treat clients who are not eligible for Medicare may also request a waiver of the Medicare enrollment requirement.

Any individual or group provider that is not enrolled in Medicare and does not plan to enroll, must select one of the following appropriate attestation statements in the Provider Enrollment Management System (PEMS) application:

- "I certify that I am a Billing Provider and I do not provide billable services to individuals enrolled in both Medicare and Medicaid. I understand that if, at a future time, one or more client(s) in my group practice are eligible for services billable to Medicare, I will be required to enroll in and bill Medicare. I understand I will be required to submit an enrollment application listing this Medicare certification information within 10 days of Medicare enrollment. I understand that Medicaid is the payor of last resort, and I am legally required to bill all non-Medicaid insurances applicable to the client before I bill Medicaid."
- "I certify that I am a Non-Billing Provider and my group practice does not provide billable services to individuals enrolled in both Medicare and Medicaid. I understand that if, at a future time, a member in my group practice is a performing provider for services billable to Medicare, my group practice will be required to enroll in and bill Medicare. I understand that my group practice will be required to submit an enrollment application listing this Medicare certification information within 10 days of Medicare enrollment. I understand that without a valid exception, I cannot request a Medicare waiver if my group practice is Medicare-enrolled. I understand that Medicaid is the payor of last resort, and my group practice is legally required to bill all non-Medicaid insurance applicable to the client before Medicaid."

1.1.9.11 Group Information Changes

If additions or changes occur in a group's enrollment information (for example, a performing provider leaves or enters the group, changes the physical address or the accounting/mailing address, or a provider is no longer licensed) after the enrollment process is completed, the provider group must notify Texas Medicaid in writing within 90 calendar days of occurrence of the changes. Failure to provide this information may lead to administrative action by HHSC. Filing claims and receiving payment without having followed this requirement constitutes a program violation and may also result in administrative, civil, or criminal liability.

Refer to: Subsection 1.10, "Medicaid Fraud, Waste, and Abuse Policy" in this section for additional information.

1.2 Payment Information

Texas Medicaid reimbursements are available to all enrolled providers by check or electronic funds transfer (EFT). Providers are strongly encouraged to utilize EFT, which allows for more rapid reimbursement.

1.2.1 Using EFT

HHSC recommends that all Texas Medicaid providers receive payment by EFT. EFT is a method for directly depositing funds into a designated bank account. EFT does not require special software, and providers can enroll immediately.

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1.2.2 Advantages of EFT

Advantages of EFT include:

- Electronically-deposited funds are available more quickly than with paper checks.
- Providers do not have to worry about lost or stolen checks.
- TMHP includes provider and Remittance and Status (R&S) Report numbers with each transaction submitted. If the bank's processing software captures and displays the information, both numbers would appear on the banking statement.

1.2.3 EFT Enrollment Procedures

To enroll for EFT, providers must submit a completed Electronic Funds Transfer (EFT) maintenance request to TMHP through PEMS. A voided check or letter on bank letterhead, containing the bank routing and account information, must be attached to the enrollment request.

After the Electronic Funds Transfer (EFT) Authorization Agreement has been processed, TMHP issues a prenotification transaction during the next cycle directly to the provider's bank account. This transaction serves as a checkpoint to verify EFT is working correctly.

If the bank returns the prenotification without errors, the provider will begin receiving EFT transactions with the third cycle following the enrollment form processing. Providers will continue to receive paper checks until they begin to receive EFT transactions.

If the provider changes bank accounts, the provider must submit a new Electronic Funds Transfer (EFT) Authorization Agreement to TMHP Provider Enrollment. To update the EFT information, the provider can submit a PEMS Maintenance - EFT request. The prenotification process is repeated and, once completed, the EFT transaction is deposited to the new bank account.

1.2.4 Receiving Paper Checks

Providers must have a current physical and accounting/mailing address and telephone number on file so that they can promptly receive reimbursement checks and other TMHP correspondence. Providers must submit all changes to addresses and telephone numbers electronically using PEMS.

1.2.5 Stale-Dated Checks

Stale-dated checks (i.e., checks that are older than 180 days) that have not been cashed are voided and applied to either IRS levies or outstanding accounts receivable. Once a check has been voided, the associated claims may not be payable, and the transaction will be finalized after 24 months. Providers may submit a voided check appeal to TMHP Cash Financial at the following address:

Texas Medicaid & Healthcare Partnership
Attn: Cash Financial
12365A Riata Trace Parkway
Austin, TX 78727

TMHP encourages providers to receive payment via EFT to eliminate stale-dating issues. EFT ensures that providers receive payments through direct deposit in a bank account of their designation.

Refer to: Subsection 1.2.3, "EFT Enrollment Procedures" in this section.

1.3 * Provider Disenrollment

Payment denial codes are applied to a billing practice location that has not submitted a claim for a period of 24 months or more. The billing practice location will be considered disenrolled and claims will not be reimbursed until the billing practice location is reenrolled.

A courtesy letter will be sent to all providers whose billing practice locations have been identified as not having submitted any claims over the previous 18 months. Providers will have six months to submit claims and prevent the billing practice location from being disenrolled. Providers are encouraged to

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submit claims electronically through TexMedConnect or EDI for timely processing, which will help prevent billing practice locations from being disenrolled. If the provider is enrolled in both Medicaid and the CSHCN Services Program, the billing practice location for both programs will be examined to determine whether claims activity has occurred.

After 24 months without submitting a claim, providers will be sent a disenrollment letter, and a payment denial code will be applied to their billing practice location. If a provider's Medicaid billing practice location is disenrolled, any enrollments associated with the disenrolled billing practice location with the CSHCN Services Program will also be disenrolled. Claims that are submitted for a disenrolled practice location after the payment denial code has been applied will be denied.

To have the payment denial code applied to a billing practice location end-dated, a reenrollment application must be submitted. Upon successful reenrollment of the billing practice location, the payment denial code will be end-dated; however, the gap in enrollment will remain. Claims for dates of service during the gap in enrollment will be denied.

1.3.1 Excluded Entities and Providers

The United States Health and Human Services (HHS)-OIG and the HHSC-OIG exclude certain individuals and entities from participation in all federal or state health-care programs. The exclusions restrict individuals from receiving any reimbursement for items or services furnished, ordered, or prescribed.

All current providers and providers who are applying to participate in state health-care programs must screen their employees and contractors every month to determine whether they are excluded individuals or entities. These screenings are a condition of the provider's enrollment, revalidation, or re-enrollment into state health-care programs.

Providers can determine whether an individual or entity is excluded by searching the List of Excluded Individuals/Entities (LEIE) website at https://oig.hhs.gov/exclusions/. A downloadable version of the database is available but it does not include Social Security Numbers (SSNs) or Employer Identification numbers (EINs). The Texas HHSC-OIG website is found at https://oig.hhs.texas.gov/exclusions. If a name matches a name on the exclusion list, it can be verified online with a SSN or EIN.

Providers must search the LEIE website monthly to capture any exclusions or reinstatements that have occurred since the last search. Providers must immediately report to HHS-OIG any exclusion information they discover when searching the LEIE database.

CFR section 1003.102(a)(2), states that civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid clients. In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded provider or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded.

1.4 Provider Reenrollment

Reenrollments are when a provider submits an enrollment application after being disenrolled, terminated, excluded, or otherwise removed. Reenrollments are reviewed by OIG. The new application may be submitted electronically using PEMS. A PEMS existing enrollment application is required when one of the following changes:

1.4.1 Medicare Number

If Medicare has issued a new Medicare number, the provider must complete an Existing Enrollment transaction in PEMS in order to enroll with the new information.

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1.4.2 Provider Status (Individual, Group, Performing Provider, or Facility)

Providers leaving group practices must submit a PEMS existing enrollment request to disenroll from the group's practice location. If the provider has joined a new group or wants to enroll to bill for services provided, submit a PEMS existing enrollment application.

1.4.3 Physical Address

If a provider moves or has an address change and the new address is within the same Medicare locality, the provider must update their address information within 90 days of the change. Providers should update their address information through a maintenance request using PEMS. A PEMS existing enrollment application must be submitted to add additional practice locations.

1.4.4 Change in Principal Information

As defined in Subsection 1.1.9.3, "Owner/Creditor/Principal Entry" in this section, change in principal information includes a change in corporate officers or directors, professional association membership, and managing employees. The change must be reported to TMHP within 30 calendar days of when it occurs.

Refer to: Subsection 1.7.3.3, "Online Provider Lookup (OPL)" in this section.

Providers can request an Electronic Remittance & Status (ER&S) Report each time a new enrollment or location is added by contacting the Electronic Data Interchange (EDI) help desk directly and completing an Electronic Remittance Advice (ERA) Agreement. This form must be completed and returned to EDI to ensure there is no suspension in the provider's ability to access their ER&S statement on the secure provider portal through www.tmhp.com.

Providers must also contact any third-party EDI vendors with whom they are contracted to add any new provider locations to their ER&S Report. To obtain a PDF copy of the ER&S Report on the TMHP Home Page, the provider must create an administrator account for each provider location belonging to them.

Providers that have a newly enrolled location must ensure that any prior authorizations affected have been updated to reflect the new provider location.

1.5 Change of Ownership Requirements

The new owner must do the following:

- Obtain recertification as a Title XVIII (Medicare) facility under the new ownership
- Submit CMS Acknowledgment of Change of Ownership Letter
- Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in language that specifies who is liable for overpayments that were identified subsequent to the change of ownership, that includes dates of service before the change of ownership)
- Submit any new enrollment application relating to a change of ownership to TMHP Provider Enrollment within 30 calendar days of the change

When the change of ownership has been processed, if there is a new NPI with the change of ownership, when the application is completed, the original NPI used by the provider to bill claims could be deactivated and the provider could lose the ability to download R&S Reports from the TMHP portal, as well as the ability to verify client eligibility online. Claims status inquiries through the TMHP portal will also be unavailable. After an NPI has been deactivated, the provider can call the TMHP Automated Inquiry System (AIS) to check on client eligibility and the status of claims. Paper R&S Reports can be printed by the TMHP Contact Center, and delivered to providers, up to 30 days from the date the NPI is deactivated.

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1.6 Claims Filing During Enrollment

Providers must adhere to claim filing deadlines throughout the enrollment, re-enrollment, and revalidation processes. Claims submitted by newly enrolled providers must be received within 95 days of the date that enrollment is complete and within 365 days of the date of service.

Note: *Claims can be submitted for dates of service on or after the provider's effective date of enrollment. Providers can find the effective date for their enrollment in their Welcome Letter in PEMS.*

Providers that are enrolling in Texas Medicaid for the first time or that are making a change that requires the issuance of a new NPI can submit claims within 95 days of the date that enrollment is complete, as long as claims are submitted within 365 days of the date of service.

Providers that are revalidating an existing enrollment can continue to file claims while they are completing the revalidation process. TMHP must receive claims within 95 days of the date of service.

For clients who have retroactive eligibility, the 95-day deadline is based on the date of service or the date on which the client eligibility information is added to the TMHP eligibility file, whichever is later. For clients who have dual Medicare and Medicaid eligibility, when a service is a benefit of both Medicare and Medicaid, the claim must be filed with Medicare first. In these cases, the 95-day deadline is based on the date of Medicare disposition.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

1.7 Provider Responsibilities

1.7.1 Compliance with Texas Family Code

1.7.1.1 Child Support

The Texas Family Code 231.006 places certain restrictions on child support obligors. Texas Family Code §231.006(d) requires a person who applies for, bids on, or contracts for state funds to submit a statement that the person is not delinquent in paying child support. This law applies to an individual whose business is a sole proprietorship, partnership, or corporation in which the individual has an ownership interest of at least 25 percent of the business entity. This law does not apply to contracts/agreements with governmental entities or nonprofit corporations.

The required statement has been incorporated into the HHSC Provider Agreement.

The law also requires that payments be stopped when notified that the contractor/provider is more than 30 days delinquent in paying child support. Medicaid payments are placed on hold when it is discovered that a currently enrolled provider is delinquent in paying child support. A provider application may be denied or terminated if the provider is delinquent in paying child support.

1.7.1.2 Reporting Child Abuse or Neglect

Title 5 Texas Family Code (TFC) §261.101 states: "(a) A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter; (b) If a professional has cause to believe that a child has been abused or neglected, or may be abused or neglected, or that a child is a victim of an offense under section 21.11, Penal Code, and the professional has cause to believe that the child has been abused as defined by section 261.001 or 261.401, the professional shall make a report no later than the 48th hour after the hour the professional first suspects that the child has been, or may be abused or neglected, or is a victim of an offense under section 21.11, Penal Code." A professional may not delegate to or rely on another person to make the report. In this subsection, *professional* means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is

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required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health-care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

All Medicaid providers shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of reports of child abuse and neglect and the provisions of HHSC policy. Reimbursement shall only be made to providers who have demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and HHSC policy. Provider staff shall respond to disclosures or suspicions of abuse or neglect of minors, by reporting to the appropriate agencies as required by law.

All providers shall adopt this policy as their own, report suspected sexual abuse of a child as described in this policy and as required by law, and develop internal policies and procedures that describe how to determine, document, and report instances of sexual or nonsexual abuse.

This information is also available on the HHSC and TMHP websites at https://www.hhs.texas.gov/handbooks/family-planning-program-policy-manual/3200-abuse-neglect-reporting and www.tmhp.com.

1.7.1.3 Procedures for Reporting Abuse or Neglect

Professionals as defined in the law are required to report no later than the 48th hour after the hour the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

Nonprofessionals shall immediately make a report after the nonprofessional has cause to believe that the child's physical or mental health or welfare has been adversely affected by abuse.

A report shall be made regardless of whether the provider staff suspect that a report may have previously been made.

Reports of abuse or indecency with a child must be made to one of the following:

- Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (the DFPS Texas Abuse/Neglect Hotline, at 1-800-252-5400, operated 24 hours a day, 7 days a week)
- Any local or state law enforcement agency
- The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred
- The agency designated by the court to be responsible for the protection of children

The law requires the report to include the following information if known:

- The name and address of the minor
- The name and address of the minor's parent or the person responsible for the care, custody, or welfare of the child if not the parent
- Any other pertinent information concerning the alleged or suspected abuse

Reports can be made anonymously.

A provider may not reveal whether the child has been tested or diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

If the minor's identity is unknown (e.g., the minor is at the provider's office anonymously to receive testing for HIV or a sexually transmitted disease [STD]), no report is required.

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1.7.1.4 Procedures for Reporting Suspected Sexual Abuse

All providers shall ensure that their employees, volunteers, or other staff report a victim of abuse who is a minor 14 years of age or younger who has engaged in sexual activity with any individual to whom the minor is not married. Sexual activity would be indicated if the minor is pregnant or has a confirmed STD acquired in a manner other than through perinatal transmission.

Sexual activity may include, but is not limited to, the actions described in Penal Code §21.11(a) relating to indecency with a child; §21.01(2) defining *sexual contact*; §43.01(1) or (3)-(5) defining various sexual activities; §22.011(a)(2) relating to sexual assault of a child; or §22.021(a)(2) relating to aggravated sexual assault of a child.

Providers may voluntarily use the HHSC checklist for monitoring all clients who are 14 years of age or younger, unmarried, and sexually active. The checklist, if used, as well as any report of child abuse, shall be retained as part of the client's record by each provider and made available during any monitoring conducted by HHSC.

Refer to: Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

1.7.1.5 Training

All providers must develop training for all staff on the policies and procedures in regard to reporting child abuse. New staff must receive this training as part of their initial training/orientation. Training must be documented. As part of the training, staff must be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

1.7.1.6 Reporting Abuse and Neglect of the Elderly or Disabled

Title 2 Human Resources Code (HRC) §48.051 states: "(a) Except as prescribed by Subsection (b), a person having cause to believe that an elderly or disabled person is in the state of abuse, neglect, or exploitation, including a disabled person receiving services as described by Section 48.252, shall report the information required by Subsection (d) immediately to the Department of Health and Human Services and Department of Protective and Regulatory Services. (b) If a person has cause to believe that an elderly or disabled person, other than a disabled person receiving services as described by Section 48.252, has been abused, neglected, or exploited in a facility operated, licensed, certified, or registered by a state agency, the person shall report the information to the state agency that operates, licenses, certifies, or registers the facility for investigation by that agency. (c) The duty imposed by Subsections (a) and (b) applies without exception to a person whose knowledge concerning possible abuse, neglect, or exploitation is obtained during the scope of the person's employment or whose professional communications are generally confidential, including an attorney, clergy member, medical practitioner, social worker, and mental health professional."

(d) The report may be made orally or in writing. It shall include:

- The name, age, and address of the elderly or disabled person;
- The name and address of any person responsible for the elderly or disabled person's care;
- The nature and extent of the elderly or disabled person's condition;
- The basis of the reporter's knowledge; and
- Any other relevant information.

(e) If a person who makes a report under this section chooses to give self-identifying information, the caseworker who investigates the report shall contact the person if necessary to obtain any additional information required to assist the person who is the subject of the report."

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1.7.1.7 Procedures for Reporting Abuse or Neglect of the Elderly or Disabled

Title 2 HRC §48.151 states: "(a) Not later than 24 hours after the department receives a report of an allegation of abuse, neglect, or exploitation under Section 48.051, the Department of Health and Human Services and Department of Protective and Regulatory Services shall initiate a prompt and thorough investigation as needed to evaluate the accuracy of the report and to assess the need for protective services, unless the department determines that the report:

- Is frivolous or patently without a factual basis; or
- Does not concern abuse, neglect, or exploitation, as those terms are defined by rules adopted by the executive commissioner under Section 48.002(c), except that if the executive commissioner has not adopted applicable rules under that section, the statutory definitions of those terms under Section 48.002(a) shall be used.

(b) The Department of Health and Human Services and Department of Protective and Regulatory Services have adopted rules for conducting investigations under this chapter.

(c) The Department of Human Services and Department of Protective and Regulatory Services by rule may assign priorities and prescribe investigative procedures for conducting investigations according to the degree of severity and immediacy of the alleged harm to the individual. Notwithstanding Subsection (a), the department's priorities and procedures may provide that an investigation is not required to be initiated within 24 hours in all cases.

(d) The Department of Human Services and Department of Protective and Regulatory Services shall prepare and keep on file a report of each investigation conducted by the department.

(e) This section does not apply to investigations conducted under Subchapter F or H."

1.7.2 Texas Medicaid and CHIP Hospital Data Collection and Reporting Requirements

In accordance with Executive Order GA-46 issued by Governor Greg Abbott on August 8, 2024, hospital providers must ask each patient during the hospital intake process whether the patient is (1) a citizen or an alien lawfully present in the United States, or (2) an alien not lawfully present in the United States. Hospital providers must report to HHSC quarterly the number of inpatient discharges of and emergency visits by all patients and patients who are (1) a citizen or an alien lawfully present in the United States, and (2) an alien not lawfully present in the United States.

Hospital providers must also report to HHSC quarterly the costs of care for patients who are not lawfully present in the United States. Hospitals are expected to begin collecting the information by November 1, 2024, and begin reporting to HHSC on March 1, 2025.

When collecting information about a patient's immigration status, hospital providers must provide notification that, as required by federal law, the response will not affect patient care.

1.7.3 Maintenance of Provider Information

Within 90 calendar days of occurrence, providers must report changes in address (physical location or accounting), telephone number, name, federal tax ID, and any other information that pertains to the structure of the provider's organization (for example, performing providers). Changes in address, office telephone or fax number, and email address should be updated by submitting a maintenance request using PEMS. A W9 is required if the provider is changing the Accounting/Billing address. A copy of the Medicare approval letter listing the additional location or site must be submitted when adding additional practice locations. Failure to provide this information may lead to administrative action by HHSC.

Refer to: Subsection 1.7.3.3, "Online Provider Lookup (OPL)" in this section.

Subsection 1.4.1, "Medicare Number" in this section.

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Providers are notified when they have an invalid address on file with TMHP. To add an additional practice location, providers must submit an existing enrollment using PEMS.

The Check Status Amount Search screen on the provider's secure homepage of the TMHP website will alert providers when payments are pending because of inaccurate or incomplete provider information. R&S Reports that are viewed on the TMHP website also notify the provider of pending payments.

Pending payments are released in the financial cycle of the following week after the address information has been updated. Payments that are pending for more than 180 days will be voided.

Other changes (in name, ownership status, federal tax ID, etc.) must be reporting to TMHP Provider Enrollment by submitting the appropriate PEMS Maintenance request. Failure to notify TMHP of changes affects accurate processing and timely claims payment. In addition, failure to timely report such changes is a violation of the rules of Medicaid, and may result in administrative, civil, or criminal liability.

Refer to: Subsection 1.10, "Medicaid Fraud, Waste, and Abuse Policy" in this section.

Providers will be prompted to verify their address(es) and make necessary changes at least once a year.

Providers that have a moderate or high risk category cannot render or submit claims for services at a new practice location until it has been approved and added to the enrollment record. Providers are encouraged to check PEMS for verification that the practice location has been approved prior to rendering or submitting claims for services.

Refer to: The Affordable Care Act (ACA) Screening Requirements on the TMHP website at www.tmhp.com for more information on risk category screening requirements.

1.7.3.1 Contracted Provider Groups

Contracted provider groups, independent physician groups, and physician management companies that have a hospital-based practice location must ensure that the organization's contact information is listed as the accounting or mailing address rather than the hospital's information. Providers can check this information in PEMS.

1.7.3.2 NPI Verification

TMHP verifies NPIs with NPPES to ensure that the NPI is active. If the NPI is shown by NPPES to be inactive, TMHP will notify the provider by letter.

TMHP will disenroll all practice locations, NPIs, and programs associated with the inactive NPI.

1.7.3.3 Online Provider Lookup (OPL)

The OPL is available on the public access portion of the TMHP website at www.tmhp.com. Provider information can be viewed by providers, clients, and anyone who accesses the TMHP website.

Providers with certain provider types must verify and update key demographic information every six months in PEMS to ensure their information is correct in the OPL. Affected provider types include, but are not limited to, physicians, nurses, dentists, and durable medical equipment providers.

If more than six months have elapsed since the required demographic information in the OPL was verified, access to the secure provider portal is blocked until the verification takes place. Upon logging into their accounts, users with administrative rights see a list of NPIs that require verification and update. After addressing each NPI listed on the page, administrative providers are able to proceed to their accounts.

If access to the secure portal has been blocked because of needed verification, nonadministrative users are not able to perform work functions on NPIs listed on the Review Required page. Nonadministrative users are advised to notify users with administrative rights so that they can verify demographic information and remove the block.

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The *My Account* page has a link to the Provider Demographic Update web page. Current information will be displayed with a button to allow editable fields to be changed. Demographic information may be updated only by authorized administrators. This authorization is controlled through the Permissions Management link, also located on the *My Account* page. Fields that can be updated online include the following:

- Primary physical address:
  - Street address lines 1 and 2
  - City, state, ZIP Code
  - County
- Telephone numbers
- Email address
- Office hours
- Accepting new clients, current clients only, or not accepting new clients
- Additional sites where services are provided
- Languages spoken
- Additional services offered
- Medicaid waiver programs
- Client age or gender limitations
- Counties served
- Does the practice have a website?
- Is the physical practice location accessible to people who have disabilities?

The following enhancements have also been made to the OPL to increase overall functionality:

- Clients are able to search for providers in up to 5 counties in a single search.
- Doing business as (DBA) names appear for providers or provider groups.
- The State of Texas Access Reform (STAR) Health program has been added as a searchable health plan.
- The default ZIP Code radius for provider search has been increased to 10 miles from 5 miles.
- Providers who make address updates may receive a confirmation email from TMHP after the address has been verified and if their email address has been provided.
- Users will be able to search for providers within a ZIP Code that crosses multiple counties.

Each provider specialty and subspecialty listed in the OPL now has a corresponding definition. Users can view the definitions by clicking "more information" on either the basic or advanced search page or by hovering over the specialty on the results page. The definitions have been added to help clients locate the correct type of provider.

Providers are able to self-declare as many as three subspecialties to identify the services they offer. Providers may declare only subspecialties that are within the scope of their practice. Users are able to search for a provider on the OPL using these subspecialties.

Clients using the OPL will use drop-down boxes to select search criteria. An initial list will display all providers that meet the specified search criteria. Clicking on any name in that list will display the provider's specific information, including a map of the office location.

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Links to health maintenance organization (HMO) websites are also provided, enabling clients to search each HMO's network of participating providers. The OPL supports both English and Spanish language users, and search results can be printed.

1.7.3.4 Updating NPI and Taxonomy Codes

Providers are required to provide their NPI in the enrollment application. During the enrollment process, taxonomy codes are auto-populated and, if an update has been made, the provider can refresh the information in PEMS. Due to copyright restrictions, TMHP is unable to publish the taxonomy descriptions. Providers must verify the taxonomy codes associated with their provider type and specialty before beginning the enrollment process.

Refer to: Subsection 1.1.2, "NPI and Taxonomy Codes" in this section.

Providers must maintain and update their NPI and/or taxonomy code information with Texas Medicaid. The available taxonomy code selections are auto-populated according to the information on file with NPPES. The taxonomy code options may not match the taxonomy code listed in the confirmation letter received from NPPES. Providers must contact the TMHP Contact Center at 1-800-925-9126 to validate their provider type and specialty associated with their NPIs.

Important: *The taxonomy code that is included in electronic transactions must match a taxonomy code that is included in the attestation record. Secondary taxonomy codes included during the attestation process are used as additional matching criteria for claims and authorization processing.*

1.7.3.5 Updating Provider Specialty

Providers that have made a change in their specialty must submit their updated specialty information to Texas Medicaid using an Existing Enrollment application in PEMS, as follows:

- Medicare-enrolled providers whose Medicare number has not changed must submit a maintenance request using PEMS. The specialty letter may be uploaded to PEMS.
- Providers that are not enrolled in Medicare or whose Medicare number has changed must submit an Existing Enrollment application.

Refer to: Subsection 1.4, "Provider Reenrollment" in this section for more information about provider reenrollment in Texas Medicaid.

1.7.4 Retention of Records and Access to Records and Premises

The provider must maintain and retain all necessary documentation, records, R&S Reports, and claims to fully document the services and supplies provided and delivered to a client with Texas Medicaid coverage, the medical necessity of those services and supplies, costs included in cost reports or other documents used to determine a payment rate or fee, and records or documents necessary to determine whether payment for those items or services was due and was properly made for full disclosure to HHSC and its designee. A copy of the claim or R&S Reports without additional documentation will not meet this requirement.

The documentation includes the following, without limitation:

- Patient clinical health records
- Other records pertaining to the patient
- Any other records of services, items, equipment, or supplies provided to the patient and payments made for those services
- Diagnostic tests
- Documents related to diagnosis

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- Charting
- Billing records
- Invoices
- Treatments
- Services
- Laboratory results
- X-rays
- Documentation of delivery of items, equipment, and supplies

Accessible information must include information that is necessary for the agencies specified in this section to perform statutory functions.

> ***Note:*** *The required information may also include, without limitation, business and accounting records with backup support documentation, statistical documentation, computer records and data, and patient sign-in sheets and schedules. Additionally, it includes all requirements and elements described in 1 TAC §§371.1607 and 371.1667 (definition of "failure to grant immediate access").*

The provider is required to submit original documents, records, and accompanying business records affidavits to representatives of the organizations listed in this section. These records should also be provided to any agents and contractors related to the organizations. At the discretion of the requestor, the provider may be permitted to instead provide copies notarized with the required business records affidavit. Requested records must be provided promptly and at no cost to the state or federal agency. If the provider was originally requested to provide original documents and subsequent requests for copies of these records are made by the provider, any and all costs associated with copying or reproducing any portion of the original records will be at the expense of the provider. This applies to any request for copies made by the provider at any point in the investigative process until such time as the agency deems the investigation to be finalized. A method of payment for the copying charge, approved by the agency, would be used to pay for the copying of the records. If copies of records are requested from the provider initially, the provider must submit copies of such records at no cost to the requestor's organization.

The provider must provide immediate access to the provider's premises and records for purposes of reviewing, examining, and securing custody of records, documents, electronic data, equipment, or other requested items, as determined necessary by the requestor to perform statutory functions. Nothing in this section will in any way limit access otherwise authorized under state or federal law. If, in the opinion of the Inspector General or other requestor, the documents may be provided at the time of the request or in less than 24 hours or the Inspector General or other requestor suspects the requested documents or other requested items may be altered or destroyed, the response to the request must be completed by the provider at the time of the request or in less than 24 hours as allowed by the requestor. If, in the opinion of the Inspector General or other requestor, the requested documents and other items requested cannot be completely provided on the day of the request, the Inspector General or requestor may set the deadline for production at 24 hours from the time of the original request.

Failure to supply the requested documents and other items, within the time frame specified, may result in payment hold to the provider's Medicaid payments, recoupment of payments for all claims related to the missing records, contract cancellation, and/or exclusion from Texas Medicaid.

As directed by the requestor, the provider or person will relinquish custody of the requested documents and other items and the requestor will take custody of the records, removing them from the premises. If the requestor should allow longer than "at the time of the request" to produce the records, the provider will be required to produce all records completed, at the time of the completion or at the end of each day of production, as directed by the requestor who will take custody of the requested items.

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If the provider places the required information in another legal entity's records, such as a hospital, the provider is responsible for obtaining a copy of these requested records for use by the requesting state and federal agencies.

These documents and claims must be retained for a minimum period of five years from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. Freestanding RHCs must retain their records for a minimum of six years, and hospital-based RHCs must retain their records for a minimum of ten years. These records must be made available immediately at the time of the request to employees, agents, or contractors of HHSC OIG, the Office of the Attorney General (OAG) Medicaid Fraud Control Unit (MFCU) or Antitrust and Civil Medicaid Fraud Section, TMHP, DFPS, HHSC, DSHS, Texas Workforce Commission (TWC), U.S. Department of Health and Human Services (HHS) representative, any state or federal agency authorized to conduct compliance, regulatory, or program integrity functions on the provider, person, or the services rendered by the provider or person, or any agent, contractor, or consultant of any agency or division delineated above. In addition, the provider must meet all requirements of 1 TAC §371.1667.

The records must be available as requested by each of these entities, during any investigation or study of the appropriateness of the Medicaid claims submitted by the provider.

1.7.4.1 Payment Error Rate Measurement (PERM) Process

CMS assesses Texas Medicaid using the PERM process to measure improper payments in Texas Medicaid. Providers will be required to provide medical record documentation to support the medical reviews that the federal review contractor will conduct for Texas Medicaid fee-for-service and Primary Care Case Management Medicaid and State Children's Health Insurance Program (SCHIP) claims.

Under the PERM process, if a claim is selected in a sample for a service that a provider rendered to a Medicaid client, the provider will be contacted to submit a copy of the medical records that support the medical review of the claim. All providers should check the TMHP system to ensure their current telephone number and addresses are correct in the system. If the information is incorrect or incomplete, providers must request a change immediately to ensure the PERM medical record request can be delivered. Client authorization for release of this information is not required.

Once a provider receives the request for medical records, the provider must submit the information electronically or in hard copy within 60-calendar days. It is important that providers cooperate by submitting all requested documentation in a timely manner because no response or insufficient documentation will count against the state as an error. This can ultimately negatively impact the amount of federal funding received by Texas for Medicaid.

1.7.5 Medicare Overpayment

Title 42 CFR §447.30 provides for withholding the federal share of Medicaid payments to recover Medicare overpayments from providers in a coordinated effort with CMS.

1.7.6 Credit Balance and Recovery Vendor

Trend Health Partners helps Texas Medicaid resolve credit balances and recover overpayments. Trend Health Partners reviews the credit balances of all current accounts with claims that received a primary or secondary payment from both TMHP and a health insurance carrier, but the health insurance carrier was liable for payment before Medicaid.

1.7.7 Release of Confidential Information

Information regarding the diagnosis, evaluation, or treatment of a client with Texas Medicaid coverage by a person licensed or certified to diagnose, evaluate, or treat any medical, dental, mental/emotional disorder, or drug abuse, is confidential information that the provider may disclose only to authorized persons. Family planning information is sensitive, and confidentiality must be ensured for all clients, especially minors.

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Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other respects. If a client's medical records are requested by a licensed Texas health-care provider or a provider licensed by any state, territory, or insular possession of the United States or any state or province of Canada, for purposes of emergency or acute medical care, a provider must furnish such records at no cost to the requesting provider. This includes records received from another physician or health-care provider involved in the care or treatment of the patient. If the records are requested for purposes other than for emergency or acute medical care, the provider may charge the requesting provider a reasonable fee and retain the requested information until payment is received.

The client's signature is not required on the claim form for payment of a claim, but HHSC recommends the provider obtain written authorization from the client before releasing confidential medical information. A release may be obtained by having the client sign the indicated block on the claim form after the client has read the statement of release of information that is printed on the back of the form. The client's authorization for release of such information is not required when the release is requested by and made to HHSC, DSHS, TMHP, DFPS, TWC, HHSC OIG, the MFCU or Antitrust and Civil Fraud Division, or HHS.

1.7.8 Compliance with Federal Legislation

HHSC complies with HHS regulations that protect against discrimination. All contractors must agree to comply with the following:

- Title VI of the Civil Rights Act of 1964 (Public Law 88-352), section 504 of the Rehabilitation Act of 1973 (Public Law 93-112), the Americans with Disabilities Act of 1990 (Public Law 101-336), Title 40, Chapter 73, of the TAC, all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. The laws provide in part that no persons in the United States (U.S.) shall, on the grounds of race, color, national origin, age, sex, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service, or other benefits provided by federal and/or state funding, or otherwise be subjected to any discrimination
- Health and Safety Code 85.113 as described in "Model Workplace Guidelines for Businesses, State Agencies, and State Contractors" on page G-2 (relating to workplace and confidentiality guidelines on AIDS and HIV)

Exception: *In the case of minors receiving family planning services, only the client may consent to release of health-care information. Providers must comply with the laws and regulations concerning discrimination. Payments for services and supplies are not authorized unless the services and supplies are provided without discrimination on the basis of race, color, sex, national origin, age, or disability. Send written complaints of noncompliance to the following address:*

Executive Commissioner
1100 West 49th Street
Austin, TX 78756-3172

Reminder: *Each provider must furnish covered Medicaid services to eligible clients in the same manner, to the same extent, and of the same quality as services provided to other patients. Services made available to other patients must be made available to Texas Medicaid clients if the services are benefits of Texas Medicaid.*

1.7.9 Tamper-Resistant Prescription Pads

Providers are required by federal law (Public Law 110-28) to use a tamper-resistant prescription pad when writing a prescription for any drug for Medicaid clients.

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Providers must take necessary steps to ensure that tamper-resistant pads are used for all written prescriptions provided to Medicaid clients. Providers may also use compliant, non-written alternatives for transmitting prescriptions such as by telephone, fax, or electronic submittal. Pharmacies are required to ensure that all written Medicaid prescriptions submitted for payment to the Vendor Drug Program are written on a compliant tamper-resistant pad.

If a prescription is not submitted on a tamper-resistant prescription form, a pharmacy may fill the prescription and obtain a compliant prescription by fax, electronic prescription, or re-written on tamper-resistant paper within 72 hours after the date the prescription was filled.

Providers may purchase tamper-resistant prescription pads from the vendor of their choice.

Special copy-resistant paper is not a requirement for prescriptions printed from electronic health records (EHRs) or ePrescribing generated prescriptions. These prescriptions may be printed on plain paper and will be fully compliant with all three categories of the tamper-resistant regulations, provided they contain at least one feature from each of the three following categories:

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

1.7.10 Utilization Control — General Provisions

Title XIX of the Social Security Act, sections 1902 and 1903, mandates utilization control of all Texas Medicaid services under regulations found at Title 42 CFR, Part 456. Utilization review activities required by Texas Medicaid are completed through a series of monitoring systems developed to ensure the quality of services provided, and that all services are both medically necessary and billed appropriately. Both clients and providers are subject to utilization review monitoring. Utilization control procedures safeguard against the delivery of unnecessary services, monitor quality, and ensure payments are appropriate and according to Texas Medicaid policies, rules, and regulations. All providers identified as a result of utilization control activities are presented to HHSC-OIG to determine any and all subsequent actions.

The primary goal of utilization control activity is to identify providers with practice patterns inconsistent with the federal requirements and Texas Medicaid scope of benefits, policies, and procedures. The use of utilization control monitoring systems allows for identification of providers whose patterns of practice and use of services fall outside of the norm for their peer groups. Providers identified as exceptional are subject to an in-depth review of all Texas Medicaid billings. These review findings are presented to the HHSC-OIG to determine any necessary action. Medical records may be requested from the provider to substantiate the medical necessity and appropriateness of services billed to Texas Medicaid. Inappropriate service utilization may result in recoupment of overpayments and/or sanctions, or other administrative actions deemed appropriate by the HHSC-OIG. There are instances when a training specialist may be directed to communicate with the provider to offer assistance with the technical or administrative aspects of Texas Medicaid.

At the direction of the HHSC-OIG, a provider's claims may be manually reviewed before payment. Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers are required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (e.g., clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were medically necessary, billed appropriately, and according to Texas Medicaid requirements and policies. Services inconsistent with Texas Medicaid requirements and policies are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied. Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider

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is removed from prepayment review only when determined appropriate by the HHSC-OIG. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns is performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions up to and including exclusion and contract cancellation, as deemed appropriate by the HHSC-OIG as defined in the rules in 1 TAC §§371.1701, 371.1703, 371.1705, 371.1707, 371.1709, 371.1711, and 371.1715. Providers placed on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

Texas Medicaid & Healthcare Partnership
Attention: Prepayment Review MC-A11 SURS
PO Box 203638
Austin, Texas 78720-3638

1.7.11 Provider Certification/Assignment

Texas Medicaid service providers are required to certify compliance with or agree to various provisions of state and federal laws and regulations. After submitting a signed claim to TMHP, the provider certifies the following:

- Services were personally rendered by the *billing provider* or under supervision of the billing provider, if allowed for that provider type, or under a substitute arrangement.
- The information on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the client's diagnosis or treatment. Exception is allowed for special preventive and screening programs (for example, family planning and THSteps).
- Health records document all services billed and the medical necessity of those services.
- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees charged to private-pay patients.
- The provider will not bill Texas Medicaid for services that are provided or offered to non-Medicaid patients, without charge, discounted or reduced in any fashion including, but not limited to, sliding scales or advertised specials. Any reduced, discounted, free, or special fee advertised to the public must also be offered to Texas Medicaid clients.
- Services were provided without regard to race, color, sex, national origin, age, or handicap.
- The provider of health care and services files a claim with Texas Medicaid agreeing to accept the Medicaid reimbursement as payment in full for those services covered under Texas Medicaid. In accordance with 1 TAC §354.1005, the reimbursement for services covers the costs for a covered service, and any function incidental to the provision of a covered service (refer to subsection 1.7.12, "Billing Clients" for more information). The client with Medicaid coverage, or others on their behalf, must not be billed for the amount above that which is paid on allowed services or for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure to follow the appropriate appeal process. However, the client may be billed for noncovered services for which Texas Medicaid does not make any payment. Before providing services, providers should *always* inform clients of their liability for services that are not a benefit of Texas Medicaid, including use of the Client Acknowledgment Statement.
- The provider understands that endorsing or depositing a Texas Medicaid check is accepting money from federal and state funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under federal and state laws.

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Providers must not bill for, and agree not to bill for, any service provided for which the client bears no liability to pay (i.e., free services). The only exceptions to this ban on billing for services that are free to the user are:

- Services offered by or through the Title V agency when the service is a benefit of Texas Medicaid and rendered to an eligible client
- Services included in the Texas Medicaid client's individualized education program (IEP) or individualized family service plan (IFSP) if the services are covered under the Title XIX state plan, even though they are free to the users of the services

Refer to: Subsection 7.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 1.7.11.1, "Delegation of Signature Authority" in this section.

1.7.11.1 Delegation of Signature Authority

A provider delegating signatory authority to a member of the office staff or to a billing service *remains responsible* for the accuracy of all information on a claim submitted for payment. A provider's employees or a billing service and its employees are equally responsible for any false billings in which they participated or directed.

If the claim is prepared by a billing service or printed by data processing equipment, it is permissible to print "Signature on File" in place of the provider's signature. When claims are prepared by a billing service, the billing service must obtain and keep a letter on file that is signed by the provider authorizing claim submission.

1.7.12 Billing Clients

A provider cannot require a down payment before providing Medicaid-allowable services to eligible clients, bill, nor take recourse against eligible clients for denied or reduced claims for services that are within the amount, duration, and scope of benefits of Texas Medicaid if the action is the result of any of the following provider-attributable errors:

- Failure to submit a claim, including claims not received by TMHP
- Failure to submit a claim to TMHP for initial processing within the 95-day filing deadline (or the initial 365-day deadline, if applicable)
- Submission of an unsigned or otherwise incomplete claim such as omission of the Hysterectomy Acknowledgment Statement or Sterilization Consent Form with claims for these procedures
- Filing an incorrect claim
- Failure to resubmit a corrected claim or rejected electronic media claim within the 120-day resubmittal period
- Failure to appeal a claim within the 120-day appeal period. Errors made in claims preparation, claims submission, or appeal process
- Failure to submit a claim to TMHP within 95 days of a denial by the DSHS Family Planning Program for family planning services
- Failure to submit a claim within 95 days from the disposition date from Medicare or a primary third-party insurance resource
- Failure to obtain prior authorization for services that require prior authorization under Texas Medicaid

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Providers must certify that they will accept the reimbursement paid by Texas Medicaid for covered services and will not bill an eligible client for covered services. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business.

Medicaid reimbursement is considered as payment in full for those services covered under Texas Medicaid. In accordance with 1 TAC §354.1005, the reimbursement for services is intended to cover the costs for a covered service, or any function incidental to the provision of a covered service, including, but not limited to:

- Signing, completing, or providing a copy of a health assessment form, such as a physical examination form required for the eligible client's enrollment in school or participation in school or other activities;
- Providing a copy of a medical record requested:
  - By or on behalf of any health care practitioner for purposes of medical care or treatment of the eligible client;
  - As a supplement to a health assessment form or other form provided incidental to a covered service; or
  - By an eligible client, for any reason, for the first time in a one-year period; and
- Providing a copy of any subsequent amendment, supplement, or correction to a medical record requested by or on behalf of the eligible client.
- If the provider has already provided the eligible client a free copy of the medical record within a one-year period, the provider is required to provide only the amended, supplemented, or corrected portion of the record, if requested, without having to copy the entire record.

Note: *A provider may bill or otherwise charge a client a reasonable fee for providing a paper copy of a medical record outside of the above scenarios. A reasonable fee for providing a paper copy of the requested records shall be a charge of no more than $25.00 for the first twenty pages and $.50 per page for every copy thereafter per 22 TAC §165.2.*

Completion of required forms submitted by a nursing facility to the physician for signature is also considered incidental to a covered service. It is not acceptable for the physician to charge Texas Medicaid clients, their family, or the nursing facility for telephone calls, telephone consultations, or signing forms.

In accordance with current federal policy, Texas Medicaid and Texas Medicaid clients cannot be charged for the client's failure to keep an appointment. Only billings for services provided are considered for payment. Clients may not be billed for the completion of a claim form, even if it is a provider's office policy.

Letters of inquiry about client billing are sometimes sent to providers in lieu of telephone calls from TMHP representatives. In either case, it is mandatory that the questions be answered with the requested pertinent information. Upon receipt, TMHP forwards these letters to HHSC. HHSC uses the information to resolve client billing/liability issues. It is mandatory that these letters be signed, dated, and returned within ten business days.

Refer to: The *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about spell-of-illness.

Subsection 4.5, "Medically Needy Program (MNP)" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

Private Pay Agreement on the TMHP website at www.tmhp.com.

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1.7.12.1 Client Acknowledgment Statement

Texas Medicaid only reimburses services that are medically necessary or benefits of special preventive and screening programs such as family planning and THSteps. Hospital admissions denied by the Texas Medical Review Program (TMRP) also apply under this policy.

The provider may bill the client only if:

- A specific service or item is provided at the client's request.
- The provider has obtained and kept a written Client Acknowledgment Statement signed by the client that states:
  - "I understand that, in the opinion of (*provider's name*), the services or items that I have requested to be provided to me on (*dates of service*) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."
  - "Comprendo que, según la opinión del (*nombre del proveedor*), es posible que Medicaid no cubra los servicios o las provisiones que solicité (*fecha del servicio*) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsibilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

A provider is allowed to bill the following to a client without obtaining a signed Client Acknowledgment Statement:

- Any service that is not a benefit of Texas Medicaid (for example, cellular therapy).
- All services incurred on noncovered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered days. Spell of illness limitations do not apply to medically necessary stays for Medicaid clients who are 20 years of age and younger.
- The reduction in payment that is due to the Medically Needy Program (MNP) is limited to children who are 18 years of age and younger and pregnant women. The client's potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If the provider accepts the client as a private pay patient, the provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the client signs written notification so there is no question how the client was accepted. Without written, signed documentation that the Texas Medicaid client has been properly notified of the private pay status, the provider cannot seek payment from an eligible Texas Medicaid client.
- The client is accepted as a private pay patient pending Texas Medicaid eligibility determination and does *not* become eligible for Medicaid retroactively. The provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted. If the client becomes eligible retroactively, the client notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Texas Medicaid claims. If the client becomes eligible, the provider *must* refund any money paid by the client and file Medicaid claims for all services rendered.

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A provider attempting to bill or recover money from a client in violation of the above conditions may be subject to exclusion from Texas Medicaid.

Important: *Ancillary services must be coordinated and pertinent eligibility information must be shared. The primary care provider is responsible for sharing eligibility information with others (e.g., emergency room staff, laboratory staff, and pediatricians).*

1.7.13 General Medical Record Documentation Requirements

The Administrative Simplification Act of HIPAA mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system or the American Dental Association's (ADA) Current Dental Terminology (CDT) system be used to report professional services, including physician and dental services. Correct use of CPT and CDT coding requires using the most specific procedure code that matches the services provided based on the procedure code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

HHSC and TMHP routinely perform retrospective reviews of all providers. HHSC ultimately is responsible for Texas Medicaid utilization review activities. This review includes comparing services billed to the client's clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client's medical record subjects the associated services to recoupment.

Note: *This list is not all-inclusive. Additional and more specific requirements may apply to special services areas.*

Note: *Health-care documentation that is maintained by a provider in a client's record can be maintained in a language other than English; however, when TMHP, HHSC, or any other state/federal agency requests a written record or conducts a documentation review, this health-care documentation must be provided in English and in a timely manner.*

- (Mandatory) All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.
- (Mandatory) Medicaid-enrolled providers must submit claims with their own NPI except when under the agreement of a substitute provider or *locum tenens*.
- (Mandatory) Each page of the medical record documents the patient's name and Texas Medicaid number.
- (Mandatory) A copy of the actual authorization from HHSC or its designee (e.g., TMHP) is maintained in the medical record for any item or service that requires prior authorization.
- (Mandatory) Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.
- (Mandatory) The selection of evaluation and management codes (levels of service) is supported by the client's clinical record documentation. Providers must follow guidelines established in the Current Procedural Terminology (CPT) Manual for Evaluation and Management Services when selecting the level of service provided.
- (Mandatory) The history and physical documents the presenting complaint with appropriate subjective and objective information.

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- (Mandatory) The services provided are clearly documented in the medical record with all pertinent information regarding the patient's condition to substantiate the need and medical necessity for the services.
- (Mandatory) Medically necessary diagnostic lab and X-ray results are included in the medical record and abnormal findings have an explicit notation of follow-up plans.
- (Mandatory) Necessary follow-up visits specify time of return by at least the week or month.
- (Mandatory) Unresolved problems are noted in the record.
- (Desirable) Immunizations are noted in the record as *complete* or *up-to-date*.
- (Desirable) Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.

Note: *An unenrolled provider that renders services and attempts to use the NPI of a provider who is enrolled in Medicaid will not be reimbursed for the services. During retrospective review, any services that were rendered by a provider that was not enrolled in Texas Medicaid and were billed using the NPI of a Medicaid-enrolled provider are subject to recoupment.*

1.7.14 Informing Pregnant Clients About CHIP Benefits

Section 24, S.B. 1188, 79th Legislature, Regular Session, 2005, requires that Medicaid providers rendering services to a pregnant Medicaid client must inform the client of the health benefits for which the client or the client's child may be eligible under the CHIP.

CHIP is available to children whose families have low to moderate income, who earn too much money to qualify for Texas Medicaid, and who do not have private insurance. Some clients may have to pay an enrollment fee.

To qualify for CHIP, a child must be:

- A Texas resident
- 18 years of age or younger
- A citizen or legal permanent resident of the United States
- Must meet all income and resource guidelines

CHIP benefits include:

- Physician, hospital, X-ray, and lab services
- Well-baby and well-child visits
- Immunizations
- Prescription drugs
- Dental services
- DME
- Prosthetic devices (with a $20,000 limit per 12-month period)
- Case coordination and enhanced services for children with special health-care needs and children with disabilities
- Physical, speech, and occupational therapy
- Home health services
- Transplants
- Mental health services

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- Vision services
- Chiropractic services

Individuals may apply for CHIP by downloading and completing the application found on www.insure-kidsnow.gov website or by calling the toll-free CHIP number at 1-800-647-6558.

1.7.15 Home Health Providers

To enroll in Texas Medicaid as a provider of home health services, Home Health Services and Home and Community Support Services Agency (HCSSA) providers must complete the Texas Medicaid Provider Enrollment Application. Medicare certification is required for providers that are licensed as a Licensed and Certified Home Health Agency. Providers that are licensed as a Licensed Home Health Agency are not required to enroll in Medicare as a prerequisite to enrollment with Texas Medicaid.

Licensed and Certified Home Health agencies that are enrolled as Medicaid providers can provide personal care services (PCS) using their existing NPI. PCS for clients who are 20 years of age and younger will be provided by the Texas Health and Human Services Commission (HHSC) under the PCS benefit.

Refer to: Subsection 2.12, "Personal Care Services (PCS) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

To provide CCP services, HCSSA providers must follow the enrollment procedures in subsection 4.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Providers may request prior authorization for home health services by contacting:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

1.7.15.1 Home Health Skilled Nursing and Home Health Aide (HHA) Services Provider Responsibilities

Providers must be a licensed and certified home health agency, enrolled in Texas Medicaid, and must comply with all applicable federal, state, and local laws and regulations and Texas Medicaid policies and procedures. All providers must maintain written policies and procedures:

- That meet the standards of the Texas Family Code, Chapter 32 for obtaining consent for the medical treatment of clients in the absence of the primary caregiver.
- For obtaining physician signatures for all telephone orders within 14 calendar days of receipt of the order.

Providers must only accept clients on the basis of a reasonable expectation that the client's needs can be adequately met in the place of service (POS). The essential elements of safe and effective home health SN or HHA services include a trained parent, guardian, or caregiver, a primary physician, competent providers, and an environment that supports the client's health and safety needs.

Necessary primary and back-up utility, communication, and fire safety systems must be available.

Note: *A parent or guardian, primary caregiver, or alternate caregiver may not provide SN or HHA services to their family member even if he or she is an enrolled provider or employed by an enrolled provider.*

1.7.16 Private Duty Nursing (PDN) Providers

Home health agencies may enroll to provide PDN under the Comprehensive Care Program (CCP). RNs and licensed vocational nurses (LVNs) may enroll independently to provide PDN under CCP.

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Home health agencies must do all of the following:

- Comply with provider participation requirements for home health agencies that participate in Texas Medicaid
- Comply with mandatory reporting of suspected abuse and neglect of children or adults
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent or guardian
- Comply with all requirements in this manual

Independently-enrolled RNs and LVNs must be enrolled as providers in CCP and comply with all of the following:

- The terms of the Texas Medicaid Provider Agreement
- All state and federal regulations and rules relating to Texas Medicaid
- The requirements of this manual, all handbooks, standards, and guidelines published by HHSC

Independently enrolled RNs and LVNs must also:

- Provide at least 30 days' written notice to clients of their intent voluntarily to terminate services except in situations of potential threat to the nurse's personal safety.
- Comply with mandatory reporting of suspected abuse and neglect of children.
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent or guardian.

Independently enrolled RNs must:

- Hold a current license from the Texas Board of Nursing (BON) or another compact state to practice as an RN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the Texas Nursing Practice Act.
- Comply with accepted professional standards and principles of nursing practice.

Independently enrolled LVNs must:

- Hold a current license from the Texas BON to practice as an LVN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the Texas Nursing Practice Act.
- Comply with accepted standards and principles of vocational nursing practice.
- Be supervised by an RN once per month. The supervision must occur when the LVN is present and be documented in the client's medical record.

1.7.17 Certified Respiratory Care Practitioner (CRCP) Services

To enroll in Texas Medicaid, a CRCP must be certified by the Texas Medical Board to practice under the Texas Occupations Code, Chapter 604. For CRCPs, Medicare certification is not a prerequisite for Medicaid enrollment. A provider cannot be enrolled if his license is due to expire within 30 days; a current license must be submitted. CRCPs must enroll as individual providers and comply with all applicable federal, state, and local laws and regulations.

1.7.18 Physical, Occupational, and Speech Therapy Providers

Physical therapists, occupational therapists, and speech-language pathologists must be enrolled in Texas Medicaid according to their specific licensure in order to be reimbursed for services rendered to Texas Medicaid clients.

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Occupational therapists, physical therapist, physical therapy assistants, or occupational therapy assistants must be registered and licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners.

Note: *Auxiliary (aide, orderly, student, or technician), a licensed therapy assistant, and a licensed speech-language pathology intern (Clinical Fellow) are not eligible to enroll as therapy providers in Texas Medicaid.*

Refer to: Subsection 1.1, "Provider Enrollment" in this section for information about enrollment procedures.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

1.7.18.1 CCP Enrollment for Children's Services—20 Years of Age and Younger

Children's therapy services are provided under the Comprehensive Care Program (CCP). Physical, occupational, and speech therapy providers must meet Medicaid and Health and Human Services Commission (HHSC) participation standards to enroll in CCP. All CCP providers must be enrolled in Texas Medicaid to be reimbursed for services.

The following facilities or organizations may also enroll in Texas Medicaid to provide CCP therapy services:

- Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)
- Home Health Services and Home and Community Support Services Agency (HCSSA) providers
- Early Childhood Intervention (ECI) providers
- School Health and Related Services (SHARS) providers

Refer to: Subsection 2.1.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about ECI enrollment.

Subsection 2.1.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about SHARS enrollment.

1.7.19 Children's Services Comprehensive Care Program (CCP)

CCP providers must meet Medicaid and Health and Human Services Commission (HHSC) participation standards to enroll in the program. All CCP providers must be enrolled in Texas Medicaid to be reimbursed for services. Provider enrollment applications can be submitted through PEMS.

Home and community support services agencies (HCSSAs) that want to provide CCP private-duty nursing (PDN), home telemonitoring, occupational therapy, physical therapy, or speech therapy services under the licensed-only home health (LHH) category must first enroll with TMHP. To enroll with TMHP in the LHH category, an HCSSA must:

- Submit a provider enrollment application through PEMS, and select the appropriate provider types based on the LHH category of service.
- Provide its license information, and check the "Only CCP services" box on the form.

1.7.20 Nondiscrimination for Vaccine Status

Medicaid providers are prohibited from refusing to provide health care services to any Medicaid client based solely on the client's refusal or failure to obtain a vaccine or immunization for a particular infectious or communicable disease unless excepted by Texas Government Code §531.02119.

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1.8 Computer-Based Training Courses for Providers

TMHP has created a web page to simplify the process of accessing the computer-based training courses that are available on the TMHP Learning Management System (LMS).

The Provider Education and Training web page gives an overview of the different types of education resources, the TMHP YouTube channel, and the LMS. Providers need to create an LMS account to access training materials. Providers can create an LMS account by clicking the Don't Have An Account? Sign Up Here button on the LMS home page.

1.9 Enrollment Criteria for Out-of-State Providers

Texas Medicaid covers medical assistance services provided to eligible Texas Medicaid clients while in a state other than Texas, as long as the client does not leave Texas to receive out-of-state healthcare that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas.

> ***Note:*** *Border state providers (providers rendering services within 50 miles driving distance of the Texas border) are considered in-state providers.*

The administrative rules governing the enrollment of out-of-state providers are found in 1 TAC §352.17. The rule provides that a Medicaid applicant or re-enrolling provider is considered out-of-state if any of the following criteria are met:

- The physical address where services are or will be rendered is located outside the Texas state border and within the United States.
- The physical address where the services or products originate or will originate is located outside the Texas state border and within the United States when providing services, products, equipment, or supplies to a Medicaid recipient in the state of Texas.
- The physical address where services are or will be rendered is located within the Texas state border, but:
  - The applicant or re-enrolling provider maintains all patient records, billing records, or both, outside the Texas state border and
  - The applicant or re-enrolling provider is unable to produce the originals or exact copies of the patient records or billing records, or both, from the location within the Texas state border where services are rendered.

An applicant or re-enrolling provider that is considered out-of-state is ineligible to participate in Medicaid unless HHSC or its designee approves the enrollment on the basis that the applicant has provided, is providing, or will provide services under one or more of the following criteria:

- The services are medically necessary emergency services to a recipient who is located outside of the state.

  > ***Note:*** *An out-of-state provider seeking enrollment under this criterion must include with the enrollment application a copy of the claim that contains the diagnosis that indicates emergency care or medical record documentation. The documentation must demonstrate that emergency care was provided to a Texas Medicaid client. Providers enrolled under this criterion will be given a time limited enrollment not to exceed one year.*

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- The services are medically necessary to a recipient who is located outside of the state, and in the expert opinion of the recipient's attending or other provider, the recipient's health would be or would have been endangered if the recipient were required to travel to Texas.

  Note: *An out-of-state provider seeking enrollment under this criterion must include supporting clinical records, signed by the attending provider, explaining why the client's health would be or would have been endangered if the client had been required to travel to Texas. Providers enrolled under this criterion will be given a time limited enrollment not to exceed one year.*

- The services are medically necessary and more readily available to a recipient in the state where the recipient is located.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include supporting clinical records, signed by the attending provider, explaining why the services are more readily available in the state where the client in located. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are medically necessary to a recipient who is eligible on the basis of participation in an adoption assistance or foster care program administered by the Texas Department of Family and Protective Services under Title IV-E of the Social Security Act.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include documentation showing that the client is an adopted child or is in a foster care program and/or is receiving adoption subsidies through the programs listed in this criterion. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are medically necessary and have been prior authorized by HHSC or its designee, and documented medical justification indicating the reasons the recipient must obtain medical care outside Texas is furnished to HHSC or its designee before providing the services and before payment.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include documentation showing that the service has been prior authorized by HHSC or its designee (TMHP, or MCO), or supporting clinical documentation (signed by the attending provider) indicating the reasons why the recipient must obtain medical care outside of Texas. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are medically necessary and it is the customary or general practice of Medicaid recipients in a particular locality within Texas to obtain services from the out-of-state provider, if the provider is located in the United States and within 50 miles driving distance from the Texas state border, or as otherwise demonstrated on a case-by-case basis.

  Note: *An out-of-state provider does not meet the criterion in this paragraph merely on the basis of having established business relationships with one or more providers that participate in Medicaid. Attach signed letter from the provider stating why it is customary or general practice of clients in a particular locality within Texas to obtain services from the out-of-state provider. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are medically necessary and the nature of the service is such that providers for this service are limited or not readily available within the state of Texas.

  Note: *An out-of-state provider that seeks enrollment under the criterion must include documentation showing that the services provided by the applicant are medically necessary and are limited or not readily available within the state of Texas.*

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- The services are medically necessary services to one or more dually eligible recipients (i.e., recipients who are enrolled in both Medicare and Medicaid) and the out-of-state provider may be considered for reimbursement of co-payments, deductibles, and co-insurance, in which case the enrollment will be restricted to receiving reimbursement only for the Medicaid-covered portion of Medicare crossover claims.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include documentation for why this criterion applies, Medicare EOB or MRAN, with documented medical justification as well as any additional information requested by HHSC or its designee. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are provided by a pharmacy that is a distributor of a drug that is classified by the U.S. Food and Drug Administration (FDA) as a limited distribution drug.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include with the enrollment application documentation for why this criterion applies with documented medical justification as well as any additional information requested by HHSC or its designee. Attach signed letter from the provider stating that the enrolling pharmacy is a distributor of a drug that is classified by FDA as a limited distribution drug, include a letter from the FDA stating that the aforementioned drug is considered a limited distribution drug. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are medically necessary and one or more of the following exceptions for good cause exist and can be documented:
  - Texas Medicaid enrolled providers rely on the services provided by the applicant.
  - Applicant maintains existing agreements as a participating provider through one or more Medicaid managed care organizations (MCO) and enrollment of the applicant leads to more cost-effective delivery of Medicaid services.
- A laboratory may participate as an in-state provider under any program administered by a health and human services agency, including HHSC, that involves laboratory services, regardless of the location where any specific service is performed or where the laboratory's facilities are located if:
  - The laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains laboratory operations in Texas;
  - The laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory, individually or collectively, employ at least 1,000 persons at places of employment located in this state; and
  - The laboratory is otherwise qualified to provide the services under the program and is not prohibited from participating as a provider under any benefits programs administered by a health and human services agency, including HHSC, based on conduct that constitutes fraud, waste, or abuse.

Out-of-state provides that seek enrollment under one or more of the above criteria must submit an enrollment application and be approved for enrollment.

TMHP must receive claims from out-of-state providers within 365 days from the date of service.

Refer to: Subsection 10.2.1, "Prior Authorization" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

1.10 Medicaid Fraud, Waste, and Abuse Policy

The OIG has the responsibility to identify and investigate cases of suspected fraud, waste, and abuse in Medicaid and other health and human services programs. This responsibility, granted through state and federal law, gives the OIG the authority to pursue administrative sanctions and to refer cases to prose-

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cutors, licensure and certification boards, and other agencies. Additionally, Texas Medicaid is required to disenroll or exclude any provider who has been disenrolled or excluded from Medicare or any other state health-care program.

Anyone participating in Texas Medicaid must understand the requirements for participation. Available methods both to learn and stay up to date on program requirements include the following:

- *Provider education*. Attendance at educational workshops and training sessions. Regular training opportunities are offered by TMHP.
- *Texas Medicaid publications*. These include the *Texas Medicaid Provider Procedures Manual* and banner messages, which are included in R&S Reports.
- *All adopted agency rules*. These include those related to fraud, waste, and abuse contained in 1 TAC Chapter 371.
- *State and federal law*. Statutes and other law pertinent to Texas Medicaid and fraud, waste, and abuse within Texas Medicaid.

In addition, providers are responsible for the delivery of health-care items and services to Medicaid clients in accordance with all applicable licensure and certification requirements and accepted health care professionals' community standards. Such standards include those related to medical record and claims filing practices, documentation requirements, and records maintenance. The TAC requires providers to follow these standards. For more information, consult 1 TAC §371.1659.

Texas Medicaid providers must follow the coding and billing requirements of the *Texas Medicaid Provider Procedures Manual* (TMPPM). However, if coding and billing requirements for a particular service are not addressed in the TMPPM, and if coding and billing requirements are not otherwise specified in program policy (such as in provider bulletins or banners), then providers must follow the most current coding guidelines. These include:

- CPT as set forth in the American Medical Association's most recently published "CPT books", "CPT Assistant" monthly newsletters, and other publications resulting from the collaborative efforts of American Medical Association with the medical societies.
- Healthcare Common Procedure Coding System (HCPCS) as developed and maintained by the federal government.
- National Correct Coding Initiative (NCCI), as set forth by the CMS and as explained in the NCCI Policy and Medicare Claims Processing Manuals. NCCI consists of procedure code combinations that a provider must not bill together. One of the codes in the pair is considered a part of the primary procedure and not reimbursable to the same provider on the same date of service.

Exception: *NCCI outlines use of modifiers some of which are not currently recognized by Texas Medicaid. See the list of modifiers utilized by Texas Medicaid in subsection 6.3.5, "Modifiers" in "Section 6: Claims Filing" (Vol. 1, General Information).*

- *Current Dental Terminology* (CDT) as published by the American Dental Association (ADA).
- Other publications resulting from the collaborative efforts of the ADA with dental societies.
- *International Classification of Diseases*, 10th Revision, Clinical Modification (ICD-10-CM).
- *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Failure to comply with the guidelines provided in these publications may result in a provider being found to have engaged in one or more program violations listed in 1 TAC §371.1659.

All providers are held responsible for any claims preparation or other activities that may be performed under the provider's authority. For example, providers are held responsible for any omissions and the accuracy of submitted information, even if those actions are performed by office staff, contractors, or

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billing services. This, however, does not absolve these other individuals for their participation in any documents provided to the state or designee with false, inaccurate, or misleading information; or pertinent omissions.

HHSC-OIG may impose one or any combination of administrative actions or administrative sanctions on Texas Medicaid providers or other persons when fraud, waste, or abuse is determined. Those who may be sanctioned include:

- Those furnishing services or items directly or indirectly.
- Those billing for services.
- Those violating any of the provisions delineated in this section.
- Affiliates of a provider or person violating any of the provisions delineated in this section.

Administrative sanctions include, without limitation:

- Exclusion from program participation for a specified period of time, permanently, or indefinitely. Anyone excluded from Texas Medicaid is also automatically excluded from all programs under Titles V and XX of the Social Security Act.
- Suspension of Medicaid payments (payment hold) to a provider.
- Recoupment of Medicaid overpayments, including any overpayments determined through statistical sampling and extrapolation.
- Restricted Medicaid reimbursement (specific services will not be reimbursed to an individual provider during the time the provider is on restricted reimbursement; however, reimbursement for other services may continue).
- Cancellation of the Medicaid provider agreement (however, a deactivation in accordance with the agreement itself is not considered a sanction).
- Exclusion or suspension under the authority of the CFR.

Administrative actions include:

- Amending a provider agreement so that it will deactivate on a specific date.
- Granting an agreement or transferring a provider to an agreement with special terms or conditions, including a probationary agreement.
- Required attendance at provider education sessions.
- Prior authorization of selected services.
- Pre-payment review.
- Post-payment review.
- Required attendance at informal or formal provider corrective action meetings.
- Submission of additional documentation or justification that is not normally required to accompany submitted claims. (Failure to submit legible documentation or justification requested will result in denial of the claim.)
- Oral, written, or personal educational contact with the provider.
- Posting of a surety bond or providing a letter of credit.
- Having a subpoena served to compel an appearance for testimony or the production of relevant evidence, as determined by the HHSC-OIG.

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Anyone facing an administrative sanction has a right to formal due process. This formal due process may include a hearing before an administrative law judge. Conversely, anyone facing an administrative action is not entitled to formal due process. People who induce, solicit, receive, offer, or pay any remuneration (including, but not limited to, bribes, kickbacks, or rebates) directly or indirectly in relation to referrals, purchases, leases, or arrangements of services covered by Medicare or Texas Medicaid may be in violation of state statutes and guilty of a federal felony offense. State law also allows for the suspension of providers convicted of a criminal offense related to Medicare or Texas Medicaid. The commission of a felony in Medicaid or Medicare programs may include fines or imprisonment ranging from five years to life in prison. Examples of inducements include a service, cash in any amount, entertainment, or any item of value.

As stated in 1 TAC §§371.1651-371.1669, following is a nonexclusive list of grounds or criteria for the Inspector General's administrative enforcement and/or referral for criminal, civil, or licensure or certification investigation and judicial action regarding program violations by any provider or person. Violations result from a provider or person who knew or should have known the following were violations. The headings of each of the following groups are provided solely for organization and convenience and are not elements of any program violation.

1) Claims and Billing.

   a) Submitting or causing to be submitted a false statement or misrepresentation, or omitting pertinent facts when claiming payment under the Texas Medicaid or other HHS program or when supplying information used to determine the right to payment under the Texas Medicaid or other HHS program;

   b) Submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to obtain greater compensation than the provider is legally entitled to;

   c) Submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to meet prior authorization requirements;

   d) Submitting or causing to be submitted under Title XVIII (Medicare) or a state health-care program claims or requests for payment containing unjustified charges or costs for items or services that substantially exceed the person's usual and customary charges or costs for those items or services to the public or the private pay patients unless otherwise authorized by law;

   e) Submitting or causing to be submitted claims with a pattern of inappropriate coding or billing that results in excessive costs to the Texas Medicaid or other HHS program;

   f) Billing or causing claims to be filed for services or merchandise that were not provided to the recipient;

   g) Submitting or causing to be submitted a false statement or misrepresentation that, if used, has the potential of increasing any individual or state provider payment rate or fee;

   h) Submitting or causing to be submitted to the Texas Medicaid or other HHS program a cost report containing costs not associated with Texas Medicaid or other HHS program or not permitted by Texas Medicaid or other HHS program policies;

   i) Presenting or causing to be presented to an operating agency or its agent a claim that contains a statement or representation that the person knows or should have known to be false;

   j) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items furnished personally by, at the medical direction of, or on the prescription or order of a person who is excluded from Texas Medicaid, other HHS program, or Medicare or has been excluded from and not reinstated within Texas Medicaid, other HHS program, or Medicare;

   k) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items that are not reimbursable by the Texas Medicaid or other HHS program;

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l) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for a service or item which requires a prior order or prescription by a licensed health-care practitioner when such order or prescription has not been obtained;

m) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for an item or service substituted without authorization for the item or service ordered, prescribed or otherwise designated by the Texas Medicaid or other HHS program;

n) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program by a provider or person who is owned or controlled, directly or indirectly, by an excluded person; *and*

o) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program by a provider or person for charges in which the provider discounted the same services for any other type of patient.

2) Records and Documentation.

a) Failing to maintain for the period of time required by the rules relevant to the provider in question records and other documentation that the provider is required by federal or state law or regulation or by contract to maintain in order to participate in the Texas Medicaid or other HHS program or to provide records or documents upon request for any records or documents determined necessary by the Inspector General to complete their statutory functions related to a fraud, waste, and abuse investigation. Such records and documentation include, without limitation, those necessary:

i) To verify specific deliveries, medical necessity, medical appropriateness, and adequate written documentation of items or services furnished under Title XIX or Title XX;

ii) To determine in accordance with established rates appropriate payment for those items or services delivered;

iii) To confirm the eligibility of the provider to participate in the Texas Medicaid or other HHS program; e.g., medical records (including, without limitation, X-rays, laboratory and test results, and other documents related to diagnosis), billing and claims records, cost reports, managed care encounter data, financial data necessary to demonstrate solvency of risk-bearing providers, and documentation (including, without limitation, ownership disclosure statements, articles of incorporation, by-laws, and corporate minutes) necessary to demonstrate ownership of corporate entities; *and*

iv) To verify the purchase and actual cost of products;

b) Failing to disclose fully and accurately or completely information required by the Social Security Act and by 42 CFR Part 455, Subpart B; 42 CFR Part 420, Subpart C; 42 CFR §1001.1101; and 42 CFR Part 431;

c) Failing to provide immediate access, upon request by a requesting agency, to the premises or to any records, documents, and other items or equipment the provider is required by federal or state law or regulation or by contract to maintain in order to participate in the Texas Medicaid or other HHS program (see subparagraphs (a) and (b) of this paragraph), or failing to provide records, documents, and other items or equipment upon request that are determined necessary by the Inspector General to complete their statutory functions related to a fraud, waste, and abuse investigation, including without limitation all requirements specified in 1 TAC §§371.1701, 371.1703, 371.1705, 371.1707, 371.1709, 371.1711, and 371.1715 of this subchapter. "Immediate access" is deemed to be within 24 hours of receiving a request, unless the requesting agency has reason to suspect fraud, waste, or abuse or to believe that requested records, documents, or other items or equipment are about to be altered or destroyed, thereby necessitating access at the actual time the request is presented or, in the opinion of the Inspector General, the request may be completed at the time of the request and/or in less than 24 hours;

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d) Developing false source documents or failing to sign source documents or to retain supporting documentation or to comply with the provisions or requirements of the operating agency or its agents pertaining to electronic claims submittal; *and*

e) Failing as a provider, whether individual, group, facility, managed care or other entity, to include within any subcontracts for services or items to be delivered within Texas Medicaid all information that is required by 42 CFR §434.10(b).

3) Program-Related Convictions.

a) Pleading guilty or nolo contendere, agreeing to an order of probation without adjudication of guilt under deferred adjudication, or being a defendant in a court judgment or finding of guilt for a violation relating to performance of a provider agreement or program violation of Medicare, Texas Medicaid, other HHS program, or any other state's Medicaid program;

b) Pleading guilty or being convicted of a violation of state or federal statutes relating to dangerous drugs, controlled substances, or any other drug-related offense;

c) Pleading guilty of, being convicted of, or engaging in conduct involving moral turpitude;

d) Pleading guilty or being convicted of a violation of state or federal statutes relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct relating to the delivery of a health-care item or service or relating to any act or omission in a program operated or financed by any federal, state, or local government agency;

e) Being convicted in connection with the interference with or obstruction of any investigation into any criminal offense that would support mandatory exclusion under 1 TAC §371.1705 of this subchapter or any offense listed within paragraph (3) of this subsection regarding program-related convictions; *and*

f) Being convicted of any offense that would support mandatory exclusion under 1 TAC §371.1705 of this subchapter.

4) Provider Eligibility.

a) Failing to meet standards required for licensure, when such licensure is required by state or federal law, administrative rule, provider agreement, or provider manual for participation in the Texas Medicaid or other HHS program;

b) Being excluded, suspended or otherwise sanctioned within any federal program involving the provision of health care;

c) Being excluded, suspended or otherwise sanctioned under any state health-care program for reasons bearing on the person's professional competence, professional performance or financial integrity;

d) Failing to fully and/or correctly complete a Provider Enrollment Agreement, Provider Re-enrollment Agreement or other enrollment form prescribed by the relevant operating agency or its agent for enrollment; *and*

e) Loss or forfeiture of corporate charter.

5) Program Compliance.

a) Failing to comply with the terms of the Texas Medicaid or other HHS program contract or provider agreement, assignment agreement, the provider certification on the Texas Medicaid or other HHS program claim form, or rules or regulations published by the Commission or a Medicaid or other HHS operating agency;

b) Violating any provision of the Human Resources Code, Chapter 32 or 36, or any rule or regulation issued under the Code;

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c) Submitting a false statement or misrepresentation or omitting pertinent facts on any application or any documents requested as a prerequisite for the Texas Medicaid or other HHS program participation;

d) Refusing to execute or comply with a provider agreement or amendments when requested;

e) Failing to correct deficiencies in provider operations after receiving written notice of them from an operating agency, the commission or their authorized agents;

f) Failing to abide by applicable federal and state law regarding handicapped individuals or civil rights;

g) Failing to comply with the Texas Medicaid or other HHS program policies, published Texas Medicaid or other HHS program bulletins, policy notification letters, provider policy or procedure manuals, contracts, statutes, rules, regulations, or interpretation previously sent to the provider by an operating agency or the commission regarding any of the authorities listed above, including statutes or standards governing occupations;

h) Failing to fully and accurately make any disclosure required by the Social Security Act, §1124 or §1126;

i) Failing to disclose information about the ownership of a subcontractor with whom the person has had business transactions in an amount exceeding $25,000 during the previous 12 months or about any significant business transactions (as defined by HHS) with any wholly-owned supplier or subcontractor during the previous five years;

j) Failing, as a hospital, to comply substantially with a corrective action required under the Social Security Act, §1886(f)(2)(B);

k) Failing to repay or make arrangements that are satisfactory to the commission to repay identified overpayments or other erroneous payments or assessments identified by the commission or any Texas Medicaid or other HHS program operating agency;

l) Committing an act described as grounds for exclusion in the Social Security Act, §1128A (civil monetary penalties for false claims) or §1128B (criminal liability for health care violations);

m) Defaulting on repayments of scholarship obligations or items relating to health profession education made or secured, in whole or in part, by HHS or the state when they have taken all reasonable steps available to them to secure repayment;

n) Soliciting or causing to be solicited, through offers of transportation or otherwise, Texas Medicaid or other HHS program recipients for the purpose of delivering to those recipients health-care items or services;

o) Marketing, supplying or selling confidential information (e.g., recipient names and other recipient information) for a use that is not expressly authorized by the Texas Medicaid or other HHS program; *and*

p) Failing to abide by applicable statutes and standards governing providers.

Important: *Providers must comply with their applicable licensing agency's laws and regulations, including any related to marketing and advertising, and any applicable state and federal laws and regulations, contractual requirements, and other guidance documents. Providers are encouraged to review the "Provider Marketing Guidelines," which are available on the HHs website at www.hhs.texas.gov/providers/medicaid-business-resources/medicaid-chip-communication-resources.*

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6) Delivery of Health-Care Services.

   a) Failing to provide health-care services or items to Texas Medicaid or other HHS program recipients in accordance with accepted medical community standards or standards required by statute, regulation, or contract, including statutes and standards that govern occupations;

   b) Furnishing or ordering health-care services or items for a recipient-patient under Title XVIII or a state health-care program that substantially exceed the recipient's needs, are not medically necessary, are not provided economically or are of a quality that fails to meet professionally recognized standards of health care; *and*

   c) Engaging in any negligent practice that results in death, injury, or substantial probability of death or injury to the provider's patients.

7) Improper Collection and Misuse of Funds.

   a) Charging recipients for services when payment for the services was recouped by the Texas Medicaid or another HHS program for any reason;

   b) Misapplying, misusing, embezzling, failing to promptly release upon a valid request, or failing to keep detailed receipts of expenditures relating to any funds or other property in trust for a Texas Medicaid or other HHS program recipient;

   c) Failing to notify and reimburse the relevant operating agency or the commission or their agents for services paid by the Texas Medicaid or other HHS programs if the provider also receives reimbursement from a liable third party;

   d) Rebating or accepting a fee or a part of a fee or charge for a Texas Medicaid or other HHS program patient referral;

   e) Requesting from a recipient in payment for services or items delivered within the Texas Medicaid or other HHS program any amount that exceeds the amount the Texas Medicaid or other HHS program paid for such services or items, with the exception of any cost-sharing authorized by the program; *and*

   f) Requesting from a third party liable for payment of the services or items provided to a recipient under the Texas Medicaid or other HHS program, any payment other than as authorized at 42 CFR §447.20.

8) Licensure Actions.

   a) Having a voluntary or involuntary action taken by a licensing or certification agency or board that requires the provider or employee to comply with professional practice requirements of the board after the board receives evidence of noncompliance with licensing or certification requirements; *and*

   b) Having its license to provide health care revoked, suspended, or probated by any state licensing or certification authority, or losing a license or certification, because of action based on assessment of the person's professional competence, professional performance, or financial integrity, non-compliance with Health and Safety Code, statutes governing occupations, or surrendering a license or certification while a formal disciplinary proceeding is pending before licensing or certification authorities when the proceeding concerns the person's professional competence, professional performance, or financial integrity.

9) MCOs and Persons Providing Services or Items Through Managed Care.

   Note: *This paragraph includes those program violations that are unique to managed care; paragraphs (1) through (8) and (11) of this section also apply to managed care.*

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a) Failing, as an MCO, or an association, group or individual health-care provider furnishing services through an MCO, to provide to recipient enrollee a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;

b) Failing, as an MCO or an association, group or individual health-care provider furnishing services through an MCO, to provide to an individual a health-care benefit, service or item that the organization is required to provide by state or federal law, regulation or program rule;

c) Engaging, as an MCO, in actions that indicate a pattern of wrongful denial or payment for a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;

d) Engaging, as an MCO, in actions that indicate a pattern of wrongful delay of at least 45 days or a longer period specified in the contract with an operating agency, not to exceed 60 days, in making payment for a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;

e) Engaging, as an MCO or an association, group or individual health-care provider furnishing services through managed care, in a fraudulent activity in connection with the enrollment in the organization's managed care plan of an individual eligible for medical assistance or in connection with marketing the organization's services to an individual eligible for medical assistance;

f) Discriminating against enrollees or prospective enrollees on any basis, including, without limitation, age, gender, ethnic origin or health status;

g) Failing, as an MCO, to comply with any term within a contract with a Texas Medicaid or other HHS program operating agency to provide healthcare services to Texas Medicaid or HHS program recipients; and

h) Failing, as an MCO, reasonably to provide to the relevant operating agency, upon its written request, encounter data and/or other data contractually required to document the services and items delivered by or through the MCO to Texas Medicaid or other HHS program recipients.

10) Cost-Report Violations.

a) Reporting noncovered or nonchargeable services as covered items; e.g., incorrectly apportioning or allocating costs on cost reports; including costs of noncovered services, supplies or equipment in allowable costs; arrangements between providers and employees, related parties, independent contractors, suppliers, and others that appear to be designed primarily to overstate the costs to the program through various devices (such as commissions or fee splitting) to siphon-off or conceal illegal profits;

b) Reporting costs not incurred or which were attributable to nonprogram activities, other enterprises or personal expenses;

c) Including unallowable cost items on a cost report;

d) Manipulating or falsifying statistics that result in overstatement of costs or avoidance of recoupment, such as incorrectly reporting square footage, hours worked, revenues received, or units of service delivered;

e) Claiming bad debts without first genuinely attempting to collect payment;

f) Depreciating assets that have been fully depreciated or sold or using an incorrect basis for depreciation; *and*

g) Reporting costs above the cost to the related party.

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11) Kickbacks and Referrals.

a) Violating any of the provisions specified in 1 TAC §371.1655 (30) of this subchapter relating to kickbacks, bribes, rebates, referrals, inducements, or solicitation;

b) As a physician, referring a Texas Medicaid or other HHS program patient to an entity with which the physician has a financial relationship for the furnishing of designated health services, payment for which would be denied under Title XVIII (Medicare) pursuant to §1877 and §1903(s) of the Social Security Act (Stark I and II). Neither federal financial participation nor this state's expenditures for medical assistance under the state Medicaid plan may be used to pay for services or items delivered within the program and within a relationship that violates Stark I or II. The Commission hereby references and incorporates within these rules the federal regulations promulgated pursuant to Stark I and II, and expressly recognizes all exceptions to the prohibitions on referrals established within those rules;

c) Failing to disclose documentation of financial relationships necessary to establish compliance with Stark I and II, as set forth in subparagraph (b) of this paragraph; *and*

d) Offering to pay or agreeing to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered or enrolled as a provider or otherwise by a state health-care regulatory or health and human service agency.

Involvement in any of these practices may result in provider exclusion or suspension from Texas Medicaid. Providers are notified in writing of any actions taken as well as procedures for appeal and reinstatement. The written notification will specify the date on which Medicaid program participation may resume. The reinstated person may then apply for a contract or provider agreement.

Providers and individuals who have been excluded from Texas Medicaid may be reinstated only by HHSC-OIG. If HHSC-OIG approves an individual's request for reinstatement, a written notice will be sent to that individual. The provider must first be reinstated into Medicaid and receive written notification specifying the date on which Medicaid program participation may resume. Once the provider has been reinstated into Medicaid, the provider may then apply for a contract or provider agreement.

Full investigation of criminal Medicaid fraud is the MFCU's responsibility and may result in a felony or misdemeanor criminal conviction.

1.10.1 Reporting Fraud, Waste, and Abuse

Anyone with knowledge about suspected Medicaid fraud, waste, and abuse of provider services must report the information to the HHSC-OIG. To report fraud, waste, and abuse, visit https://oig.hhs.texas.gov/report-fraud-waste-or-abuse and select **IG's Fraud Reporting Form**. Fraud, waste, and abuse may also be reported by calling the OIG hotline at 1-800-436-6184. All reports of fraud, waste, and abuse received through either channel remain confidential.

HHSC-OIG encourages providers to voluntarily investigate and report fraud, waste, abuse, or inappropriate payments of Medicaid funds in their own office. Providers are required to report these activities to HHSC-OIG when identified. HHSC-OIG will work collaboratively with self-reporting providers. More information about provider self-reporting is available on the OIG website at https://oig.hhs.texas.gov/resources/information-providers.

1.10.2 Suspected Cases of Provider Fraud, Waste, and Abuse

HHSC-OIG is responsible for minimizing fraud, waste, and abuse by Medicaid providers. HHSC-OIG has established and continues to refine criteria for identifying cases of possible fraud, waste, and abuse and recouping provider overpayments. When HHSC-OIG identifies fraud, waste, and abuse, a case may be referred to the MFCU or Antitrust and Civil Medicaid Fraud Section, or result in administrative enforcement.

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1.10.3 Employee Education on False Claims Recovery

Title 42 United States Code (U.S.C.) §1396a(a)(68) requires any entity that receives or makes annual Medicaid payments of at least $5,000,000 to establish written policies that provide detailed information about each employee's role in preventing and detecting waste, fraud, and abuse in federal health-care programs. These written policies, which must apply to all employees of the entity (including management) and the employees of any contractor or agent of the entity, must address:

- The federal False Claims Act (31 U.S.C. §§ 3729-3733).
- Administrative remedies for false claims and statements as provided in 31 U.S.C. §3802.
- Texas law relating to civil and criminal penalties for false claims (including Chapter 36 of the Human Resources Code; section 35A.02 of the Penal Code; Title 1, Chapter 371, Subchapter G of the TAC; and other applicable law).
- Whistleblower protections under the above laws (including section 36.115 of the Human Resources Code).

In addition, these written policies must include detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The entity must also include a specific discussion of the following in all employee handbooks:

- The above laws
- The entity's policies and procedures for detecting and preventing fraud, waste, and abuse
- The rights of employees to be protected as whistleblowers

TMHP sends a yearly letter to each provider that receives over $5,000,000 in Medicaid payments. This letter requires providers to verify that they have educated their staff on the False Claims Act. Failure to return this letter, signed by the provider, may result in an administrative hold on the provider's Texas Medicaid payments.

1.10.4 Managed Care Organization (MCO) Special Investigative Unit (SIU)

All MCOs that contract with HHSC to administer managed care benefits to Texas Medicaid clients are required to establish and maintain an SIU that works in cooperation with HHSC-OIG and the OAG.

Refer to: Texas Government Code §540.0058, §544.0352, §544.0502, 1 TAC §353.501–353.505, and §370.501–370.505 for additional information.

The MCO and SIU will do the following:

- The MCO must maintain the SIU within the MCO or contract with another entity for any investigation.
- The established SIU will identify and investigate cases of suspected fraud, waste, and abuse in Texas Medicaid in accordance with Title 1, Chapter 353, Subchapter F of the TAC.
- The MCO and SIU (as applicable) must submit the following:
  - An annual plan that has been adopted by the MCO and approved by HHSC-OIG describing how it will prevent and reduce fraud, waste, and abuse in accordance with 1 TAC, §§353.501 and 353.502.
  - A monthly open case list to OIG Medicaid Program Integrity and the MFCU.

The MCO will refer a case to both HHSC-OIG and MFCU in the following situations:

- When fraud, waste, and abuse is discovered in the Medicaid or CHIP programs. (The MCO SIU must immediately notify the HHSC-OIG and MFCU and begin payment recovery efforts, unless HHSC-OIG or MFCU notifies the MCO to stop the recovery effort, as provided in Texas Government Code §544.0502.)

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- When possible fraud, waste, and abuse is discovered in the Medicaid or CHIP programs. (The MCO SIU must refer the alleged fraud, waste, or abuse to HHSC-OIG within 30 working days of completing a review. The SIU report and referral must completely and accurately detail its findings in accordance with 1 TAC §353.502.)
- When there is reason to believe that a delay in the referral may result in:
  - Harm or death to patients
  - Loss, destruction, or alteration of valuable evidence
  - Significant monetary loss that may not be recoverable
  - Hindrance of an investigation or criminal prosecution of the offense

1.11 Texas Medicaid Limitations and Exclusions

Medicaid pays for services on behalf of clients to the provider of service according to Texas Medicaid's limitations and procedures. TMHP does not make Medicaid payments directly to clients.

The following services, supplies, procedures, and expenses are not benefits of Texas Medicaid. This list is *not* all inclusive.

- Autopsies
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Cellular therapy
- Chemolase injection (chymodiactin, chymopapain)
- Dentures or endosteal implants for adults
- Ergonovine provocation test
- Excise tax
- Fabric wrapping of abdominal aneurysms
- Hair analysis
- Heart–lung monitoring during surgery
- Histamine therapy–intravenous
- Hyperthermia
- Hysteroscopy for infertility
- Immunizations or vaccines unless they are otherwise covered by Texas Medicaid (These limitations do not apply to services provided through the THSteps Program.)
- Immunotherapy for malignant diseases
- Infertility
- Inpatient hospital services to a client in an institution for mental disease or a nursing section of public institutions for persons with intellectual disabilities
- Inpatient hospital tests that are not specifically ordered by a provider who is responsible for the diagnosis or treatment of the client's condition
- Intragastric balloon for obesity
- Joint sclerotherapy

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- Keratoprosthesis/refractive keratoplasty
- Laetrile
- Mammoplasty for gynecomastia
- More than $200,000 per client per benefit year (November 1 through October 31) for any health-care and remedial care services provided to a hospital inpatient by the hospital (If the $200,000 amount is exceeded because of an admission for an approved organ transplant, the allowed amount for that claim is excluded from the computation. This limitation does not apply to clients eligible for CCP or clients with an organ transplant.)
- More than 30 days of inpatient hospital stay per spell of illness (Each spell of illness must be separated by 60 consecutive days during which the client has not been an inpatient in a hospital.)

Important: *CCP provides medically necessary, federally allowable treatment for Medicaid/THSteps clients who are 20 years of age and younger. Some health-care services that usually would not be covered under Medicaid may be available to CCP-eligible clients. An additional 30-day spell of illness begins with the date of specified covered organ transplant. No spell-of-illness limitation exists for Medicaid THSteps clients who are 20 years of age and younger.*

- Obsolete diagnostic tests
- Oral medications, except when claims are submitted by a hospital for services that are provided given in the emergency room or the inpatient setting (Hospital take-home drugs or medications given to the client are not a benefit.)

Important: *Outpatient prescription medications are covered through the Vendor Drug Program. Refer to Subsection 1.1, "About the Vendor Drug Program" in the Outpatient Drug Services Handbook (Vol. 2, Provider Handbooks) for more information.*

- Orthoptics (except CCP)
- Outpatient and nonemergency inpatient services provided by military hospitals
- Outpatient mental health services provided by a psychiatric assistant, psychological assistant (excluding Master's level LPA), or a licensed chemical dependency counselor
- Oxygen (except CCP and home health)
- Parenting skills
- Payment for eyeglass materials or supplies regardless of cost if they do not meet Texas Medicaid specifications
- Payment to physicians for supplies (All supplies, including anesthetizing agents such as *Xylocaine*, inhalants, surgical trays, or dressings, are included in the surgical payment.)
- Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician
- Prescription medications and surgical procedures used for the purposes of transitioning biological sex, including sex change operations, except when provided to individuals with a medically verifiable genetic disorder of sex development
- Private room facilities except when:
  - A critical or contagious illness exists that results in disturbance to other patients and is documented as such.
  - It is documented that no other rooms are available for an emergency admission.
  - The hospital only has private rooms.

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- Procedures and services considered experimental or investigational

  Note: *Routine patient care costs for individuals enrolled in qualifying clinical trials may be covered as medically necessary when those services are current Texas Medicaid benefits. Refer to subsection 1.12, "Routine Patient Care Costs for Individuals Enrolled in Qualifying Clinical Trials" in this section for further information.*

- Procedures and treatments as defined by Chapter 161, Section 161.702 of the Texas Health and Safety Code
- Procedures, services, supplies, treatments, and prescription medications prohibited by Texas state law
- Prosthetic and orthotic devices (except CCP)
- Prosthetic eye or facial quarter
- Psychiatric services:
  - Outpatient behavioral health services for which no prior authorization has been given

Refer to: Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

- Quest test (infertility)
- Recreational therapy
- Review of old X-ray films
- Routine cardiovascular and pulmonary function monitoring during the course of a surgical procedure under anesthesia
- Separate fees for completing or filing a Medicaid claim form (The cost of claims filing is to be incorporated in the provider's usual and customary charges to all clients.)
- Services and supplies to any resident or inmate in a public institution
- Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of Texas Medicaid
- Services or supplies for which claims were not received within the filing deadline
- Services or supplies that are not reasonable and necessary for diagnosis or treatment
- Services or supplies that are not specifically provided by Texas Medicaid
- Services or supplies provided in connection with cosmetic surgery except:
  - As required for the prompt repair of accidental injury
  - For improvement of the functioning of a malformed body member
  - When prior authorized for specific purposes by TMHP (including removal of keloid scars)
- Services or supplies provided outside of the U.S., except for deductible or coinsurance portions of Medicare benefits as provided for in this manual
- Services or supplies provided to a client after a finding has been made under utilization review procedures that these services or supplies are not medically necessary
- Services or supplies provided to a Texas Medicaid client before the effective date of his or her designation as a client, or after the effective date of his or her denial of eligibility
- Services that are payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party

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- Services that are provided by an interpreter (except sign language interpreting services requested by a physician)
- Services that are provided by ineligible, suspended, or excluded providers
- Services that are provided by the client's immediate relative or household member
- Services that are provided by Veterans Administration facilities or U.S. Public Health Service Hospitals
- Sex change operations
- Silicone injections
- Social and educational counseling except for certain health and disability related and counseling services
- Sterilization reversal
- Sterilizations (including vasectomies) unless the client has given informed consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent (This policy complies with 42 CFR §441.250, Subpart F.)
- Take-home and self-administered drugs except as provided under the Vendor Drug Program or family planning pharmacy services or for clients being treated for a substance use disorder
- Tattooing (commercial or decorative only)
- Telephone calls with clients or pharmacies (except as allowed for case management)
- Thermogram
- Treatment of flatfoot conditions for solely cosmetic purposes, the prescription of supportive devices (including special shoes), and the treatment of subluxations of the foot

Refer to the applicable handbooks in Volume 2 of this manual for additional information.

1.12 Routine Patient Care Costs for Individuals Enrolled in Qualifying Clinical Trials

Medicaid may cover medically necessary services for individuals enrolled in a qualifying clinical trial. Routine patient costs include:

- Items or services provided during a clinical trial that would be covered otherwise, including administration charges associated with the investigational item or service. Examples include physician services, medical imaging or laboratory services to monitor, treat, prevent, or diagnose complications that arise during participation in the clinical trial when they would otherwise be covered outside of participation in the qualifying clinical trial.
- Items or services must be billed by an enrolled Texas Medicaid provider.

Services that are not covered benefits of Texas Medicaid include:

- Investigational items or services that are the subject of the qualifying clinical trial and services that would not be covered outside of the trial.
- Items or services delivered to satisfy data reporting for the study.
- Items or services that would be covered outside of the clinical trial but are already a service or benefit covered within the clinical trial.
- Items or services that are not approved by the state plan.

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Providers should use the "Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial Form" and maintain it as part of the patient's medical record. Providers must make the form available upon request. Providers are not required to submit this form with the claim.

Note: *The Medicaid Attestation Form on the Appropriateness of the Qualified Clinic Trial Form can be found in the Coverage of Routine Patient Cost in Qualifying Clinical Trials - Consolidated Appropriations Act section of the Medicaid SPA Processing Tools for States website.*

Providers must check eligibility and coverage prior to billing. Providers can obtain coverage and fee information using the Online Fee Lookup (OFL) functionality on the TMHP website.

Refer to: Subsection 4.1.10, "Eligibility Verification" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for ways to verify client eligibility.

"Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for general information about prior authorization.

Note: *Providers can obtain client eligibility information for a client who is enrolled in a Medicaid managed care organization (MCO) from the MCO's web page. Providers can also check the MCO's web page for submission of electronic claims, prior authorization requests, claim appeals and reconsiderations, exchange of clinical data, and other documentation necessary for prior authorization and claim processing.*

1.13 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Authorization to Release Confidential Information
Authorization to Release Confidential Information (Spanish)
Child Abuse Reporting Guidelines
Child Abuse Reporting Guidelines--Checklist for HHSC Monitoring
Electronic Remittance Advice (ERA) Agreement
Private Pay Agreement
Texas Medicaid Group Volume Consent Form

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Section 2: Texas Medicaid Fee-for-Service Reimbursement

Texas Medicaid Provider Procedures Manual: Vol. 1

November 2026

TEXAS
Health and Human Services

SECTION 2: TEXAS MEDICAID FEE-FOR-SERVICE REIMBURSEMENT

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2.1 Payment Information

Texas Medicaid reimbursements are available to all enrolled providers by check or electronic funds transfer (EFT).

Refer to: Subsection 1.2, "Payment Information" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2 Fee-for-Service Reimbursement Methodology

Texas Medicaid reimburses providers using several different reimbursement methodologies, including fee schedules, reasonable cost with interim rates, hospital reimbursement methodology, provider-specific encounter rates, reasonable charge payment methodology, and manual pricing. Each Texas Medicaid service describes the appropriate reimbursement for each service area.

Note: *If a client is covered by a Medicaid managed care organizations (MCO) or dental plan, providers must contact the client's MCO or dental plan for reimbursement information. The MCOs and dental plans are not required to follow the Texas Medicaid fee schedules, so there may be some differences in reimbursement based on decisions made by the individual health and dental plans.*

2.2.1 Online Fee Lookup (OFL) and Static Fee Schedules

Texas Medicaid reimburses certain providers based on rates published in the OFL and static fee schedules. These rates are uniform statewide and by provider type. According to this type of reimbursement methodology, the provider is paid the lower of the billed charges or the Medicaid rate published in the applicable static fee schedule or OFL.

Providers can obtain fee information using the OFL functionality on the TMHP website at www.tmhp.com.

The online OFL can be used to:

- Retrieve real-time fee information.
- Search for procedure code reimbursement rates individually, in a list, or in a range.
- Search and review contracted rates for a specific provider (provider must login).
- Retrieve up to 24 months of history for a procedure code by searching for specific dates of service within that 2-year period.
- Search for benefit limitations for dental and durable medical equipment (DME) procedure codes.

Providers can obtain the static fee schedules as *Microsoft Excel*® spreadsheets or portable document format (PDF) files from the TMHP website at www.tmhp.com.

Type of service (TOS) codes payable for each procedure code are available on the OFL and the static fee schedules.

The following provider types and services are reimbursed based on rates published with the rates calculated in accordance with the referenced reimbursement methodology as published in the Texas Administrative Code (TAC), Part 1 Administration, Part 15 Texas Health and Human Services Commission (HHSC), and Chapter 355 Reimbursement Rates.

- *Ambulance*. The Medicaid rates for ambulance services are calculated in accordance with 1 TAC §355.8600.
- *Ambulatory Surgical Center (ASC)*. The Medicaid rates for ASCs are calculated in accordance with 1 TAC §355.8121.
- *Case Management for Children and Pregnant Women*. The Medicaid rates for this service are calculated in accordance with 1 TAC §355.8401.

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- *Targeted Case Management for Early Childhood Intervention (ECI)*. The Medicaid rate for this service is reimbursed in accordance with 1 TAC §§355.8421.
- *Specialized Skills Training for ECI*. The Medicaid rate for this service is reimbursed in accordance with 1 TAC § 355.8422
- *Certified Nurse-Midwife (CNM)*. The Medicaid rates for CNMs are calculated in accordance with 1 TAC §355.8161.
- *Certified Registered Nurse Anesthetist (CRNA)*. According to 1 TAC §355.8221, the Medicaid rate for CRNAs is 92 percent of the rate reimbursed to a physician anesthesiologist for the same service.
- *Certified Respiratory Care Practitioner (CRCP) Services.* The Medicaid rate per daily visit for 99503 is calculated in accordance with 1 TAC §355.8089.
- *Chemical Dependency Treatment Facility (CDTF)*. The Medicaid rates for CDTF services are calculated in accordance with 1 TAC §355.8241.
- *Chiropractic Services*. The Medicaid rates for chiropractic services are calculated in accordance with 1 TAC §355.8085.
- *Dental*. The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §355.8085, 1 TAC §355.8441(11), and 1 TAC §355.455(b).
- *Durable Medical Equipment, Prostheses, Orthoses and Supplies (DMEPOS)*. DMEPOS items provided by home health agencies and providers/suppliers of DMEPOS are reimbursed in accordance with 1 TAC §355.8023. DMEPOS items provided by the Comprehensive Care Program (CCP) are reimbursed in the same manner, in accordance with 1 TAC §355.8441.
- *Family Planning Services*. The Medicaid rates for family planning services are calculated in accordance with 1 TAC §355.8581.
- *Genetic Services*. The procedure codes and Medicaid rates for genetic services are listed in the OFL or the Physician - Genetics fee schedule on the TMHP website at www.tmhp.com.
- *Hearing Aid and Audiometric Evaluations*. Hearing screening services for newborns are provided at the birthing facility before discharge and reimbursed in accordance with the reimbursement methodology for the specific type of birthing facility. Outpatient hearing screening and diagnostic testing services for children are provided by physicians and are reimbursed in accordance with the reimbursement methodology for physician services at 1 TAC §355.8085, 1 TAC §355.8141, and 1 TAC §355.8441.
- *Texas Medicaid (Title XIX) Home Health Services*. The reimbursement methodology for home health nursing and aide services delivered by home health agencies are statewide visit rates calculated in accordance with 1 TAC §355.8021.
- *Independent Laboratory*. The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for a clinical laboratory service cannot exceed the Medicare payment for that service. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/Texas Health Steps medical and newborn screening laboratory services provided by the Department of State Health Services (DSHS) Laboratory are reimbursed based on the Medicare payment for that service.
- *Indian Health Services*. The reimbursement methodology for services provided in Indian Health Services Facilities operating under the authority of Public Law 93-638 is located at 1 TAC §355.8620.
- *In-Home Total Parenteral Nutrition (TPN) Supplier*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8087.

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- *Licensed Clinical Social Worker (LCSW)*. According to 1 TAC §355.8091, the Medicaid rate for LCSWs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.
- *Licensed Marriage and Family Therapist (LMFT)*. According to 1 TAC §355.8091, the Medicaid rate for LMFTs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.
- *Licensed Midwife (LM).* According to 1 TAC §355.8161, covered professional services provided by an LM and billed under the LM's own provider number are reimbursed the lesser of the LM's billed charges or 70 percent of the reimbursement for the same professional service paid to a physician (M.D. or D.O.).
- *Licensed Professional Counselor (LPC)*. According to 1 TAC §355.8091, the Medicaid rate for LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.
- *Maternity Service Clinic (MSC)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8085.
- *Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)*. According to Title 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.
- *Physical (PT), Occupational (OT), and Speech (ST) Therapy Services*. Covered therapy services provided by home health agencies, comprehensive outpatient rehabilitation facilities or outpatient rehabilitation facilities, independent therapists (including Early Childhood Intervention) and physicians and other practitioners are reimbursed according to 1 TAC §355.8097.
- *Physical Therapists/Independent Practitioners*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8085.
- *Physician*. The Medicaid rates for physicians and other practitioners are calculated in accordance with 1 TAC §355.8085.
- *Physician Assistant (PA)*. According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.
- *Psychologist*. The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8085.
- *Radiological and Physiological Laboratory and Portable X-Ray Supplier*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8085.
- *Renal Dialysis Facility*. The Medicaid rates for these providers are composite rates based on calculations specified by the Centers for Medicare & Medicaid Services (CMS).
- *School Health and Related Services (SHARS)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8443.
- Texas Health Steps reimburses by provider type in accordance with 1 TAC §355.8441. Approved providers enrolled in Texas Medicaid are reimbursed for THSteps services in the same manner as they are reimbursed for other Medicaid services. THSteps CCP reimburses for DME and expendable supplies in accordance with 1 TAC §355.8441(2).
- Telemedicine, telehealth, and home telemonitoring services are reimbursed in accordance with 1 TAC 355.7001.

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- *Tuberculosis (TB) Clinics*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8085.
- *Vision Care (Optometrists, Opticians)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355. 8001 and §355.8085.

2.2.1.1 Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare and Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices. The limit is 60 percent of the Medicaid rate for the non-emergency service furnished in physician offices.

Reimbursement for non-emergent and non-urgent services that are rendered by the facility during the emergency room visit will be limited to 125 percent of the adult, physician office visit fee for procedure code 99202. Reimbursement will not be reduced for those services that were rendered to address conditions that meet any of the following criteria:

- Problems of high-severity
- Problems that require urgent evaluation by a physician
- Problems that pose immediate and significant threats to physical or mental function
- Critically ill or critically injured

Non-emergent and non-urgent services that are rendered by rural hospitals will be reimbursed at 55 percent of the allowed rates.

Non-rural hospitals will receive a flat rate which is limited to 125 percent of the adult, physician office visit fee for procedure code 99202.

Diagnostic services, such as laboratory and radiology, will not be reduced by 40 percent.

Refer to: Subsection 9.2.60.4.5, "Physician Services Provided in the Emergency Department" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about non-emergent and non-urgent services rendered in the emergency department.

Subsection 4.2.2.1, "Emergency Department Payment Reductions" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about non-emergent and non-urgent services rendered in the emergency department.

These procedures are designated with note code "1" in the current fee schedule or OFL on the TMHP website at www.tmhp.com.

The following services are excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs)
- Surgical services that are covered ASC/hospital-based ambulatory surgical center (HASC) services
- Anesthesiology and radiology services
- Prenatal services when billed with modifier TH and the appropriate E/M procedure code to the highest level of specificity
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client's health

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- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

2.2.1.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2.2.1.3 Drugs and Biologicals

Physician-administered drugs and biologicals are reimbursed under Texas Medicaid as access-based fees under the physician fee schedule in accordance with 1 TAC §355.8085. Physicians and other practitioners are reimbursed for physician-administered drugs and biologicals at the lesser of their usual and customary or billed charges and the Medicaid fee established by the HHSC. The Medicaid fee is an estimate of the provider's acquisition cost for the specific drug and biological. An invoice must be submitted when it is in the provider's possession. Submission of an invoice will document that the provider is billing the lesser of the usual and customary charge or the access-based fee.

HHSC reserves the option to use other data sources to determine Medicaid fees for drugs and biologicals when AWP or ASP calculations are determined to be unreasonable or insufficient.

Prescriptions are covered under the Texas Vendor Drug Program (VDP). The reimbursement methodology for pharmacy services is located at 1 TAC §§355.8541–355.8551.

Important: *Outpatient prescription medications are covered through the Medicaid Vendor Drug Program. Refer to Subsection 1.1, "About the Vendor Drug Program" in the Outpatient Drug Services Handbook (Vol. 2, Provider Handbooks) for more information.*

2.2.2 Cost Reimbursement

Medicaid providers who are cost reimbursed are subject to cost reporting, cost reconciliation, and cost settlement processes, including time study requirements.

The following providers are cost reimbursed in accordance with the noted TAC rules:

- 1 TAC §355.743—Mental health (MH) case management
- 1 TAC §355.746—Mental retardation (MR) service coordination
- 1 TAC §355.781—MH rehabilitative services
- 1 TAC §355.8443—School Health and Related Services (SHARS)
- 1 TAC §355.8061—Outpatient Hospital Reimbursement
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology

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2.2.3 Reasonable Cost and Interim Rates

Outpatient hospital services are reimbursed in accordance with 1 TAC §355.8061. The reimbursement methodology is based on reasonable costs, and providers are reimbursed at an interim rate based on the provider's most recent Medicaid cost report settlement. To determine the provider's payable amount, the interim rate is applied to the claim details allowed amount.

2.2.4 Hospitals

Inpatient and outpatient hospital services are reimbursed as follows:

- 1 TAC §355.8052—Inpatient Hospital Reimbursement
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology
- 1 TAC §355.8058—Inpatient Direct Graduate Medical Education (GME) Reimbursement
- 1 TAC §355.8060—Reimbursement Methodology for Freestanding Psychiatric Facilities
- 1 TAC §355.8061—Outpatient Hospital Reimbursement
- 1 TAC §355.8065—Disproportionate Share Hospital (DSH) Reimbursement Methodology
- 1 TAC §355.8066—Hospital-Specific Limit Methodology

2.2.5 Provider-Specific Visit Rates

Medicaid provider-specific prospective payment system (PPS) visit rates for RHCs are calculated in accordance with 1 TAC §355.8101, and those for federally qualified health centers (FQHCs) are calculated in accordance with 1 TAC §355.8261.

Refer to: Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*)

Section 8, "Rural Health Clinic" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.6 Manual Pricing

When services or products do not have an established reimbursement amount, the detail or claim is manually reviewed to determine an appropriate reimbursement. The manual pricing methodology for DME and expendable supplies is included with the reimbursement methodology for these products. DME and medical supplies, other than nutritional products, that have no established fee are subject to manual pricing at the documented MSRP less 18 percent or the provider's documented invoice cost.

2.3 Reimbursement Reductions

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

2.4 Using Payouts to Satisfy Accounts Receivables Across Programs and Alternate Legacy Identifiers (IDs)

The TMHP accounts receivable process identifies funds that a provider owes to TMHP and subtracts these funds from payments to the provider. TMHP satisfies outstanding accounts receivables using all available funds from the providers' Medicaid payouts, as well as managed care payouts, until the accounts receivables have been recovered. Outstanding balances are recovered as follows:

- For outstanding fee-for-service accounts receivables, TMHP first recovers funds from any available *fee-for-service* payments. If there is still an accounts receivable balance for that week's financial cycle, TMHP recovers funds from any available *managed care* payments.

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- For outstanding managed care accounts receivables, TMHP first recovers funds from any available *managed care* payments. If there is still an accounts receivable balance for that week's financial cycle, TMHP will recover funds from any available *fee-for-service* payments

1099 Reports

Providers receive one 1099 report for each legacy ID. The 1099 report has combined information for both fee-for-service and managed care programs.

Paper Remittance and Status (R&S) Report

The summary page of the R&S report has combined information from the fee-for-service and managed care programs.

The Financial Transactions Sub-Owner Recoupment page has accounts receivable for both programs. A column on the page identifies the program (Medicaid [fee-for-service] or Managed Care) from which the funds were recouped.

The Financial Transactions Accounts Receivable page has the accounts receivable for both programs. A column identifies the program (Medicaid [fee-for-service] or Managed Care) from which the funds were recouped.

The Original Date in the Accounts Receivable section of the R&S Report reflects the date on which the accounts receivable first appeared on the R&S Report.

ER&S Report

The Pending and Non-Pending ER&S Reports have combined information for both programs.

2.4.1 HHSC Recoupment of Accounts Receivables from Legacy Identifiers (IDs)

HHSC recoups the outstanding accounts receivable balances of all existing Medicaid and managed care legacy IDs from alternate legacy IDs that use the same Tax ID or National Provider Identifier (NPI).

If a Medicaid or managed care provider has a legacy ID that is no longer active or has been terminated and that legacy ID has an outstanding accounts receivable balance, the balance is recouped from future payments made to any and all legacy IDs that have the same Tax ID or NPI. Recoupments are reflected on future R&S Reports.

Note: *This process affects only managed care claims that are submitted to TMHP.*

Refer to: Subsection 2.2.5, "Accounts Receivable" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care claims and outstanding accounts receivables.

Subsection 2.2.5, "Accounts Receivable" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care claims and outstanding accounts receivables.

2.4.2 Medicaid Funds May Be Used to Satisfy Children with Special Health Care Needs (CSHCN) Services Program Accounts Receivables

A service that is rendered to a CSHCN Services Program client who receives retroactive Medicaid eligibility may be reimbursed by the CSHCN Services Program or by Medicaid, but not by both.

The CSHCN Services Program is the payer of last resort. The CSHCN Services Program does not supplement a client's Medicaid benefits. However, services that are not a benefit of Medicaid may be covered by the CSHCN Services Program. If dual Medicaid and CSHCN Services Program eligibility is determined, claims that have already been paid by the CSHCN Services Program will be reprocessed under the appropriate program.

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An accounts receivable is created for each CSHCN Services Program claim that is reprocessed and subsequently reimbursed under Medicaid so that the amount the CSHCN Services Program originally reimbursed can be returned to the CSHCN Services Program.

If the CSHCN Services Program payout during the week's financial cycle in which the claim was reprocessed is not sufficient to satisfy the accounts receivable, the provider's Medicaid claim payouts are used to satisfy the CSHCN Services Program accounts receivable.

Note: *The deduction from Medicaid claim payouts does not exceed the amount Medicaid reimbursed the provider when the CSHCN Services Program claim was reprocessed.*

2.5 Additional Payments to High-Volume Providers

High volume provider payments are made to outpatient hospitals per1 TAC §355.8061 and ASCs/HASCs per 1 TAC §355.8121.

Outpatient hospital services are those services provided by outpatient hospitals and ASCs/HASCs. The definition of a high-volume outpatient hospital provider is one that was paid a minimum of $200,000 during the qualifying period.

The reimbursement rate for non-high-volume hospitals is as follows with the application of the hospital specific interim rate:

Non-High-Volume Provider	Current Allowable Rate
Children's hospitals	72.27 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	72.27 percent of the allowable charges
Other hospitals	68.44 percent of the allowable charges

The reimbursement rate for high-volume hospitals is as follows with the application of the hospital specific interim rate:

High-Volume Provider	Current Allowable Rate
Children's hospitals	76.03 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	76.03 percent of the allowable charges
Other hospitals	72 percent of the allowable charges
ASCs/HASCs that qualify as high-volume providers	Additional 5.2 percent increase in payment rates

2.6 Out-of-State Medicaid Providers

Texas Medicaid covers medical assistance services provided to eligible Texas Medicaid clients while in a state other than Texas, as long as the client does not leave Texas to receive out-of-state medical care that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas when the service meets one or more requirements of 1 TAC §354.1440 (a). TMHP must receive claims from out-of-state providers within 365 days from the date of service.

Note: *Border state providers (i.e., providers rendering services within 50 miles of the Texas border) are considered in-state providers for Texas Medicaid.*

Refer to: Subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

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2.7 Medicare Crossover Claim Reimbursement

2.7.1 Medicare-Only Crossover Claims

Per Title 42 Code of Federal Regulations (CFR) 455.410(d), Medicare-only providers can enroll in Texas Medicaid and submit Medicare crossover claims to HHSC for proof of Medicaid nonpayment in a Remittance and Status (R&S) Report. With this proof of nonpayment, Medicare-only providers may pursue Medicare reimbursement for these claims.

2.7.2 Part A

Providers must accept Medicare assignment to receive Medicaid payment for any portion of the coinsurance and deductible amounts for services rendered to Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients. If a provider has accepted a Medicare assignment, the provider may receive, on behalf of the QMB or MQMB client, payment for deductible or coinsurance according to current payment guidelines.

Any payments made by Medicare and Medicaid must be considered payment in full. Providers that accept Medicare or Medicaid assignment cannot legally require the client to pay the Medicare coinsurance or deductible amounts or any remaining amount after Medicaid payment has been made.

The payment of the Medicare Part A coinsurance and deductibles for Medicaid clients who are Medicare beneficiaries is based on the following:

- If the Medicare payment amount equals or exceeds the Medicaid payment rate, Medicaid does not pay the Medicare Part A coinsurance/deductible on a Medicare crossover claim.
- If the Medicare payment amount is less than the Medicaid payment rate, Medicaid pays the Medicare Part A coinsurance/deductible, but the amount of the payment is limited to the lesser of the coinsurance/deductible or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

2.7.3 Part B

Texas Medicaid reimburses coinsurance liability for MQMB clients on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program and, if Medicare did not exist, would be covered by Medicaid.

For Medicare crossover claims, Texas Medicaid reimburses the lesser of the following:

- The coinsurance and deductible payment
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service (If this amount is less than the deductible, then the full deductible is reimbursed instead.)

If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid does not make a payment for coinsurance.

Important: *Medicaid payment of a client's coinsurance/deductible liabilities satisfies the Medicaid obligation to provide coverage for services that Medicaid would have paid in the absence of Medicare coverage. The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.*

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2.7.4 Part C: Medicare Advantage Plans (MAPs)

2.7.4.1 Contracted MAPs

HHSC makes a per-client-per-month payment to MAPs that contract with HHSC. The payment to the MAP includes all costs associated with the Medicare coinsurance and deductible for a client who is dually eligible for Medicare and Medicaid. TMHP does not reimburse the coinsurance or deductible amounts for these claims. These costs must be billed to the MAP and must not be billed to TMHP or the Medicaid client.

Refer to: A list of MAPs that are contracted with HHSC is available on the TMHP website at www.tmhp.com/topics/edi/map-contractors. The list is updated as additional plans receive approved contracts.

2.7.4.2 Noncontracted MAPs

Texas Medicaid reimburses professional and outpatient facility crossover claims the lesser of the following:

- The coinsurance and deductible amounts
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service

For Medicare Part B cost sharing obligations, all deductible obligations will be reimbursed at 100 percent of the deductible amount owed, even if the cost sharing comparison results in a lower payment. For all other cost sharing obligations (including Medicare Part A and Part B coinsurance, and C), the cost sharing comparison is performed according to current guidelines.

Exception: *Texas Medicaid will reimburse coinsurance liability for MQMB clients on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program, and would be covered by Medicaid when the services are provided, if Medicare did not exist.*

If the Medicare payment is equal to or exceeds the allowed Medicaid fee or encounter rate for the service, Texas Medicaid will not make a payment for coinsurance and deductible.

Important: *Medicaid payment of a client's coinsurance/deductible liabilities satisfies the Medicaid obligation to provide coverage for services that Medicaid would have paid in the absence of Medicare coverage. The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.*

2.7.5 Exceptions

2.7.5.1 Full Amount of Part B and Part C Coinsurance and Deductible Reimbursed

Texas Medicaid reimburses the full amount of the Medicare Part B and Part C (noncontracted MAPs only) coinsurance and deductible for the following services:

- All ambulance services
- Services rendered by psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors
- Procedure codes R0070 and R0075 for services rendered by physicians

2.7.5.2 Nephrology (Hemodialysis, Renal Dialysis) and Renal Dialysis Facility Providers

Texas Medicaid pays the Medicare coinsurance less 5 percent and full Medicare deductible for Medicare crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers.

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2.8 Home Health Agency Reimbursement

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.

Home Health Agency providers should note the following:

- The client's primary physician must request professional, SN, and HHA services through a home health agency, and sign and date the POC.
- Claims are approved or denied according to eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of one-month for medical supplies according to the billing requirements.
- SN, HHA, OT, and PT services must be provided through a Medicaid-enrolled home health agency. These services must be billed using the home health agency's legacy ID. File these services on a UB-04 CMS-1450 claim form.
- OT and PT are always billed as POS 2 (home) and may be prior authorized to be provided in the home of the client or the home of the caregiver/guardian.

Note: *Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a home health services benefit. These services may be considered a benefit for clients who qualify for CCP.*

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in this section.

2.8.1 Pending Agency Certification

Home health agencies submitting claims before the enrollment process is complete or without prior authorization for services issued by the TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is when all Texas Medicaid provider enrollment forms are received and approved by TMHP.

Upon the receipt of notice of Texas Medicaid enrollment, the agency must contact the TMHP Home Health Services Prior Authorization Department before serving a Texas Medicaid client for services that require a prior authorization number. Prior authorization cannot be issued before Texas Medicaid enrollment is complete. Regular prior authorization procedures are followed at that time.

Home health agencies that provide laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

2.8.2 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies Home Health Services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that "a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for Home Health Services care services and may not establish or review a plan of treatment."

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A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency's assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, medical supplies, DME, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or five percent of the agency's total operating expenses, whichever is less.

Providers must submit claims for CCP services and general home health services on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number. Claims that are denied because of an ownership conflict will continue to be denied until the home health agency submits documentation that indicates that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency that is providing the services. Providers should send documentation to TMHP Provider Enrollment at the address indicated in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

2.9 Federal Medical Assistance Percentage (FMAP)

The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services and State medical and medical insurance expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

The "Federal Medical Assistance Percentages" are for Medicaid. Section 1905(b) of the Act specifies the formula for calculating Federal Medical Assistance Percentages.

"Enhanced Federal Medical Assistance Percentages" are for the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Act specifies the formula for calculating Enhanced Federal Medical Assistance Percentages. The FMAPs are subject to change.

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Section 3: TMHP Electronic Data Interchange (EDI)

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TEXAS
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SECTION 3: TMHP ELECTRONIC DATA INTERCHANGE (EDI)

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3.1 TMHP EDI Overview

The Texas Health and Human Services Commission (HHSC) and the Texas Medicaid & Healthcare Partnership (TMHP) encourage providers to submit claims using electronic methods. Providers can participate in the most efficient and effective method of submitting requests to TMHP by submitting through the TMHP EDI Gateway. TMHP uses the Health Insurance Portability and Accountability Act (HIPAA)-compliant American National Standards Institute (ANSI) ASC X12 5010 file format through a Secure File Transfer Protocol (SFTP) connection for maximum security. Providers can access TMHP's electronic services through the TMHP website at www.tmhp.com, TexMedConnect, vendor software, and third party billing agents. Providers may also submit claims using paper forms.

3.1.1 Advantages of Electronic Services

- *It's fast.* No more waiting by the mailbox or telephone inquiries; know what's happening to claims in less than 24 hours and receive reimbursement for approved claims within a week. TexMedConnect users can submit individual requests interactively and receive a response immediately.
- *It's free.* All electronic services offered by TMHP are free, including TexMedConnect and its technical support and training.
- *It's easy.* TMHP offers computer-based training (CBT) for TexMedConnect, Medicaid billing, and many other topics, including those for the Children with Special Health Care Needs (CSHCN) Services Program, and Long Term Care, as well as a large library of reference materials and manuals on www.tmhp.com.
- *It's safe.* TMHP EDI services use an SFTP connection, just like the United States government, banks, and other financial institutions, for maximum security.
- *It's accurate.* TexMedConnect and most vendor software programs have features that let providers know when they've made a mistake, which means fewer rejected and denied claims. Rejected claims are returned with messages that explain what's wrong, so the claim can be corrected and resubmitted right away. Denied claims appear on the provider's Remittance and Status (R&S) Report along with paid and pending claims.
- *It's there when it's needed.* Electronic services are available day and night; from home, the office, or anywhere in the world.
- *It makes record keeping and research easy.* Not only can TexMedConnect be used to send and receive claims, it can check client eligibility, retrieve Electronic Remittance and Status (ER&S) Reports, perform claim status inquiries, and archive claims. TexMedConnect can generate and print reports on everything it sends, receives, and archives.

3.1.2 Electronic Services Available

- Eligibility verification
- Claims submission
- Claim status inquiry (CSI)
- ER&S Reports
- Appeals (also known as correction and resubmission)

3.1.3 Paper Remittance and Status (R&S) Reports No Longer Available

TMHP no longer produces or distributes paper R&S Reports. This initiative saves the state of Texas the cost of printing and mailing Paper R&S Reports.

All R&S Reports are now available online through the secure portion of the TMHP website at www.tmhp.com. Providers who receive an ER&S Report with third party software are not affected by this change.

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Online R&S Reports are available as a portable document format (PDF) file every Monday morning—four days earlier than paper R&S Reports were available. Providers must have a provider administrator account on the TMHP website to receive R&S Reports. Providers who do not have a provider administrator account should create one to avoid delays or interruptions to business processes.

Refer to: The Account Management web page of the TMHP website for information about creating an account, obtaining a username and password, and granting permissions.

3.2 Electronic Billing

Providers who want to transition from paper billing to electronic billing must decide how they will submit their claims to TMHP. Providers can use TexMedConnect on the TMHP website at www.tmhp.com, vendor software that submits files directly to TMHP, or they may use a third party billing agent (e.g., billing companies and clearinghouses) who submit files on the provider's behalf.

3.2.1 TexMedConnect

TexMedConnect is a free, web-based, claims submission application provided by TMHP. Technical support and training for TexMedConnect are also available free from TMHP. Providers can submit claims, eligibility requests, claim status inquiries, appeals, and download ER&S Reports (in either PDF or ANSI 835 formats) using TexMedConnect. TexMedConnect can interactively submit individual claims that are processed in seconds. To use TexMedConnect, providers must have:

- An internet service provider (ISP)
- Microsoft® Edge®
- Google Chrome®
- Mozilla Firefox®

A broadband connection is recommended but not required. Providers that use TexMedConnect can find the online TexMedConnect manuals for Acute Care and Long Term Care on the TexMedConnect Info web page in the EDI section of the TMHP website at www.tmhp.com/resources/texmedconnect.

3.2.2 Vendor Software

Providers that do not use TexMedConnect must use vendor software to create, submit, and retrieve data files. Providers can use software from any vendor listed on the EDI Vendor Testing List, which is located in the EDI section of the TMHP website at www.tmhp.com. There are hundreds of software vendors that have a wide assortment of services and that have been approved to submit electronic files to TMHP. Providers that plan to access TMHP's electronic services with vendor software should contact the vendor for details on software requirements. TMHP does not make vendor recommendations or provide any assistance for vendor software. Not all vendor software offers the same features or levels of support. Providers are encouraged to research their software thoroughly to make certain that it meets their needs and that it has completed testing and has been certified with TMHP.

3.2.3 Third Party Billing Agents

Billing agents are companies or individuals who submit electronic files to TMHP on behalf of the provider. Generally, this means that the provider uses a product that sends billing or other information to the billing agent who processes it and transmits it to TMHP and other institutions. A complete list of billing agents who have completed the testing process and been certified by TMHP can be found on the EDI Vendor Testing List, which is located in the EDI section of the TMHP website at www.tmhp.com. TMHP does not make billing agent recommendations or provide any assistance for billing agents' software or services. TMHP has no information on the software or other requirements of billing agents. Providers should contact the billing agent to obtain information about their products and processes.

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3.3 Gaining Access

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

Providers that download the ANSI 835 file through TexMedConnect and providers that use vendor software must request a submitter ID. A submitter ID is necessary for vendor software to access TMHP's electronic services. It serves as an electronic mailbox for the provider and TMHP to exchange data files. To order a submitter ID, providers must call the EDI Help Desk at 1-888-863-3638, Option 3. Providers that use a billing agent do not need a submitter ID.

Providers may receive an ER&S Report by completing the Electronic Remittance and Status (ER&S) Agreement and submitting it to the EDI Help Desk after setting up access to the TMHP EDI Gateway.

Refer to: Electronic Remittance Advice (ERA) Agreement on the TMHP website at www.tmhp.com.

3.4 Training

Providers should contact the TMHP Contact Center at 1-800-925-9126 for billing and training questions. Information about training opportunities is available in the Provider Education section of the TMHP website at www.tmhp.com. Providers may also use the many reference materials and workbooks available on the website. The TMHP EDI Help Desk provides technical assistance and does not provide training.

3.5 Electronic Transmission Reports

Providers are required to retain all claim and electronic file transmission records. Providers must verify that all claims submitted to TMHP are received and accepted. Providers must also track claims submissions against their claims payments to detect and correct all claim errors.

Refer to: Subsection 1.7.4, "Retention of Records and Access to Records and Premises" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about provider responsibility and electronic submissions.

If an electronic file transmission record is missing, providers can request that the transmission report file be reset by contacting the TMHP EDI Help Desk at 1-888-863-3638, Option 3. The TMHP EDI Help Desk will then reset the files for the production submitter ID provided. Requests for transmission reports produced in the previous 30 days will be provided at no cost to providers. Requests for transmission reports produced more than 30 days before the request will result in a charge of $500 plus 8.25 percent sales tax of $41.25 for a total charge of $541.25. Providers that hold a tax-exempt certificate will not be assessed the sales tax. This cost is per transmission report.

3.6 Provider Check Amounts Available Online

Acute care providers can search, view, and print on the TMHP website at www.tmhp.com all payment amounts issued during the previous year.

The features of the online check amount include:

- The ability to search information up to one year before the date of the search.
- All results are displayed on a single screen.
- All results can be printed on a single report.
- The 52 weeks of reimbursement payment information includes the:
  - Payment date

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- Payee name
- Payment amount
- Program for which payment was issued
- Hold amount
- Payment status

Providers must have or must create an administrative account to view their payment amounts online. Providers can then grant "View Payment Amounts" security permission to the office staff of their choice. Providers can access their check amounts by logging into their accounts from the TMHP website and then pressing **View Payment Amounts**.

Provider check amounts are also available through the automated inquiry system (AIS) telephone line and ER&S Reports.

3.7 Third Party Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before access to the production server is allowed. Vendors that wish to begin testing may call the EDI Help Desk at 1-888-863-3638, Option 3. After the successful submission of a Trading Partner Agreement, vendors must then complete end-to-end testing on the TMHP test server. Software vendors and billing agents must be partnered with at least one Texas provider before a test submitter ID can be issued. When end-to-end testing has been completed, the software vendor or billing agent will be added to the EDI Submitter List. Providers and billing agents may then order production submitter IDs for use with the vendor's software. Companion guides and vendor specifications are available on the EDI page of the TMHP website at www.tmhp.com.

3.7.1 Automated Maintenance Process for All Electronic Submitters

All submitter folders have a maximum limit of 7500 files, and no files can be more than 30 days old. Files that exceed these limits will be purged by TMHP on a daily basis. Providers should review, retrieve, and backup their electronic response files within 30 days. Files not retrieved within the 30-day time period or files that exceed a maximum file count of 7500 will be purged by TMHP. All electronic submitters are responsible for the maintenance of their submitter folders. Files that are submitted using EDI version 5010 are limited to a maximum of 5,000 transactions per file. Files that have more than 5,000 transactions will be rejected.

Requests for transmission reports produced after the 30-day period, or resulting from a purge of over 7500 files will require fees, as outlined in Subsection 3.5, "Electronic Transmission Reports" in this section.

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3.7.2 Supported File Types

TMHP EDI supports the following electronic HIPAA-compliant ANSI ASC X12 5010 transaction types:

Electronic Transaction Types	
270	Eligibility request
271	Eligibility response
276	Claim status inquiry
277	Claim status inquiry response
835	ER&S Report
837D	Dental claims
837I	Institutional claims
837P	Professional claims

Note: *Dental providers who submit American National Standards Institute, Accredited Standards Committee X12 (ANSI ASC X12N) 837D transactions through the TMHP Electronic Data Interchange (EDI) are required to include the header date of service (HDOS) to comply with International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) claims processing guidelines.*

3.8 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Electronic Remittance Advice (ERA) Agreement
Claim Status Inquiry Authorization

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Section 4: Client Eligibility

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Health and Human
Services

SECTION 4: CLIENT ELIGIBILITY

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4.1 General Medicaid Eligibility

A person may be eligible for medical assistance through Medicaid if the following conditions are met:

- The applicant must be eligible for medical assistance at the time the service is provided. It is not mandatory that the process of determining eligibility be completed at the time service is provided; the client can receive retroactive eligibility. Services or supplies *cannot* be paid under Texas Medicaid if they are provided to a client before the effective date of eligibility for Medicaid or after the effective date of denial of eligibility. Having an application in process for Medicaid eligibility does *not* guarantee the applicant will be eligible.
- The service must be a benefit and determined medically necessary (except for preventive family planning, annual physical exams, and Texas Health Steps [THSteps] medical or dental checkup services) by Texas Medicaid and must be performed by an approved provider of the service.
- Applicants for medical assistance potentially are eligible for Medicaid coverage up to three calendar months before their application for assistance, if they have unpaid or reimbursable Medicaid-covered medical bills and have met all other eligibility criteria during the time the service was provided. The provision also includes deceased individuals when a bona fide agent requests application for services. An application for retroactive eligibility must be filed with the Health and Human Services Commission (HHSC); it is not granted automatically. The applicant must request the prior coverage from an HHSC representative and complete the section of the application about medical bills.

Clients who are not eligible for Medicaid but meet certain income guidelines may receive family planning services through other family planning funding sources. Clients not eligible for Medicaid are referred to a family planning provider. Clients seeking other services may be eligible for state health-care programs, some of which are described in this section.

Refer to: HHSC website at www.healthytexaswomen.org for information about family planning and the locations of family planning clinics that receive HHSC Family Planning Program funding.

4.1.1 Your Texas Benefits Medicaid Card

Clients receive a Your Texas Benefits Medicaid card that can be used to verify the client eligibility for various state-funded programs, including Medicaid.

The front of the card includes the client's name, member ID, the ID of the agency that issued the card, and the date on which the card was sent.

The back of the card provides:

- An eligibility verification contact number. The number can be used to determine:
  - Program eligibility dates.
  - Retroactive eligibility (when applicable).
  - Eligible services (when applicable).
  - Medicaid managed care eligibility.
- An eligibility website address for clients and non-pharmacy providers.
- A non-managed care pharmacy claims assistance contact number.
- The Medicaid Client Transfer Line at 1-800-252-8263.

Client TPR and other insurance information can also be verified using the benefit card.

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Refer to: Subsection 4.1.10, "Eligibility Verification" in this section for additional ways to verify client eligibility.

Your Texas Benefits Medicaid card (English and Spanish) on the TMHP website at www.tmhp.com.

4.1.2 Retroactive Eligibility

Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and added to the TMHP eligibility file.

The date on which the client's eligibility is added to the TMHP eligibility file is the add date. To ensure 95-day filing deadlines are met and to check current and retroactive client eligibility, providers can log in to My Account and use one of the following resources:

- The TMHP electronic data interchange (EDI)
- The Medicaid Client Portal for Providers

Additionally, providers can call the Automated Inquiry System (AIS) at 1-800-925-9126 to verify a client eligibility.

If a person is not eligible for medical services under Texas Medicaid on the date of service, reimbursement for all care and services provided must be resolved between the provider and the client receiving the services. Providers are not required to accept Medicaid for services provided during the client's retroactive eligibility period and may continue to bill the client for those services. This guideline does not apply to nursing facilities certified by the Texas Health and Human Services Commission (HHSC).

If it is the provider's practice not to accept Medicaid for services provided during the client's retroactive eligibility period, the provider must apply the policy consistently for all clients who receive retroactive eligibility. Providers must inform the client about their policy before rendering services. If providers accept Medicaid assignment for the services provided during the client's retroactive eligibility period and want to submit a claim for Medicaid-covered services, providers must refund payments received from the client before billing Medicaid for the services.

Examples of Medicaid identification forms are found at the end of this section. Actual Medicaid forms can be identified by a watermark.

Refer to: Your Texas Benefits Medicaid card (English and Spanish) on the TMHP website at www.tmhp.com.

4.1.3 Expedited Eligibility (Applies to Medicaid-eligible Pregnant Women Throughout the State)

HHSC processes Medicaid applications for pregnant women within 15 business days of receipt. Once eligibility has been certified, a Your Texas Benefits Medicaid card will be issued to verify eligibility and to facilitate provider reimbursement.

4.1.4 Medicaid Buy-In Program for Employed Individuals with Disabilities

The Medicaid Buy-In (MBI) Program allows employed individuals with disabilities to receive Medicaid services by paying a monthly premium. Some MBI participants, based on income requirements, may be determined to have a $0 premium amount and therefore are not required to make a premium payment. Individuals with earnings of less than 250 percent of the federal poverty limits (FPL) may be eligible to participate in the program. Applications for the program are accepted through HHSC's regular Medicaid application process.

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Participants will receive the Your Texas Benefits Medicaid card. MBI participants in urban service areas will be served through Texas Medicaid fee-for-service.

4.1.5 Newborn Eligibility

A newborn child may be eligible for Medicaid for up to 1 year if:

- The child's mother received Medicaid at the time of the child's birth.
- The child's mother is eligible for Medicaid or would be eligible if pregnant.
- The child resides in Texas.

If the newborn is eligible for Medicaid coverage, providers must not require a deposit for newborn care from the guardian. The hospital or birthing center must report the birth to HHSC Eligibility Services at the time of the child's birth.

After the child has been added to the HHSC eligibility file, a Your Texas Benefits Medicaid card will be issued. Newborn clients will receive the Your Texas Benefits Medicaid card within 7 business days of being certified. A temporary Medicaid Eligibility Verification (Form H1027) may be issued by request through a local office or can be downloaded from YourTexasBenefits.com. Form H1027 includes the client's Medicaid identification number and effective date of coverage.

Providers can verify the client's add date and retroactive eligibility by:

- Accessing the Medicaid Client Portal for Providers.
- Using TexMedConnect.
- Calling AIS at 1-800-925-9126.

After the newborn becomes a Medicaid client, the website will verify that the client is eligible, even if the card has not been produced yet.

Note: *Claims submitted for services provided to a newborn eligible for Medicaid may be filed using the mother's Medicaid identification number until the newborn's individual Medicaid number has been assigned. Once the newborn's Medicaid number is available, all subsequent claims must be filed using the newborn client's Medicaid number. Claims filed with the mother's Medicaid number after the newborn has been assigned an individual Medicaid number may cause a delay in reimbursement.*

The Medicaid number on the Medicaid Eligibility Verification (Form H1027) may be used to identify newborns eligible for Medicaid.

Refer to: Your Texas Benefits Medicaid card (English and Spanish) on the TMHP website at www.tmhp.com.

4.1.6 Potential Supplemental Security Income (SSI)/Medicaid Eligibility for Premature Infants

The Supplemental Security Income (SSI) program includes financial and Medicaid benefits for people who are disabled. When determining eligibility for SSI, the Social Security Administration (SSA) must establish that the person meets financial and disability criteria. When determining financial eligibility for a newborn child, SSA does not consider the income and resources of the child's parents until the month following the month the child leaves the hospital and begins living with the parents. Determinations of disability are made by the state's Disability Determination Services and may take several months. Federal regulations state that infants with birth weights less than 1,200 grams are considered to meet the SSI disability criteria.

The SSA issued a policy to local SSA offices to make presumptive SSI disability decisions and payments for these children, making it possible for a child to receive SSI and Medicaid benefits while waiting for a final disability determination to be made by Disability Determination Services. The child's parent or

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legal guardian must file an SSI application with the SSA. It is in the child's best interest that the application with the SSA be filed as soon as possible after birth. The SSA accepts a birth certificate with the child's birth weight or a hospital medical summary as evidence for the presumptive disability decision.

Providers should not change their current newborn referral procedures to HHSC for children who are born to mothers who are eligible for Medicaid as described in this section. However, providers are encouraged to refer parents and guardians of low birth weight newborns to the local SSA office for an SSI application.

4.1.7 Foster Care

Most children in the state of Texas foster care program are automatically eligible for Medicaid.

Extended health-care coverage is also available for some former foster care youth clients enrolled in an institution of higher education through the Former Foster Care in Higher Education (FFCHE) program.

To ensure that these children have access to the necessary health-care services for which they are eligible, providers can accept the Medicaid Eligibility Verification (Form H1027) as evidence of Medicaid eligibility. Although this form may not list the client's Medicaid identification number, it is an official state document that establishes Medicaid eligibility.

Providers should honor the Medicaid Eligibility Verification (Form H1027) as proof of Medicaid eligibility and must bill Texas Medicaid as soon as a Medicaid ID number is assigned. Medicaid ID numbers will be assigned approximately one month from the issue date of the Medicaid Eligibility Verification (Form H1027). The form includes a Department of Family and Protective Services (DFPS) client number that provides an additional means of identification and tracking for children in foster care.

Note: *The DFPS client number is accepted by Medicaid Vendor Drug Program (VDP)-enrolled pharmacies to obtain outpatient prescribed drug benefits. VDP pharmacies must submit subsequent pharmacy claims with the Medicaid ID number after it has been assigned.*

Reminder: *Adoption agencies/foster parents are not considered third party resources (TPRs). Medicaid is primary in these circumstances.*

4.1.8 Former Foster Care

HHSC provides Medicaid health-care coverage to former foster care youth who:

- Are 18 through 25 years of age.
- Were in Texas foster care on their 18th birthday or older and were receiving Medicaid when they aged out of Texas foster care.
- Are U.S. citizens or have a qualified alien status (i.e., green card).

4.1.9 Medicaid Managed Care Eligibility

All clients who are determined to be eligible for Texas Medicaid are first enrolled as fee-for-service clients. Specific client groups within the Texas Medicaid population are eligible for managed care based on criteria such as age, location, and need. A client who is determined to be eligible for Medicaid managed care is enrolled in the appropriate managed care organization (MCO) or dental plan with a separate eligibility date. In most cases, Medicaid managed care enrollment is not retroactive.

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for more information about managed care eligibility and enrollment.

4.1.10 Eligibility Verification

To verify a client's Texas Medicaid eligibility, use the following options:

- Verify electronically through TMHP EDI, TexMedConnect, or the Medicaid Client Portal for Providers. Providers must submit one of the following for each client:

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  - Medicaid or Children with Special Health Care Needs (CSHCN) Services Program identification number.
  - One of the following combinations: Social Security number and last name; Social Security number and date of birth; or last name, first name, and date of birth. Providers can narrow the search by entering the client's county code or sex.
- Verify the client's Medicaid eligibility using the Medicaid Eligibility Verification (Form H1027).
- Contact the TMHP AIS at 1-800-925-9126 or 1-512-335-5986.

Note: *Providers can obtain client eligibility information for a client who is enrolled in a Medicaid managed care organization (MCO) from the MCO's web page. Providers can also check the MCO's web page for submission of electronic claims, prior authorization requests, claim appeals and reconsiderations, exchange of clinical data, and other documentation necessary for prior authorization and claim processing.*

4.1.11 Advantages of Electronic Eligibility Verification

Verifying eligibility using TexMedConnect or EDI has the following advantages:

- They are available 24-hours a day 7 days a week.
- Providers can submit up to 5000 verification requests per EDI transmission.
- Providers can create client eligibility lists for verification in TexMedConnect. Each client group can contain up to 250 clients. Providers can create up to 100 groups for each National Provider Identifier (NPI).

The eligibility search function through the Medicaid Client Portal for Providers have the following advantages:

- It displays the client's:
  - Name, Patient Control Number (PCN), and status.
  - Texas Health Steps information (when applicable).
  - Medicaid health plans and their contact information.
  - Main doctor and the doctor's contact information.
  - Main dental home.
  - Main dental provider.
  - Medicaid benefits.
- It allows providers to search for details about a client's eligibility by month and year.
- It allows providers to view and print the client's:
  - Current and previous Medicaid eligibility information.
  - CHIP, CSHCN Services Program, Medicare, and other insurance plans.
  - Medical, dental, vision, and pharmacy benefits and limitations.
  - Medicaid Cards

Electronic eligibility responses contain:

- Eligibility restrictions, such as lock-in, emergency, or women's health.
- Medicare Part A, B, and C eligibility and effective dates
- Other insurance information, including name and address, and effective dates. EDI transactions also indicate the patient relationship to policy holder.

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4.1.12 Contract with Outside Parties

The *State Medicaid Manual*, Chapter 2, "State Organization," (Section 2080.18) allows states to contract with outside agents to confirm for providers the eligibility of a Medicaid client. Medicaid providers may contract with these agents for eligibility verification with a cost to the provider. The provider remains responsible for adhering to the claims filing instructions in this manual. The provider, not the agent, is responsible for meeting the 95-day filing deadline and other claims submission criteria.

4.2 Medicaid Identification and Verification

Providers are responsible for requesting and verifying current eligibility information by using the methods listed in subsection 4.1.10, "Eligibility Verification" in this handbook or by asking clients for their Your Texas Benefits Medicaid card (electronic or paper copies) or Medicaid Eligibility Verification form (H1027).

Providers can verify client eligibility electronically by:

- Using TexMedConnect.
- Accessing the Medicaid Client Portal for Providers.
- Calling AIS at 1-800-925-9126.

Providers must accept Your Texas Benefits Medicaid cards and Medicaid Eligibility Verification forms (H1027) as valid proof of eligibility. Providers should retain a copy for their records to ensure the client is eligible for Medicaid when the services are provided. Clients should share eligibility information with their providers.

Providers should request additional identification if they are unsure whether the person presenting the form is the person identified on the form.

Providers should check the Eligibility Date to see whether the client has possible retroactive eligibility for previous bills.

Only those clients listed on the Medicaid Eligibility Verification form or the Your Texas Benefits Medicaid card are eligible for Medicaid. If a person insists he or she is eligible for Medicaid but cannot produce a current Your Texas Benefits Medicaid card or Medicaid Eligibility Verification (Form H1027), providers can verify eligibility through the methods listed in subsection 4.1.10, "Eligibility Verification" or by calling the TMHP AIS at 1-800-925-9126. Providers must document this verification in their records and treat these clients as if they had presented a Your Texas Benefits Medicaid card (electronic or printed copy of the card) or Medicaid Eligibility Verification (Form H1027).

When a client's Your Texas Benefits Medicaid card has been lost or stolen, HHSC issues a temporary Medicaid verification Form H1027. Clients can also request a replacement card by visiting YourTexasBenefits.com's Medicaid Client Portal or by calling the Texas Medicaid Call Transfer line at 1-800-252-8263. The following is a sample of forms:

- *Form H1027-A*. Medicaid eligibility verification is used to indicate eligibility for clients who receive regular Medicaid coverage.
- *Form H1027-B.* Medicaid Qualified Medicare Beneficiary (MQMB) is issued to clients eligible for MQMB coverage.
- *Form H1027-C*. Qualified Medicare Beneficiary (QMB) is issued to clients who are eligible for QMB coverage only.
- *Form H1027-F*. Temporary Medicaid identification for clients receiving Former Foster Care in Higher Education (FFCHE) health care.

Refer to: Subsection 4.9.1, "QMB/MQMB Identification" in this section.

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The Medicaid Eligibility Verification (Form H1027) is acceptable as evidence of eligibility during the eligibility period specified unless the form contains limitations that affect the eligibility for the intended service. Providers must accept any of the documents listed above as valid proof of eligibility. If the client is not eligible for medical assistance or certain benefits, the client is treated as a private-pay patient.

Refer to: Subsection 4.1.10, "Eligibility Verification" in this section.

Providers can determine whether a client's eligibility has limitations by:

- Checking TMHP EDI.
- Accessing the Medicaid Client Portal for Providers.
- Using TexMedConnect.
- Calling AIS at 1-800-925-9126.

Clients may be required to use a designated primary care provider or pharmacy. QMB clients will be limited to Medicaid coverage of the Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare coinsurance or deductible according to current payment guidelines.

If the client is identified as eligible and no other limitations of eligibility affect the intended service, proceed with the service. Eligibility during a previous month does not guarantee eligibility for the current month. The Medicaid Eligibility Verification (Form H1027) and the Your Texas Benefits Medicaid card (electronic or paper) are the only documents that are honored as verification of Medicaid eligibility.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for TPL information.

In accordance with current federal policy, Texas Medicaid and Texas Medicaid clients cannot be charged for the client's failure to keep an appointment. Only claims for services provided are considered for payment. Clients may not be billed for the completion of a claim form, even if it is a provider's office policy.

4.3 Restricted Medicaid Coverage

The following sections are about limitations that may appear on the Your Texas Benefits Medicaid card, indicating that the client's eligibility is restricted to specific services. Unless "LIMITED" appears on the form, the client is not locked into a single provider.

4.3.1 Emergency Only

The word "EMERGENCY" on the form indicates the client is restricted to coverage for an emergency medical condition. "Emergency medical condition" is defined in subsection 4.3.2.2, "Exceptions to Lock-in Status" in this section.

Certification for emergency Medicaid occurs after the services have been provided. The coverage is retroactive and limited to the specific dates that the client was treated for the emergency medical condition.

Clients limited to emergency medical care are not eligible for family planning, THSteps, Comprehensive Care Program (CCP) benefits, or outlier payments for hospital claims. Only services directly related to the emergency or life-threatening situations are covered.

Undocumented aliens and aliens with a nonqualifying entry status are identified for emergency Medicaid eligibility by the classification of type programs (TPs) 30, 31, 32, 33, 34, 35, and 36. Under Texas Medicaid, undocumented aliens are only eligible for emergency medical services, including emergency labor and delivery.

Any service provided after the emergency medical condition is stabilized is not a benefit.

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If a client is not eligible for Medicaid and is seeking family planning services, providers may refer the client to one of the clinics listed on the HHSC website at www.healthytexaswomen.org.

4.3.2 Client Lock-in Program

Texas Medicaid fee-for-service clients can be required to use a designated primary care provider and/or a primary care pharmacy.

The client is assigned to a designated provider for access to medical benefits and services when one of the following conditions exists:

- The client received duplicative, excessive, contraindicated, or conflicting health-care services, including drugs.
- A review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services.

After analysis through the neural network component of the Medicaid Fraud and Abuse Detection System (MFADS), qualified medical personnel validate the initial identification and determine candidates for lock-in status. The validation process includes consideration of medical necessity. For the lock-in status designation, medical necessity is defined as the need for medical services to the amount and frequency established by accepted standards of medical practice for the preservation of health, life, and the prevention of more impairments.

Except for specialist consultations, services rendered to a client by more than one provider for the same or similar condition during the same time frame may not be considered medically necessary.

4.3.2.1 Lock-in Medicaid Identification

Clients with lock-in status receive the Your Texas Benefits Medicaid card with "Lock-in" printed on the card. The designated provider and pharmacy names are printed on the card under the word "Lock-in."

When a Texas Medicaid fee-for-service client in the Lock-in Program attempts to obtain nonemergency services from someone other than their designated lock-in primary care provider, the provider must do one of the following:

- Verify the lock-in status by:
  - Accessing the Medicaid Client Portal for Providers.
  - Calling AIS at 1-800-925-9126.
- Attempt to contact the client's designated lock-in primary care provider for a referral. If the provider is unable to obtain a referral, the provider must inform clients that they are financially responsible for the services.

4.3.2.2 Exceptions to Lock-in Status

Lock-in clients may go to any provider for the following services or items:

- Ambulance services
- Anesthesia
- Annual well-woman checkup
- Assistant surgery
- Case management services
- Chiropractic services
- Counseling services provided by a chemical dependency treatment facility
- Eye exams for refractive errors
- Eyeglasses

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- Family planning services (regardless of place of service [POS])
- Genetic services
- Hearing aids
- Home health services
- Laboratory services (including interpretations)
- Licensed clinical social worker (LCSW) services
- Licensed professional counselor (LPC) services
- Mental health rehabilitation services
- Intellectual disability/related condition assessment performed by an intellectual or developmental disability (IDD) provider
- Nursing facility services
- Primary home care
- Psychiatric services
- Radiology services (including interpretations)
- School Health and Related Services (SHARS)
- Comprehensive Care Program (CCP)
- THSteps medical and dental services

For referrals or questions, contact:

HHSC
Office of Inspector General
Lock-in Program - MC 1323
PO Box 85200
Austin, TX 78708
LockIn_Program@hhs.texas.gov

If an emergency medical condition occurs, the lock-in restriction does not apply. The term emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the client's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Important: *A provider who sends in an appeal because a claim was denied with explanation of benefits (EOB) 00066 must include the performing provider NPI, not just a name or group NPI. Appeals without a performing provider NPI are denied. The NPI of the designated provider must be entered in the appropriate paper or equivalent electronic field for nonemergency inpatient and outpatient claims to be considered for reimbursement.*

Note: *Only when the designated provider or designated provider representative has given permission for the client to receive nonemergency inpatient and/or outpatient services, including those provided in an emergency room, can the facility use the designated provider's NPI for billing.*

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4.3.2.3 Selection of Designated Provider and Pharmacy

Texas Medicaid fee-for-service clients identified for lock-in status can participate in the selection of one primary care provider, primary care pharmacy, or both from a list of participating Medicaid providers. Eligible providers cannot be under administrative action, sanction, or investigation. In general, the designated primary care provider's specialty is general practice, family practice, or internal medicine. Other specialty providers may be selected on a case-by-case basis. Primary care providers can include, but are not limited to the following:

- A physician
- Physician assistant
- Physician group
- Advanced practice nurse
- Outpatient clinic
- Rural health clinic (RHC)
- Federally qualified health center (FQHC)

If the client does not select a primary care provider or primary care pharmacy, HHSC selects one for the client.

When a candidate for the designated provider is determined, HHSC contacts the provider by letter. The designated provider receives a confirmation letter from HHSC that verifies the name of the client confirming the name of the client, primary care provider or primary care pharmacy, and the effective date of the lock-in arrangement.

4.3.2.4 Pharmacy services

The primary care pharmacy helps the Lock-in Program ensure that prescriptions that are filled for clients with lock-in status are written either by the primary care provider or other health-care providers to whom the primary care provider has referred the client. HHSC has identified by therapeutic class those medications that require additional monitoring. When a medication that requires additional monitoring is prescribed by an emergency room provider, the primary care pharmacy may be reimbursed for dispensing up to 72 hours or three business days of the prescribed dosage, which allows for holidays and weekends. The primary care pharmacy may dispense the remainder of the medication after receiving approval by the primary care provider or the other providers that HHSC deems to be appropriate.

Some circumstances allow a client to be approved to receive medications from a pharmacy other than the primary care pharmacy. A pharmacy override occurs when the Lock-in Program approves an individual client's request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. The Lock-in Program is notified when the client or pharmacist contacts the Lock-In Program at LockIn_Program@hhs.texas.gov to request a pharmacy override.

The Lock-in Program staff refers the client to the notification letter titled "What You Need to Know About the Lock-in Program," which was sent at initial lock-in. This letter explains the pharmacy override process. The client is instructed to have the alternate pharmacy call the Lock-in Program to request the override.

The following are allowable circumstances for pharmacy override approval:

- The recipient moved out of the geographical area (more than 15 miles from the lock-in pharmacy).
- The lock-in pharmacy does not have the prescribed medication, and the medication will remain unavailable for more than two to three days.
- The lock-in pharmacy is closed for the day, and the recipient needs the medication urgently.

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- The lock-in pharmacy does not carry the medication and is either unable to order it or unwilling to stock it.
- The lock-in pharmacy no longer wants to be the designated pharmacy for a particular lock-in client.
- The client has valid complaints against the lock-in pharmacy or its staff.

For questions about pharmacy services for clients that are locked into a primary care pharmacy, contact the Lock-in Program by emailing LockIn_Program@hhs.texas.gov.

4.3.2.5 Duration of Lock-in Status

The Lock-in Program duration of lock-in status is the following:

- Initial lock-in status period–minimum of 36 months.
- Second lock-in status period–additional 60 months.
- Third lock-in status period–will be for the duration of eligibility and all subsequent periods of eligibility.
- Clients who have been arrested for, indicted for, convicted of, or admitted to a crime that is related to Medicaid fraud will be assigned lock-in status for the duration of eligibility and subsequent periods of eligibility.

HHSC uses the same time frames for clients with a lock-in status as noted by the word "LIMITED" on the Your Texas Benefits Medicaid card.

Clients are removed from lock-in status at the end of the specified limitation period if their use of medical services no longer meets the criteria for lock-in status. A medical review also may be initiated at the client's or provider's request. Clients or providers can reach the Lock-in Program by emailing LockIn_Program@hhs.texas.gov to request this review.

Providers may request to no longer serve as a client's designated provider at any time during the lock-in period by emailing LockIn_Program@hhs.texas.gov. Providers are asked to serve or refer the client until another arrangement is made. New arrangements are made as quickly as possible.

4.3.2.6 Referral to Other Providers

Texas Medicaid fee-for-service clients with a lock-in status may be referred by their designated provider to other providers. For the referred provider to be paid, the NPI of the referring designated provider must be in the referring provider field of the claim form. Claims submitted electronically must have the NPI of the referring designated provider in the Referring Provider Field. Providers must consult with their vendor for the location of this field in the electronic claims format.

Refer to: Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

4.3.2.7 Hospital Services

An inpatient hospital claim for a lock-in Medicaid fee-for-service client is considered for reimbursement if the client meets Medicaid eligibility and admission criteria. Hospital admission personnel should check the name of the client's designated provider usingTexMedConnect or the Medicaid Client Portal for Providers and share the designated provider's name with the admitting physician if the two are different.

Provider claims for nonemergency inpatient services for lock-in Texas Medicaid fee-for-service clients are considered for payment *only* when the designated NPI appears on the claim form as the billing, performing, or referring physician.

Providers can get information about claim reimbursement for lock-in clients by calling the TMHP AIS at 1-800-925-9126.

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4.3.2.8 Lock-in Status Claims Payment

Payment for services to a lock-in Medicaid client is made to the designated provider only, unless the services result from a designated provider referral or emergency. An automated review process determines if the claim includes the lock-in primary care provider's NPI as the billing, performing, or referring provider. If the lock-in primary care provider's NPI is not indicated on the claim, the claim is not paid. Exceptions to this rule include emergency care and services that are included in subsection 4.3.2.2, "Exceptions to Lock-in Status" in this section. Appeals for denied claims are submitted to TMHP and must include the designated NPI for reimbursement consideration.

Claims for provider services for Texas Medicaid fee-for-service clients must include the NPI and taxonomy code for the designated primary care provider as the billing or performing provider or a referral number in the prior authorization number (PAN) field.

4.3.3 Hospice Program

HHSC manages the Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client's terminal illness and for certain physician services (not the treatments).

Medicaid Hospice provides palliative care to all Medicaid-eligible clients (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses. Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

Texas Medicaid clients who are 21 years of age and older and who elect hospice coverage waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Texas Medicaid clients who are 20 years of age and younger and who elect hospice care are not required to waive their rights to concurrent hospice care and treatment of the terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Medicare and Medicaid clients must elect both the Medicare and Medicaid Hospice programs.

Concurrent hospice care and treatment services include:

- Services related or unrelated to the client's terminal illness
- Hospice care (palliative care and medical and support services related to the terminal illness.

Direct policy questions about the hospice program to HHSC at 1-512-438-3161. Direct all other general questions related to the hospice program, such as billing, claims, rate key issues, and authorizations to HHSC at 1-512-438-2200.

HHSC pays the provider for a variety of services under a per diem rate for any particular hospice day in one of the following categories:

- Routine home care
- Continuous home care
- Respite care
- Inpatient care

4.3.3.1 Hospice Medicaid Identification

Individuals who elect hospice care are issued a Your Texas Benefits Medicaid card. Hospice status can verified by using TexMedConnect or the Medicaid Client Portal for Providers. Clients can cancel their election at any time.

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4.3.3.2 Physician Oversight Services

Physician oversight is defined as "physician supervision of clients under the care of home health agencies or hospices that require complex or multidisciplinary care modalities." These modalities involve regular physician client status review of related laboratory and other studies, communication with other health professionals involved in patient care, integration of new information into medical treatment plans, and adjustment of medical therapy. Medicaid hospice does not reimburse for physician oversight services.

4.3.3.3 Medicaid Services Unrelated to the Terminal Illness

When services are unrelated to the Medicaid Hospice client's terminal illness, Medicaid (TMHP) pays its providers directly. Providers of services that are unrelated to the terminal illness are required to follow Medicaid prior authorization and claims filing deadlines.

Refer to: "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about prior authorizations for Medicaid hospice clients.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about filing claims for Medicaid Hospice Clients.

4.3.4 Presumptive Eligibility

Presumptive eligibility allows qualified hospitals and entities to determine whether an individual can get short-term Medicaid. Clients who have PE receive immediate, short-term Medicaid eligibility while their regular Medicaid application is processed. PE eligibility categories receive full coverage with the exception of pregnant women who receive ambulatory care services only.

4.3.4.1 PE Medicaid Identification

"PE" on a Your Texas Benefits Medicaid card indicates that a client has presumptive eligibility. PE clients may be identified using TexMedConnect or the Medicaid Client Portal for Providers. An individual who is certified for presumptive eligibility receives the regular Your Texas Benefits Medicaid card.

4.3.4.2 Services

Presumptive eligibility (PE) provides full coverage for all PE types of assistance with the exception of pregnant women. Pregnant women only receive ambulatory care services. Labor, delivery, inpatient services, and THSteps medical are not covered during the PE period for pregnant women. If the woman is determined to be eligible for regular Medicaid for the same period of time, regular Medicaid coverage overlays the PE period and provides a full range of services. Client eligibility for PE coverage must be determined by a qualified hospital or qualified entity. Once eligibility has been determined, services may be obtained from any enrolled Medicaid provider. The claims filing procedures for clients who have PE are the same as those for all other Medicaid clients.

There are five client types of assistance (TA) and one client type program (TP) that provide full Medicaid coverage through presumptive eligibility. Services reimbursed under the presumptive eligibility process are fee-for-service only.

The following are eligible for presumptive eligibility:

- TA74—Children under 1 year of age presumptive
- TA75—Children 1–5 years of age presumptive
- TA76—Children 6–18 years of age presumptive
- TA83—Former Foster Care Children presumptive
- TA86—Parents and caretaker relatives presumptive
- TP42—Pregnant women presumptive

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The length of coverage depends on several factors:

- If the individual submits an application for regular Medicaid, the PE Medicaid coverage ends the date the state makes a determination for regular Medicaid.
- If the individual does not submit an application for regular Medicaid, the PE coverage ends the last day of the month following the PE determination.

4.3.4.3 Qualified Provider Enrollment

To make PE determinations, the provider must be a qualified hospital or qualified entity. A qualified hospital:

- Is a Medicaid provider.
- Notifies HHSC of its intent to make presumptive eligibility determinations.
- Agrees to make presumptive eligibility determinations according to HHSC policies and procedures.
- Can make presumptive eligibility determinations for pregnant women, children, former foster care children, and parents and other caretakers.
- Helps individuals complete and submit online applications for regular Medicaid.
- Helps individuals understand which documents to send to the state to determine whether they qualify for regular Medicaid.
- Has not been disqualified.

A qualified entity meets the same criteria as a qualified hospital, except that a qualified entity:

- Can be a hospital, clinic, school, or other entity.
- May only make presumptive eligibility determinations for pregnant women.

For more information on how to become a qualified hospital or entity, visit www.TexasPresumptiveEligibility.com.

4.3.4.4 Process

Qualified hospital or entity staff determine eligibility for PE coverage based on the client's statement of residency, income, household composition, citizenship or immigration status, and pregnancy (for Pregnant Women Presumptive). The client is certified for PE if their statement indicates that they meet Medicaid eligibility criteria.

If the client chooses to apply for regular Medicaid, qualified hospital or entity staff assist the client in completing the application. The application is then forwarded to HHSC to determine the client's eligibility for regular Medicaid.

The period of PE begins on the date the qualified hospital or entity makes the determination and ends when HHSC makes the final Medicaid determination.

4.4 CHIP Perinatal Program

The Children's Health Insurance Program (CHIP) Perinatal Program provides CHIP perinatal benefits for 12 months to the unborn children of non-Medicaid-eligible women. This program allows pregnant women who are ineligible for Medicaid because of income or immigration status to receive prenatal care and provides CHIP benefits to the child upon delivery for the duration of the coverage period. Continuous Medicaid coverage for 12 months is provided from birth to CHIP Perinatal newborns whose mothers received Emergency Medicaid for the labor and delivery. The 12 months of continuous Medicaid coverage for the newborn is available only if the mother received Medicaid for labor and delivery.

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4.4.1 Program Benefits

CHIP Perinatal benefits are provided by select CHIP health plans throughout the state. Benefits for the unborn child include:

- Up to 20 prenatal visits:
  - First 28 weeks of pregnancy—one visit every four weeks.
  - From 28 to 36 weeks of pregnancy—one visit every two to three weeks.
  - From 36 weeks to delivery—one visit per week.
  - Additional prenatal visits are allowed if they are medically necessary.
- Pharmacy services, limited laboratory testing, assessments, planning services, education, and counseling.
- Prescription drug coverage based on the current CHIP formulary.
- Hospital facility charges and professional services charges related to the delivery. Preterm labor that does not result in a birth and false labor are not covered benefits.

Program benefits after the child is born include:

- Two postpartum visits for the mother.
- Medicaid benefits for the newborn.

4.4.2 Claims

Providers who serve CHIP Perinatal clients must follow the claims filing guidelines in subsection 6.19.1, "CHIP Perinatal Newborn Transfer Hospital Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

4.4.3 Client Eligibility Verification

The *State Medicaid Manual*, Chapter 2, "State Organization," (Section 2080.18) allows states to contract with outside agents to confirm for providers the eligibility of a Medicaid client. Medicaid providers may contract with these agents for eligibility verification with a cost to the provider. The provider remains responsible for adhering to the claims filing instructions in this manual. The provider, not the agent, is responsible for meeting the 95-day filing deadline and other claims submission criteria.

A number is issued for the baby based on the submission of the Emergency Medical Services Certification Form H3038 or CHIP Perinatal - Emergency Medical Services Certification, Form H3038P for the mother's labor with delivery.

Establishing Medicaid for the newborn requires the submission of the Emergency Medical Services Certification Form H3038 or CHIP Perinatal - Emergency Medical Services Certification, Form H3038P for the mother's labor with delivery. If Form H3038 or H3038P is not submitted, Medicaid cannot be established for the newborn from the date of birth for 12 continuous months of Medicaid coverage. Once enrolled, clients are identified as type program (TP) 36 for the mother and TP 45 for the newborn.

Establishing Medicaid (and issuance of a Medicaid number) can take up to 45 days after Form H3038 or H3038P is submitted. Medicaid eligibility for the mother and infant can be verified by:

- Using TexMedConnect.
- Accessing the Medicaid Client Portal for Providers.
- Calling AIS at 1-800-925-9126.

For clients enrolled in the CHIP Program, the CHIP health plan assigns a client ID to be used for billing. Providers should contact the CHIP health plan for billing information.

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Newborns whose mother received Medicaid including emergency Medicaid are eligible to receive Medicaid benefits beginning at the date of birth and will not be assigned a client ID from the CHIP health plan.

HHSC requires the expectant mother's provider to fill out the Emergency Medical Services Certification (Form H3038 or H3038P).

The expectant mother will receive this form from HHSC before her due date, along with a letter reminding her to send information about the birth of her child after delivery. The letter will instruct the expectant mother to take the form to her provider, have the provider fill out the form, then mail the form back to HHSC in a preaddressed, postage-paid envelope. In many cases this activity will occur after delivery when the mother is being discharged from the hospital.

Once HHSC receives the completed Emergency Medical Services Certification (Form H3038 or H3038P), Emergency Medicaid coverage will be added for the mother for the period of time identified by the health care provider. The Emergency Medical Services Certification (Form H3038 or H3038P) is the same form currently required to complete Emergency Medicaid certification.

The CHIP perinatal mother whose income is at or below pregnant women's Medicaid FPL will not be required to fill out a new application or provide new supporting documentation to apply for Emergency Medicaid. HHSC will determine the woman's eligibility for Emergency Medicaid by using income and other information the mother to-be provided when she was determined to be eligible for CHIP perinatal coverage, as well as information included on the Emergency Medical Services Certification (Form H3038 or H3038P).

If a woman fails to return the completed Emergency Medical Services Certification (Form H3038 or H3038P) within a month after her due date, HHSC will send her another Emergency Medical Services Certification Form H3038 or H3038P with a postage-paid envelope. If the woman fails to submit Emergency Medical Services Certification (Form H3038 or H3038P), and the hospital cannot locate a Type Program 36 for her in the TMHP online provider lookup tool, then the hospital can bill her for facility fees incurred during her stay.

4.4.3.1 Confirming Receipt of Form H3038 or H3038P

Providers who would like to confirm receipt of form H3038 or H3038P can contact MAXIMUS at 1-877-KIDS-NOW (1-877-543-7669), prompt #6 (for reporting changes) after 48 hours from fax submission. If the submission is by regular mail, providers should allow five business days before contacting MAXIMUS. When calling this number, providers should be prepared to provide the following information:

- National Provider Identifier (NPI)
- Provider name
- Name of person calling
- CHIP perinatal case number (Without the case number, MAXIMUS cannot provide confirmation of receipt. Confirmation of receipt cannot be provided based on client name or address.)

Each form H3038 or H3038P should be faxed one at a time, rather than in a batch. It is important that the form be filled out completely and accurately. If the form is not filled out accurately, it will delay processing and MAXIMUS may not be able to confirm receipt after 48 hours from fax submission.

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4.4.3.2 Eligibility Verification for Clients Without a Medicaid ID

Providers should first attempt to verify if a Medicaid number has been issued by calling TMHP at 1-800-925-9126 and using the prompt for AIS or speaking to a representative. Providers can verify eligibility using TexMedConnect or the Medicaid Client Portal for Providers. If a provider is unable to locate a Medicaid number for the mother or infant 45 days after form H3038 or H3038P was faxed, the provider can contact the HHSC Central Processing Center (CPC) in one of the following ways:

- By email at CPC@hhsc.state.tx.us
- By telephone at 1-866-291-1258

CPC needs the following information to respond to requests or inquiries. Providers should submit the information only once. All submissions must be sent in a secure manner. If there are multiple inquiries that are over 45 days, providers can submit them together.

Required information includes the following:

- CHIP perinatal case number
- Mother's name as it appears on her CHIP Perinatal card
- Dates of service
- Date Form H3038 or H3038P was faxed to MAXIMUS
- Baby's first and last name
- Baby's date of birth
- Name and telephone number of the person completing the request

CPC will research inquiries and respond to the provider within 10 business days. This time frame is an approximation and may only apply if all information, including complete contact information, is provided and fewer than 25 names were submitted.

4.4.3.3 Mother's eligibility

For mothers who currently receive CHIP perinatal, have an income at or below the pregnant women's Medicaid FPL, and receive emergency Medicaid coverage, providers can check eligibility by:

- Accessing the Medicaid Client Portal for Providers.
- Calling AIS at 1-800-925-9126.

4.4.3.4 Newborn's eligibility

For CHIP Perinatal newborns who have a family income at or below pregnant women's Medicaid limits FPL, providers can obtain eligibility information and the newborn's PCN by performing an eligibility verification using the following sources:

- Accessing the Medicaid Client Portal for Providers.
- Calling AIS at 1-800-925-9126.

TMHP cannot provide CHIP Perinatal Program eligibility information for the newborn or mother, regardless of the client's income level. For CHIP Perinatal Program eligibility information, contact the CHIP health plan.

A report of birth remains an important step to ensure timely Medicaid eligibility for the newborn. A birth must be reported to the state through the typical birth registry process (e.g., use of Texas Electronic Registration system [TER]). In TER, the screen containing the Medicaid/CHIP number should continue to be populated with the mother's alpha-numeric CHIP Perinatal Program number (e.g., J12345678). In addition, a mother can report the birth by calling 1-877-KIDS-NOW (1-877-543-7669).

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4.4.4 Submission of Birth Information to Texas Vital Statistics Unit

Hospital providers must submit birth registry information to the DSHS Vital Statistics Unit in a timely manner. Once received by the Vital Statistics Unit, birth information is transmitted to the state's eligibility systems, so a PCN (Medicaid number) can be issued for newborns whose mothers were at or below the pregnant women's FPL. Hospitals should use the CHIP Perinatal health plan ID to enter the mother's CHIP perinatal coverage ID number in the Medicaid/CHIP number field on the Texas Electronic Registration (TER) screen. This number will appear as an alpha-numeric combination, starting with a letter followed by eight digits. For example, G12345678.

For more information, go to the HHSC website at https://www.dshs.texas.gov/vital-statistics or call Texas Vital Statistics at 1-800-452-9115.

4.5 Medically Needy Program (MNP)

The MNP with spend down is limited to children 18 years of age and younger and pregnant women.

The MNP provides Medicaid benefits to children (18 years of age and younger) and pregnant women whose income exceeds the eligibility limits under one of the Medical Assistance Only (MAO) programs but is not enough to meet their medical expenses. Coverage is available for services within the amount, duration, and scope of Texas Medicaid. Individuals are considered adults beginning the month following their 19th birthday.

Medicaid benefits, including family planning and THSteps preventive services through the MNP, are available to:

- Pregnant women.
- Children 18 years of age and younger.

MNP provides access to Medicaid benefits. Applications are made through HHSC. HHSC determines eligibility for the appropriate Medicaid program.

If spend down is applicable, HHSC issues a Medical Bills Transmittal (Form H1120) to the MNP applicant that indicates the spend down amount, months of potential coverage (limited to the month of application and any of the three months before the application month that the applicant has unpaid medical bills), and HHSC contact information.

The applicant is responsible for paying the spend down portion of the medical bills. The TMHP Medically Needy Clearinghouse (MNC) determines which bills may be applied to the applicant's spend down according to state and federal guidelines. No Medicaid coverage may be granted until the spend down is met.

Newborns of mothers who met spend down and received Medically Needy with Spend Down (TP 56) or Medically Needy with Spend Down-Emergency (TP 32) to cover the newborns birth, are eligible for coverage from the date of birth until the month the child turns one. Hospitals and other providers that complete newborn reporting forms should continue to follow the procedures in subsection 3.2.4, "Newborn Care" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for these newborns.

4.5.1 Spend Down Processing

Applicants are instructed to submit their medical bills or completed claim forms for application toward their spend down to TMHP MNC along with the Medical Bills Transmittal/Insurance Information Form H1120. Charges from the bills or completed claim forms are applied in date of service order to the spend down amount, which is met when the accumulated charges equal the spend down amount.

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Providers can assist medically needy clients with their applications by giving them current, itemized statements or completed claim forms to submit to MNC. MNC holds manually completed claim forms used to meet spend down for ten calendar days preceding the completion of the spend down case, then forwards them to claims processing. The prohibition against billing clients does not apply until Medicaid coverage is provided.

Current itemized statements or completed claim forms must include the following:

- Statement date
- Provider name
- Client name
- Date of service
- All services provided and charges
- Current amount due
- Any insurance or client payments with date of payment (the date and amount of any insurance or payments)

Important: *Amounts used for spend down are deducted from the total billed amount by the provider. Using older bills may provide earlier eligibility for the client.*

Bills for past accounts must be current, itemized statements (dated within the last 60 days) that are from the provider and that verify the outstanding status of the account and the current balance due. Accounts that have had payments made by an insurance carrier, including Medicare, must be accompanied by the carrier's EOB or Remittance Advice and show the specific services covered and amounts paid.

Unpaid bills incurred before the month of potential eligibility (the month with spend down) may be used to meet spend down. Itemized statements must be dated within 60 days of the date they are received at TMHP MNC.

The unpaid balance on currently due accounts may be applied toward the spend down regardless of the date of service. All bills or completed claim forms must be itemized showing the provider's name, client's name, dates of service, statement date, services provided, charge for each service, total charges, amounts and dates of payments, and total due.

Clients have 30 days to submit their bills or completed claim forms. Thirty-day extensions are available to the client as necessary to gather all needed information. The provider can assist by furnishing the additional information to the applicant.

All communication about submission of billing information is carried out between MNC and the applicant; however, providers can assist clients by:

- Providing clients with current itemized statements or completed claim forms.
- Encouraging clients to submit *all* of their medical bills or completed claim forms incurred from *all* providers at the same time.
- Submitting manual claim forms directly to MNC or to applicants for the MNP, that can be used to meet spend down.

Bills or claim forms submitted to MNC are for application toward the spend down only. Submitting a bill or claim forms for spend down is *not* a claim for reimbursement. *No* claims reimbursement is made from such submittals unless the claim form is complete. The provider must file a Medicaid claim after eligibility has been established to have reimbursement considered by Texas Medicaid. If the provider assisted the client with submission of a claim form, the MNC retains all claim forms for ten calendar days preceding the completion of the spend down case. The MNC then forwards all claim forms directly to claims processing to have reimbursement considered by Texas Medicaid.

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MNC informs the applicant and HHSC when the spend down is met. HHSC certifies the applicant for Medicaid and sends the Medicaid Identification form to the applicant when Medicaid eligibility is established. The TMHP MNC mails notification letters to providers when clients have met spend down. The notification letter states that an invoice was submitted for the spend down and that the provider should submit claims for any bills that fall within the indicated spend down month. Clients are encouraged to inform medical providers of their Medicaid eligibility and make arrangements to pay the charges used to meet the spend down amount. When notified of Medicaid eligibility, the provider asks if the client has retroactive eligibility for previous periods.

Providers may inquire about status, months of potential eligibility, Medicaid or case number, and general case information by calling the TMHP Contact Center at 1-800-925-9126.

Medically needy applicants who have a case pending or have not met their spend down are considered private-pay clients and may receive bills and billing information from providers. No claims are filed to Medicaid. A claim that is inadvertently filed is denied because of client ineligibility.

4.5.2 Closing an MNP Case

Medically needy cases are closed by MNC for the following reasons:

- Bills were not received within the designated time frame (usually 30 days from the date on which the case is established by the HHSC worker).
- The client failed to provide requested additional case/billing information within 30 days of the MNC request date.
- Insufficient charges were submitted to meet spend down, and the client did not respond to a request for additional charges to be submitted within 30 days of the notification letter.

Charges submitted after the spend down has been met will not reopen the case automatically. The client must call the Client Hotline at 1-800-335-8957.

Note: *For information regarding the Medically Needy Program for CSHCN Services Program clients refer to the CSHCN Services Program Provider Manual.*

4.6 Medicaid Buy-in for Children (MBIC) Program

The MBIC program is mandated by S.B. 187, 81st Legislature, Regular Session, 2009, to provide acute care Medicaid coverage for children who are 18 years of age and younger and have disabilities. This program creates a state option for children who are ineligible for Supplemental Security Income (SSI) for reasons other than disability.

Children with disabilities must meet the following requirements to be eligible for MBIC:

- Be 18 years of age or younger.
- Have a family income that is no more than 300 percent of FPL before allowable deductions.
- Meet citizenship, immigration, and residency requirements.
- Be unmarried.
- Not reside in a public institution.

Exception: *Clients who are enrolled in the MBIC program before they enter a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) will continue to receive MBIC benefits until eligibility for the appropriate institutional Medicaid program is determined.*

MBIC clients will be enrolled as Medicaid fee-for-service. MBIC clients have access to the same benefits as Medicaid clients who have disabilities. Claims and prior authorization requests for MBIC clients may be submitted according to current guidelines for Medicaid fee-for-service as indicated in this manual.

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MBIC benefits are available to enrolled clients through the end of the month that contains their nineteenth birthday. Clients whose birthday falls on the last day of February of a leap year (e.g., February 29, 2004) will be eligible for benefits through the end of March following their nineteenth year.

4.7 Healthy Texas Women (HTW) Program

The goal of the HTW program is to expand access to women's health and family planning services to reduce unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and wellbeing of women and their families in the eligible population.

HTW provides family planning services, related preventive health services that are beneficial to reproductive health and other preventive health services that positively affect maternal health and future pregnancies for women who:

- Are 15 through 44 years of age

  Note: *Women who are 15 through 17 years of age must have a parent or legal guardian apply on their behalf.*

- Are a United States citizen or eligible immigrant
- Are a resident of Texas
- Do not currently receive benefits through a Medicaid program (including Medicaid for Pregnant Women), Children's Health Insurance Program (CHIP), or Medicare Part A or B.
- Have a household income at or below 204.2 percent of the federal poverty level
- Are not pregnant
- Do not have other insurance that covers the services HTW provides

Exception: *A client who has other private health insurance may be eligible to receive HTW services if a spouse, parent, or other person would cause physical, emotional, or other harm to the client because the client filed a claim on the health insurance.*

Refer to: Subsection 2.1, "Guidelines for HTW Providers" in the *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*).

4.8 Medicaid for Breast and Cervical Cancer (MBCC)

The MBCC program provides full Medicaid benefits to women who meet the program's eligibility requirements. The goal of the program is to improve timely access to breast and cervical cancer treatment for uninsured women who are screened and identified by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) of the Centers for Disease Control and Prevention (CDC). Additionally, the Texas State Legislature provided funding in 2007 to expand the pool of providers who provide screening and diagnostic services to women so that any provider can diagnose a woman for breast or cervical cancer and she may become eligible for Medicaid through MBCC.

DSHS receives funds from the CDC and awards the funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services under the Breast and Cervical Cancer Services (BCCS) program.

4.8.1 Initial MBCC Program Enrollment

The woman must be diagnosed and in need of treatment for one of the following biopsy-confirmed breast or cervical cancer diagnoses:

- Grade 3 cervical intraepithelial neoplasia (CIN III)
- Severe cervical dysplasia

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- Cervical carcinoma in situ
- Primary cervical cancer
- Ductal carcinoma in situ
- Primary breast cancer

A woman may also be eligible for MBCC if she has a diagnosis of metastatic or recurrent breast or cervical cancer and a need for treatment.

Eligibility is determined by a BCCS contractor, DSHS, and HHSC as follows:

- The BCCS contractor screens the client for eligibility if she has a qualifying diagnosis and, if applicable, helps the woman to complete Form H1034, Medicaid for Breast and Cervical Cancer application. The BCCS contractor reviews and collects all of the required eligibility documentation. The woman cannot apply for MBCC at a local HHSC eligibility office.
- DSHS verifies the client's qualifying diagnosis and submits Form 1034 to HHSC eligibility staff.
- HHSC Centralized Benefits Services staff makes the final Medicaid eligibility determination.

Refer to: The Breast and Cervical Cancer Treatment Information page of the DSHS website for more information about the enrollment process.

4.8.2 MBCC Program Eligibility

To be eligible for MBCC, a woman must be:

- 64 years of age or younger and have been screened for breast or cervical cancer and found to need treatment for either breast or cervical cancer.
- A U.S. citizen or eligible immigrant.
- Uninsured or otherwise not eligible for Medicaid.
- A resident of Texas.

A woman who is eligible to receive Texas Medicaid under MBCC receives full Medicaid benefits beginning the day after she received a qualifying diagnosis and for the duration of her cancer treatment. Services are not limited to the treatment of breast and cervical cancer.

4.8.3 Continued MBCC Program Eligibility

After a woman is enrolled in the MBCC program, eligibility may continue if she meets one of the following criteria:

- She is being treated for active disease as defined above,
- She has completed active treatment while in MBCC and is currently receiving hormonal treatment,
- She has completed active treatment while in MBCC and is currently receiving active disease surveillance for TNRBC.

A woman may continue to receive Medicaid benefits as long as she meets the eligibility criteria and provides proof that she is receiving active treatment for breast or cervical cancer. Women who are no longer in MBCC may reapply if they are diagnosed with a new breast or cervical cancer or a metastatic or recurrent breast or cervical cancer.

Note: *Active disease surveillance (for the purposes of determining eligibility for MBCC) is periodically monitoring disease progression in order to quickly treat cancerous and precancerous conditions that arise from the presence of a previously diagnosed TNRBC.*

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If the client's cancer is in remission and the physician determines that the client requires only routine health screening for a breast or cervical condition (e.g. annual breast examinations, mammograms, and Pap tests as recommended by the American Cancer Society and the U.S. Preventative Services Task Force), the client is not considered to be receiving treatment; and MBCC coverage will not be renewed. A client who is subsequently diagnosed with a new, metastatic, or recurrent breast or cervical cancer may reapply for MBCC benefits.

4.9 Medicare and Medicaid Dual Eligibility

Medicaid clients who are also eligible for Medicare Part A (inpatient coverage), Part B (medical coverage), or Part C (noncontracted Medicare Advantage Plans [MAPs]), may be covered by Texas Medicaid as follows:

- QMB clients are eligible for coinsurance and deductible payments according to the current payment guidelines.
- MQMB clients are eligible for coinsurance and deductible payments according to the current payment guidelines, and receive Medicaid benefits for services that are not a benefit of Medicare or exceed Medicare benefit limitations.

Medicare Part A and Part C (Noncontracted MAPs Only)

For QMB and MQMB clients who are eligible for Medicare Part A, including clients enrolled in MAPs, claims may be reimbursed to providers for the client's Medicare coinsurance and deductible up to the Medicaid allowed amount for the service less the amount paid by Medicare.

For Medicare Part C, the coinsurance and deductible payment guidelines apply for noncontracted MAPs only.

Medicare Part B

For QMB and MQMB clients who are eligible for Medicare Part B, Texas Medicaid reimburses the lesser of the following to providers:

- The coinsurance and deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service (If this amount is less than the deductible, then the full deductible is reimbursed instead.)

If the Medicare payment is equal to, or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid does not make a payment for coinsurance.

> ***Note:*** *If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, no additional payment is made for coinsurance and deductible.*

QMB clients are not eligible for Medicaid coverage for benefits that are not covered by Medicare, and QMB clients are not eligible for THSteps or CCP Medicaid benefits.

QMB and MQMB coverage guidelines do not impact clients who are living in nursing facilities and who receive a vendor rate for client care through HHSC.

Claims for Medicare copayments can also be submitted to TMHP.

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Refer to: Subsection 2.7.5, "Exceptions" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about exceptions for Medicare Part B and Part C (noncontracted MAPs).

Subsection 6.12.1.2, "Medicare Copayments" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about HMO copayments.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about filing claims for MQMBs and QMBs.

4.9.1 QMB/MQMB Identification

The term "QMB" or "MQMB" on TexMedConnect indicates the client is a Qualified Medicare Beneficiary or a Medicaid Qualified Medicare Beneficiary. The Medicare Catastrophic Coverage Act of 1988 requires Medicare premiums, deductibles, and coinsurance payments to be paid for individuals determined to be QMBs or MQMBs who are enrolled in Medicare Part A and meet certain eligibility criteria (see 1 TAC §§358.201 and 358.202).

Refer to: Your Texas Benefits Medicaid card (English and Spanish) on the TMHP website at www.tmhp.com.

4.9.2 Medicare Part B Crossovers

The following qualify as Medicare Part B crossover claims: QMB, MQMB, and client TPs 13 or 14, with base plan 10, and category R.

If the provider has not accepted Medicare assignment, the provider may receive payment of the Medicare deductible or coinsurance according to current guidelines on behalf of the QMB, MQMB, client TPs 13 or 14, base plan 10, and category R client. If the provider has collected money from the client and also received reimbursement from TMHP, the provider is required to refund the client's money.

The Social Security Act requires that Medicaid payment for physician services under Medicare Part B be made on an assignment-related basis.

If Medicaid does not reimburse all or a part of the deductible or coinsurance, the provider is not allowed to bill the client.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

4.9.3 Clients Without QMB or MQMB Status

Medicare is primary to Medicaid, and providers must bill Medicare first for their claims. Medicaid's responsibility for coinsurance and deductibles is determined in accordance with the Medicaid benefits and limitations including the 30-day spell of illness. TMHP denies claims if the client's coverage reflects Medicare Part A coverage and Medicare has not been billed first.

Providers must check the client's Medicare card for Part A coverage before billing Texas Medicaid.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

4.9.4 Medicare Part C

Providers can verify a client's Medicare Part C eligibility by:

- Checking TMHP EDI.
- Accessing the Medicaid Client Portal for Providers.
- Using TexMedConnect.

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In response to an eligibility inquiry, providers receive the client's Medicare Part C eligibility effective date, end date, and add date.

HHSC contracts with some Medicare Advantage Plans (MAPs) and offers a per-client-per-month payment. The payment to the MAP includes all costs associated with the Medicaid cost sharing for dual-eligible clients. MAPs that contract with HHSC will reimburse providers directly for the cost sharing obligations that are attributable to dual-eligible clients enrolled in the MAP. These payments are included in the capitated rate paid to the HMO and must not be billed to TMHP or a Medicaid client.

TMHP now processes certain claims for clients enrolled in a Medicare Advantage Plan (Part C).

Refer to: Subsection 6.12, "Filing Medicare Primary Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

A list of MAPs that have contracted with HHSC is available in the "EDI" section of the TMHP website at www.tmhp.com. The list will be updated as additional plans initiate contracts.

4.9.5 Medicare Part D

Providers can verify a client's Medicare Part D eligibility by accessing the Medicaid Client Portal for Providers.

4.10 Health Insurance Premium Payment (HIPP) Program

The HIPP Program reimburses for the cost of medical insurance premiums. A Medicaid client is eligible for the HIPP Program when Medicaid finds it more cost effective to reimburse a Medicaid client's group health insurance premiums than to reimburse his or her medical bills directly through Medicaid.

By ensuring access to employer sponsored health insurance, individuals who are eligible for the HIPP Program may receive services that are not normally covered through Medicaid. Also, members of the family who are not eligible for Medicaid may be eligible for the HIPP Program.

Providers can benefit from this program by helping the uninsured population, saving money for the state of Texas, and receiving a higher payment from the group health insurance carrier. Providers can increase HIPP Program enrollment by displaying brochures to educate their Medicaid clients about the program.

For more information, call the TMHP-HIPP Program at 1-800-440-0493 or visit www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program.

4.11 Long-Term Care Providers

A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare-certified must:

- Seek reimbursement from Medicare before billing Texas Medicaid for services provided to an individual who is eligible to receive similar services under the Medicare program.
- Appeal Medicare claim denials for payment, as directed by the department.

A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare-certified is not required to seek reimbursement from Medicare before billing Texas Medicaid for a person who is Medicare-eligible and has been determined to not be homebound.

4.12 State Supported Living Centers

Inpatient hospital care for individuals who are eligible for Supplemental Security Income (SSI) Medicaid and reside in a State Supported Living Center (SSLC) must be billed to TMHP. Medicaid providers who render off-campus acute care services to Medicaid-eligible SSLC residents are also required to submit claims directly to Medicaid. This is applicable only to residents of the SSLCs operated by HHSC.

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Claims and prior authorization requests for acute care services that are rendered to these clients must be submitted directly to Medicaid.

Providers may contact HHSC for assistance or information about billing procedures for state school services.

4.13 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Your Texas Benefits Medicaid card (English and Spanish)
Informational Claims Submission Form
Other Insurance Form
Use and Release of Health Information Authorization
Use and Release of Health Information Authorization (Spanish)
Tort Response Form

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Section 5: Fee-for-Service Prior Authorizations

Texas Medicaid Provider Procedures Manual: Vol. 1

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TEXAS
Health and Human Services

SECTION 5: FEE-FOR-SERVICE PRIOR AUTHORIZATIONS

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5.1 General Information About Prior Authorization

Some fee-for-service Medicaid services require prior authorization as a condition for reimbursement. Information about whether a service requires prior authorization, as well as prior authorization criteria, guidelines, and timelines for the service, is contained in the handbook within Volume 2 that contains the service.

Prior authorization is not a guarantee of payment. Even if a procedure has been prior authorized, reimbursement can be affected for a variety of reasons, e.g., the client is ineligible on the date of service (DOS) or the claim is incomplete. Providers must verify client eligibility status before providing services.

In most instances prior authorization must be approved before the service is provided. Prior Authorization for urgent and emergency services that are provided after business hours, on a weekend, or on a holiday may be requested on the next business day. TMHP considers providers' business hours as Monday through Friday, from 8 a.m. to 5 p.m., Central Time. Prior authorization requests that do not meet these deadlines may be denied.

To avoid unnecessary denials, the request for prior authorization must contain correct and complete information, including documentation of medical necessity. The documentation of medical necessity must be maintained in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for prior authorization.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for the TMHP-approved holidays.

Note: *Authorization requests for services administered by a client's managed care organization (MCO) or dental plan must be submitted to the client's MCO or dental plan according to the guidelines that are specific to the plan under which the client is covered.*

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care prior authorizations.

5.1.1 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

When an authorization request is submitted for a client who has received retroactive Texas Medicaid eligibility, providers should notify TMHP to avoid potential delays. Providers can notify TMHP of the retroactive client eligibility in one of the following ways:

- Add a comment in the additional comments field for authorization requests that are submitted online on the TMHP website at www.tmhp.com.
- Add a comment on the cover sheet or the authorization request form for authorizations that are faxed to TMHP.

If the authorization request is made by telephone, the caller can indicate to the representative at TMHP that the client has retroactive Texas Medicaid eligibility.

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For services provided to fee-for-service Medicaid clients during the client's retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client's add date and before a claim for those services is submitted to TMHP. For services provided on or after the client's add date, the provider must obtain prior authorization within 3 business days of the date of service.

The provider is responsible for verifying the client's eligibility. Providers are strongly encouraged to verify the client's eligibility frequently. Providers can verify eligibility by:

- Accessing the Medicaid Client Portal for Providers.
- Using TexMedConnect.
- Calling the Automated Inquiry System (AIS) at 1-800-925-9126.

If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: "Section 4: Client Eligibility" (*Vol. 1, General Information*).

5.1.2 Prior Authorization Requests for Newly Enrolled Providers

TMHP cannot issue a prior authorization before Medicaid enrollment is complete. Upon notice of Medicaid enrollment, the provider must contact the appropriate TMHP Authorization Department to request prior approval before providing services that require prior authorization. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted.

Retroactive authorizations are not issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. Providers should refer to specific handbook sections for details about authorization requirements, claims filing, and timeframe guidelines for authorization request submissions. Retroactive authorizations may be granted according to the timeframe guidelines for the specific service requested, and do not exceed those timeframes.

Note: *All claims must adhere to the claims filing deadlines as outlined in this manual. Retroactive authorizations cannot exceed the claims filing deadline, and are not issued if the date of services is more than 95 days from the date of enrollment as identified by the add date.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

5.1.3 Prior Authorization for Services Rendered Out-of-State

Texas Medicaid covers medical assistance services that are provided to eligible Texas Medicaid clients while they are in a state other than Texas; however, clients are not covered if they leave Texas to receive out-of-state medical care that can be received in Texas. Services that are provided outside of the state are covered by Texas Medicaid to the same extent that medical assistance is furnished and covered in Texas when the service meets one or more requirements of Texas Administrative Code (TAC) Title 1 §352.17.

Note: *Border state providers (providers that render services within 50 miles of the Texas border) are considered in-state providers for Texas Medicaid.*

Services that are rendered outside of the state must be prior authorized by Texas Medicaid, and TMHP must receive claims from out-of-state providers within 365 days of the date of service. Out-of-state providers that seek reimbursement for services that are rendered outside of the state must submit a Texas Medicaid Provider Enrollment application and be approved for enrollment in Texas Medicaid.

Transplant services that are provided out-of-state but available in Texas will not be reimbursed by Texas Medicaid. When requesting an out-of-state prior authorization for a pre-transplant evaluation, the provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an out-of-state pre-transplant evaluation.

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Medical assistance and transplant services that are provided to eligible Texas Medicaid clients must meet the criteria included in subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*). If services are rendered to eligible Texas Medicaid clients that do not meet the criteria, the services are not a benefit of Texas Medicaid and will not be considered for reimbursement.

Refer to: Subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.6, "Out-of-State Medicaid Providers" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

5.1.4 Prior Authorization Requests for Clients with Private Insurance

If a client's primary coverage is private insurance and Medicaid is secondary but prior authorization is required for Medicaid reimbursement, providers must follow the guidelines and requirements listed in the handbook for that service.

5.1.5 Prior Authorization Requests for Clients with Medicare/Medicaid

If a client's primary coverage is Medicare, providers must always confirm with Medicare whether a service is a Medicare benefit for the client.

If a service that requires prior authorization from Medicaid is a Medicare benefit and Medicare approves the service, prior authorization from TMHP is not required for reimbursement of the coinsurance or deductible. If Medicare denies the service, then prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare's final disposition. The Medicare Remittance Advice and Notification (MRAN) that contains Medicare's final disposition must accompany the prior authorization request.

If a service requires prior authorization through Medicaid and the service is not a benefit of Medicare, providers may request prior authorization from TMHP before receiving the denial from Medicare.

Note: *Refer to the appropriate handbooks in this manual for additional prior authorization guidelines for clients with dual eligibility.*

5.1.6 Prior Authorizations for Personal Care Services (PCS)

Before sending a prior authorization request for personal care services to TMHP, the Texas Department of State Health Services (DSHS) will fax the communication tool to the provider. The provider must verify that the information listed on the tool is accurate. If any information on the communication tool is inaccurate, the provider must call the DSHS case manager listed on the tool within three business days of receipt to explain the inaccuracy. The DSHS case manager will correct the communication tool and will fax the updated tool to the provider. The provider must review the updated communication tool and call the DSHS case manager if any inaccuracies remain.

If the provider does not contact the DSHS case manager within three business days of receipt of the communication tool, the case manager will send a prior authorization request to TMHP to have the authorization issued with the information provided on the communication tool.

Important: *If a provider fails to notify the DSHS case manager of inaccurate information within three business days of receipt of the communication tool, HHSC will not consider making changes to authorizations for past dates of service.*

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It is the PCS provider's responsibility to know the prior authorization period for each client who has an open authorization and to ensure that, before the authorization expires, a DSHS case manager has conducted a reassessment and extended the authorization through TMHP. If a provider has not received an updated provider notification letter from TMHP within 30 days of the authorization's expiration date, the provider should do one of the following:

- Call the TMHP PCS Prior Authorization Inquiry Line at 1-888-648-1517 and ask whether an authorization is in process.
- Call the TMHP PCS Client Line at 1-888-276-0702, Option 2, and ask for a referral to have DSHS conduct a reassessment.
- Call the DSHS regional office, and notify the DSHS case manager that a new authorization has not been received.

Clients can experience a gap in service if an authorization is not updated before it expires. Providers will not be reimbursed for services provided after an authorization has expired and before a new authorization has been issued.

Providers must retain current client information on file.

5.1.6.1 Authorizations for Multiple PCS Clients Within the Same Household

DSHS case managers synchronize PCS authorizations within households that have multiple clients who are receiving PCS.

Synchronization of authorizations within households are made as PCS reassessments come due. When clients are due for reassessment, the DSHS case manager assess all eligible clients in the home and submit authorizations for all eligible clients in the household for the same 52-week authorization period. Some authorizations within a household may be shortened or closed and then reinstated to be in alignment with other clients in the same household. DSHS case managers communicate with the provider about the actions that are being taken using the existing Communication Tool.

Note: *There should be no lapse in services to the client.*

5.1.6.2 Verifying the National Provider Identifier (NPI) on PCS Authorizations

When an authorization notification letter is received by a PCS provider, the provider should verify that the correct NPI was used on the prior authorization for the PCS client. Providers must verify that the NPI on the prior authorization is correct for the location at which the client is receiving services.

Providers who provide services through the Agency option or the Consumer Directed Services (CDS) option must ensure that the NPI on the prior authorization is accurate for the option the client is using. If a provider discovers that the NPI used on the prior authorization is incorrect, the provider should contact the DSHS case manager and ask for the correct NPI to be submitted to TMHP.

5.1.7 Prior Authorization for Outpatient Self-Administered Prescription Drugs

Refer to: Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

5.1.8 Prior Authorization for Nonemergency Ambulance Transport

According to 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client's home after discharge from a hospital when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated).

Refer to: The *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about ambulance services.

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According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

HRC states that a provider of nonemergency ambulance transport is entitled to payment from the nursing facility, health-care provider, or other responsible party that requested the service if payment under the Medical Assistance Program is denied because of lack of prior authorization and the ambulance provider submits a copy of the claim for which payment was denied.

Refer to: Subsection 5.1.8.1, "Appealing Non-Emergent Ambulance Claims Denied for Missing Prior Authorization Number" in this section for more information about appeals.

The *Medical Transportation Program Handbook* (*Vol. 2, Provider Handbooks*) for more information about the Medical Transportation Program.

TMHP responds to nonemergency transport prior authorization requests within 2 business days of receipt of requests for 60 days or less. Providers should submit all requests for a prior authorization number (PAN) in sufficient time to allow TMHP to issue the PAN before the date of the intended transport.

If the client's medical condition is not appropriate for transport by ambulance, nonemergency ambulance services are not a benefit. Prior authorization is a condition for reimbursement but is not a guarantee of payment. The client and provider must meet all of the Medicaid requirements, such as client eligibility and claim filing deadlines.

Medicaid providers who participate in one of the Medicaid Managed Care health maintenance organization (HMO) plans must follow the HMO's prior authorization requirements.

The TMHP Ambulance Unit reviews the prior authorization request to determine whether the client's medical condition is appropriate for transport by ambulance. Incomplete information may cause the request to be suspended for additional medical information or be denied.

The following information helps TMHP determine the appropriateness of the transport:

- An explanation of the client's physical condition that establishes the medical necessity for transport. The explanation must clearly state the client's condition requiring transport by ambulance.
- The necessary equipment, treatment, or personnel to be used during the transport.
- The origination and destination points of the client's transport.

Prior authorization is required when an extra attendant is needed for any nonemergency transport.

When a client's condition changes, such as a need for oxygen or additional monitoring during transport, the prior authorization request must be updated.

Refer to: Subsection 2.4.9, "Extra Attendant" in the *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*).

5.1.8.1 Appealing Non-Emergent Ambulance Claims Denied for Missing Prior Authorization Number

Medicaid fee-for-service ambulance providers can appeal claims that have been denied for a missing prior authorization number that was not provided by the requesting physician, facility, or hospital for nonemergent transport. The ambulance provider must include proper documentation with the appeal.

An ambulance provider is required to maintain documentation that represents the client's medical condition and other clinical information to substantiate medical necessity, the level of service, and the mode of transportation requested. This supporting documentation is limited to documents developed or maintained by the ambulance provider.

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The Appeals Process

The ambulance provider must submit the appeal as soon as it is realized that the requesting provider did not obtain the prior authorization. The appeal must be submitted according to all filing deadlines.

Refer to: "Section 7: Appeals" (*Vol. 1, General Information*) for information about filing deadlines.

The following documentation must be included with the appeal to support the need for transport:

- Documentation representing the client's medical condition.
- Other clinical information to support medical necessity.
- Level of service given.
- Mode of transportation requested.
- A copy of the run sheet, which must be signed by the emergency medical technician (EMT) in attendance, and which must also include the name and telephone number of the employee requesting the service for the physician, facility, or hospital.

5.1.8.2 Prior Authorization Types, Definitions

One-Time, Nonrepeating

One-time, nonrepeating requests are reserved for those clients who require a one-time transport. The request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client's condition. Without a signature and date, the form is considered incomplete.

Recurring

Recurring requests, up to 60 days, are reserved for those clients whose transportation needs are not anticipated to last longer than 60 days. The request must be signed and dated by a physician, PA, NP, or CNS. Without a signature and date, the form is considered incomplete. The request must include the approximate number of visits needed for the repetitive transport (e.g., dialysis, radiation therapy).

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

5.1.8.3 Nonemergency Prior Authorization Process

To obtain prior authorization, providers must submit a completed Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form by fax to the TMHP Ambulance Unit at 512-514-4205. Prior authorization can also be requested through the TMHP website at www.tmhp.com.

The Nonemergency Ambulance Prior Authorization Form must not be modified. If the form is altered in any way, the request may be denied. The form must be filled out by the facility or the physician's staff that is most familiar with the client's condition. For nonemergency ambulance transportation services rendered to a client, ambulance providers may coordinate the nonemergency ambulance prior authorization request between the requesting provider, which may include a physician, nursing facility, healthcare provider, or other responsible party. Ambulance providers may assist in providing necessary information such as their National Provider Identifier (NPI) number, fax number, and business address to the requesting provider. However, the Non-emergency Ambulance Prior Authorization Request form must be signed, dated, and submitted by the Medicaid-enrolled requesting provider, not the ambulance provider.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

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Medicaid providers may request prior authorization using one of the following methods:

- The client's physician, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), health-care provider, or other responsible party completes the online prior authorization request on the TMHP website at www. tmhp.com.
- Hospitals may call TMHP at 1-800-540-0694 to request prior authorization Monday through Friday, 7 a.m. to 7 p.m., Central Time. A request may be submitted up to 60 days before the date on which the nonemergency transport will occur.

A request for a one-day transport may be submitted on the next business day following the transport in some circumstances; however, every attempt should be made to obtain prior authorization before the transport takes place. Authorization requests for one day transports submitted beyond the next business day will be denied.

A request for a recurring transport must be submitted before the client is transported by ambulance.

After a prior authorization request has been approved, if the client's condition deteriorates or the need for equipment changes so that additional procedure codes must be submitted for the transport, the requesting provider must submit a new Nonemergency Ambulance Prior Authorization Request form.

Clients who require a hospital-to-hospital or hospital-to-outpatient medical facility transport are issued a PAN for that transport only.

Refer to: Subsection 4.2.1, "Prior Authorization Requirements" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on nonemergency prior authorization for hospitals.

TMHP reviews all of the documentation it receives. An online prior authorization request submitted through the TMHP website is responded to with an online approval or denial. Alternately, a letter of approval or denial is faxed to the requesting provider. The client is notified by mail if the authorization request is denied or downgraded. Reasons for denial include documentation that does not meet the criteria of a medical condition that is appropriate for transport by ambulance, or the client is not Medicaid-eligible for the dates of services requested. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406. Providers may not appeal prior authorization request denials.

The requesting provider must contact the transporting ambulance provider with the PAN and the dates of service that were approved.

Refer to: Subsection 5.5.1, "Prior Authorization Requests Through the TMHP Website" in this section for additional information, including mandatory documentation requirements and retention.

Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the hospital fax the supporting documentation. Incomplete online or faxed request forms are not considered a valid authorization request and are denied.

A nonemergency transport will be denied when a claim is submitted with a Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form that is completed and signed after the service is rendered. In addition, a Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form that is completed and signed after the service is rendered will not be accepted on appeal of the denial.

The hospital must maintain documentation of medical necessity, including a copy of the authorization from TMHP in the client's medical record for any item or service that requires prior authorization. The services provided must be clearly documented in the medical record with all pertinent information regarding the client's condition to substantiate the need and medical necessity for the services.

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Refer to: Subsection 4.2.1, "Prior Authorization Requirements" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

5.1.8.4 Nonemergency Ambulance Exception Request

Clients whose physician has documented a debilitating condition and who require recurring trips that will extend longer than 60 days may qualify for an exception to the 60-day prior authorization request.

To request an exception, providers must submit all of the following documentation:

- A completed Nonemergency Ambulance Exception form that is signed and dated by a physician. Without a physician's signature and date, the form is considered incomplete.
- Medical records that support the client's debilitating condition, which may include, but is not limited to:
  - Discharge information.
  - Diagnostic images (e.g., MRI, CT, X-rays)
  - Care plan.

Note: *Documentation submitted with statements similar to "client has a debilitating condition" are insufficient.*

5.1.8.5 Documentation of Medical Necessity and Run Sheets

5.1.8.5.1 Documentation of Medical Necessity

Retrospective review may be performed to ensure documentation supports the medical necessity of the transport.

Documentation to support medical necessity must include one of the following:

- The client is bed-confined before, during and after the trip and alternate means of transport is medically contraindicated and would endanger the client's health (i.e., injury, surgery, or the use of respiratory equipment). The functional, physical, and mental limitations that have rendered the client bed-confined must be documented.

  Note: *Bed-confined is defined as a client who is unable to stand, ambulate, and sit in a chair or wheelchair.*

- The client's medical or mental health condition is such that alternate means of the transport is medically contraindicated and would endanger the client's health (e.g., injury, surgery, or the use of respiratory equipment).
- The client is a direct threat to himself or herself or others, which requires the use of restraints (chemical or physical) or trained medical personnel during transport for client and staff safety (e.g., suicidal).

When physical restraints are needed, documentation must include, but is not limited to, the following:

- Type of restraint
- Time frame of the use of the restraint
- Client's condition

Note: *The standard straps used in an ambulance transport are not considered a restraint.*

5.1.8.5.2 Run Sheets

The run sheet is used as a medical record for ambulance services and may serve as a legal document to verify the care that was provided, if necessary. The ambulance provider does not have to submit the run sheet with the claim.

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The ambulance provider must have documentation to support the claim. Without documentation that would establish the medical necessity of a nonemergency ambulance transport, the transport may not be covered by Texas Medicaid.

The ambulance provider may decline the transport if the client's medical or mental health condition does not meet the medical necessity requirements.

It is the responsibility of the ambulance provider to maintain (and furnish to Texas Medicaid upon request) concise and accurate documentation. The run sheet must include the client's physical assessment that explains why the client requires ambulance transportation and cannot be safely transported by an alternate means of transport.

Coverage will not be allowed if the trip record does not contain a sufficient description of the client's condition at the time of the transfer for Texas Medicaid to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the client's condition is limited to statements or opinions such as the following:

- "Patient is nonambulatory."
- "Patient moved by drawsheet."
- "Patient could only be moved by stretcher."
- "Patient is bed-confined."
- "Patient is unable to sit, stand or walk."

The run sheet should "paint a picture" of the client's condition and must be consistent with documentation found in other supporting medical record documentation (including the nonemergency prior authorization request.)

5.1.8.6 Nonemergency Prior Authorization and Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the eligibility "add date," which is the date the client's Medicaid eligibility is added to TMHP's eligibility file.

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

For services that are provided to fee-for-service Medicaid clients during a client's retroactive eligibility period (i.e., the period from the effective date to the add date), providers must obtain prior authorization within 95 days of the client's add date and before submitting a claim for those services to TMHP.

For services provided on or after the client's add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying the client's eligibility. Providers are strongly encouraged to verify the client's eligibility frequently. Providers can verify eligibility by:

- Checking the TMHP electronic data interchange (EDI).
- Accessing the Texas Medicaid Client Portal for Providers.
- Using TexMedConnect.
- Calling the Automated Inquiry System (AIS) at 1-800-925-9126.

If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

If a client's Medicaid eligibility is pending, a PAN must be requested before a nonemergency transport. Initially this request will be denied for Medicaid eligibility. When Medicaid eligibility is established, the requestor has 95 days from the date on which the eligibility was added to TMHP's files to contact the TMHP Ambulance Unit and request that authorization be considered.

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To inquire about Medicaid eligibility, providers can contact AIS at 1-800-925-9126.

5.1.9 Nonemergency Transport Authorization for Medicare and Medicaid Clients

Providers should simultaneously request prior authorization for the nonemergency transport from TMHP for an Medicaid Qualified Medicare Beneficiary (MQMB) client in the event the service requested is denied by Medicare as a non-covered service.

Note: *Qualified Medicare Beneficiary (QMB) clients are not eligible for Medicaid benefits. Providers can contact Medicare for the Medicare prior authorization guidelines.*

5.2 Authorization Requirements for Unlisted Procedure Codes

Providers have the option to obtain prior authorization before rendering the service if all of the required information is available. When requesting a fee-for-service prior authorization for an unlisted procedure code, providers must submit the following information with the prior authorization request:

- Client's diagnosis.
- Medical records that show the prior treatment for this diagnosis and the medical necessity of the requested procedure.
- A clear, concise description of the procedure to be performed.
- Reason for recommending this particular procedure
- A procedure code that is comparable to the procedure being requested.
- Documentation that this procedure is not investigational or experimental.
- Place of service in which the procedure is to be performed.
- The physician's intended fee for this procedure including the manufacturer's suggested retail price (MSRP) or other payment documentation.

If any of this information is unavailable at the time the prior authorization is requested, the request will be returned as incomplete; however, this is not a denial of reimbursement. If the required information becomes available before the service is performed, the prior authorization request can be resubmitted, or the required medical necessity and payment documentation can be submitted with the claim after the service is provided to be considered for reimbursement.

The prior authorization number must appear on the claim when it is submitted to TMHP. Claims submitted without the appropriate prior authorization will be denied.

5.3 Benefit Code

A benefit code is an additional data element that identifies a state program.

Providers that participate in the following programs must use the associated benefit code when they submit prior authorizations:

Program	Benefit Code
Comprehensive Care Program (CCP)	CCP
Texas Health Steps (THSteps) Medical	EP1
THSteps Dental	DE1
Family Planning Agencies*	FP3
Hearing Aid Dispensers	HA1
***Agencies only—Benefit codes should not be used for individual family planning providers.**	

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Program	Benefit Code
Maternity	MA1
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) providers	EC1
Tuberculosis (TB) Clinics	TB1
Intellectual or Developmental Disability (IDD) case management providers	MH2
***Agencies only—Benefit codes should not be used for individual family planning providers.**	

5.4 Submitting Prior Authorization Forms

A physician or health care provider may submit a medical prior authorization recertification request up to 60 days before the expiration of the current authorization of services. Once submitted, the recertification request will be reviewed and a determination will be issued before the existing authorization ends.

For some services, a prior authorization recertification for a course of treatment cannot be issued 60 days before the end of the current authorization period. For example, physical therapy, occupational therapy, speech therapy, and private duty nursing prior authorizations cannot be recertified 60 days before the end of the current authorization period because of requirements for timely documentation. This limitation applies to both fee-for-service and managed care clients.

When a recertification request cannot be reviewed 60 days before the current prior authorization ends, the provider will receive a response from TMHP explaining that the request has been submitted too early, and the provider will need to resubmit at a later time. For managed care clients, providers should contact the client's specific MCO for details.

Providers must complete all essential fields on prior authorization forms submitted to TMHP to initiate the prior authorization process.

If any essential field on a prior authorization request has missing, incorrect, or illegible information, TMHP returns the original request to the provider with the following message:

> "TMHP Prior Authorization could not process this request because the request form submitted has missing, incorrect, or illegible information in one or more essential fields. Please resubmit the request with all essential fields completed with accurate information for processing by TMHP within 14 business days of the request receipt date."

TMHP uses the date that the complete and accurate request form is received to determine the start date for services. Previous submission dates of incomplete forms returned are not considered when determining the start date of service.

Providers that need to update information on a prior authorization request form must strike through the incorrect information with a single line. The original content must remain legible, and the change must be initialed and dated by the original signatory or ordering physician when applicable. Changes that have been made using correction fluid (e.g., Wite-Out) will not be accepted.

Providers must respond to an incomplete prior authorization request within 14 business days of the request receipt date. Incomplete prior authorization requests are requests that are received by TMHP with missing, incomplete, or illegible information.

Prior to denying an incomplete request, TMHP's Prior Authorization department will attempt to get the correct information from the requesting provider. The Prior Authorization department will make a minimum of three attempts to contact the requesting provider before sending a letter to the client about the status of the request and the need for additional information.

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If the information that is necessary to make a prior authorization determination is not received within 14 business days of the request receipt date, the request will be denied as "incomplete." To ensure timely processing, providers should respond to requests for missing or incomplete information as quickly as possible.

For fee-for-service (FFS) Medicaid requests that require a physician review before a final determination can be made, TMHP's Physician Reviewer will complete the review within three business days of receipt of the completed prior authorization request. An additional three business days will be allowed for requests that require a peer-to-peer review with the client's prescribing physician.

For Children with Special Health Care Needs (CSHCN) Services Program requests that do not appear to meet CSHCN medical policy, the TMHP prior authorization nurse will refer those requests to the CSHCN Services Program for review and determination. The CSHCN Services Program will complete the review within three business days of receipt of the completed prior authorization request.

Note: *Providers may resubmit a new, complete request after receiving a denial for an incomplete request; however, the timeliness submission requirements will apply.*

Essential fields contain information needed to process a prior authorization request and include the following:

- Client name
- Client Medicaid number (patient control number [PCN])
- Client date of birth
- Provider name
- National Provider Identifier (NPI)
- *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code
- Quantity of service units requested based on the CPT or HCPCS code requested

5.4.1 Recreating TMHP Prior Authorization and Authorization Forms to Fill Out Electronically

Providers are allowed to recreate a Texas Medicaid or CSHCN Services Program prior authorization or authorization form in order to transfer it to an electronic format only if there are no alterations in the form's content or placement of information (field location).

To ensure that the most current version of the form is utilized, all forms submitted to the prior authorization department for processing must include the form number, effective date and revision date, if applicable, as it appears on the original TMHP form that is published on the TMHP Forms web page.

Important: *Prior authorization and authorization forms recreated and filled out electronically on the provider's computer must continue to be printed and faxed or submitted by mail. To submit prior authorization and authorization requests electronically, providers must use the prior authorization tool available on the TMHP website.*

5.5 Prior Authorization Submission Methods

Prior authorization requests can be submitted by fax, mail, telephone, and online through the TMHP website at www.tmhp.com. The methods to use to request the prior authorization depends on the service being requested.

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5.5.1 Prior Authorization Requests Through the TMHP Website

Online prior authorization requests for some services in the following areas can be submitted through the TMHP website at www.tmhp.com:

- Home Health
- Home Telemonitoring
- Special Medical Prior Authorization (SMPA)
- CCP
- Ambulance
- Substance Use Disorder (SUD) services

The benefits of submitting prior authorization requests through the TMHP website include:

- Online editing to ensure that the required information is being submitted correctly.
- The prior authorization number is issued within seconds of submission and confirms that the prior authorization request was accepted. Before providing services, providers must confirm that the prior authorization was approved.
- Notification of approvals and denials are available more quickly.
- Extension requests and status checks can be performed online for prior authorization requests that were submitted online.

Providers can access online prior authorization requests from the Prior Authorization page located under the Topics tab on the TMHP website at www.tmhp.com.

Instructions for submitting prior authorization requests on the TMHP website are located in the Help section at the bottom of the Prior Authorization page.

Prior authorizations that are submitted online will be processed using the same guidelines as prior authorizations submitted by other methods.

Before providers can submit online prior authorization requests, providers must register on the TMHP website and assign an administrator for each National Provider Identifier (NPI), if one is not already assigned. Users who are configured with administrator rights automatically have permission to submit prior authorization requests.

The NPI administrator can assign submission privileges for nonadministrator accounts. Billing services and clearinghouses must obtain access to protected health-care information through the appropriate administrator of each NPI provider number for which they are contracted to provide services.

5.5.1.1 Duplicate Validation Check

Prior authorizations submitted to TMHP electronically on the TMHP website are subject to a duplicate validation check. Prior authorizations that are duplicates of a previously submitted authorization return an immediate response with an associated duplicate submission error message.

The error message instructs providers to either update or remove details of the prior authorization submission.

If there is a modifier needed for authorization or claims processing, providers should indicate the primary modifier in the field labeled “Modifier 1.”

The appropriate modifier that identifies the type of therapy being requested needs to be used when providers submit requests for physical, occupational, and speech therapy.

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5.5.1.2 Document Requirements and Retention

If information provided in the online request is insufficient to support medical necessity, TMHP Prior Authorization staff may ask the provider to submit additional paper documentation to support the medical necessity for the service being requested.

Submission of prior authorization requests on the secure pages of the TMHP website does not replace adherence to and completion of the paper forms/documentation requirements outlined in this manual and other publications.

Documentation requirements include, but are not limited to, the following:

- Documentation that supports the medical necessity for the service requested.
- Completion and retention in the client's medical record of all required prior authorization forms
- Adherence to signature and date requirements for prior authorization forms and other required forms that are kept in the client record, including the following:
  - All prior authorization forms completed and signed before the online prior authorization request is made
  - Original handwritten or electronic signatures (Stamped signatures and images of wet signatures are not accepted by Texas Medicaid.)
- A printed copy of the Online Request Form, which must be retained in the client's medical record

Any provider, client, or client's responsible adult who is required to sign a prior authorization form or any supporting documentation may do so using a wet or electronic signature. Any electronic signature technologies that are used must comply with all federal and state statutes and administrative rules.

Any required documentation that is missing from the client's medical record subjects the associated payments for services to be recouped.

5.5.1.2.1 Acknowledgment Statement

Before submitting each prior authorization request, providers (and submitters on behalf of providers) must affirm that they have read, understood, and agree to the certification and terms and conditions of the prior authorization request.

Providers and submitters are separately held accountable for their declarations after they have acknowledged their agreement and consent by checking the "We Agree" checkbox after reviewing the certification statement and terms and conditions.

5.5.1.2.2 Certification Statement

"The Provider and Authorization Request Submitter certify that the information supplied on the prior authorization form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Authorization Request Submitter understand that payment of claims related to this prior authorization will be from federal and state funds, and that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

"By checking 'We Agree' you agree and consent to the Certification above and to the TMHP `Terms and Conditions.'"

5.5.1.2.3 Terms and Conditions

"I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or U.S. Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by Medicaid for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or

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similar cost-sharing charge. I certify that the services listed above are/were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

"Notice: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim, based on information provided on the Prior Authorization form, will be from federal and state funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable federal or state law."

Omission of information or failure to provide true and accurate information or notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

5.5.2 Prior Authorization Requests to TMHP by Fax, Telephone, or Mail

When submitting prior authorization requests through fax or mail, providers must submit the requests on the approved form. If necessary, providers may submit attachments with the form. Providers must follow the guidelines and requirements listed in the handbook for the service. Providers can refer to the provider handbooks for the guidelines and requirements listed for a specific service.

Prior authorization requests must be signed and dated by a physician or dentist who is familiar with the client's medical condition before the request is submitted to TMHP. When allowed, prior authorizations must be signed and dated by an advanced practice registered nurse (APRN) or PA who is familiar with the client's medical condition before the request is submitted to TMHP. Prior authorization requests for services that may be signed by a licensed health-care provider other than a physician, dentist, or when allowed by an APRN and PA, do not require handwritten signatures and dates. Electronic signatures from an RN or therapist are acceptable when submitting therapy requests for CCP.

All signatures must be electronic, digital or handwritten. An electronic or digital signature must be derived using software that creates a digital signature logo with a system-generated date and time stamp or includes the logo of the digital software used. Photocopy or ink stamp of a handwritten signature or a typed signature without a digital stamp are not permitted. TMHP will not authorize any dates of services on the request earlier than the date of the provider's signature. The prior authorization request that contains the original signature must be kept in the client's medical record for future access and possible retrospective review. These documentation requirements also apply to telephone authorizations. To avoid delays, providers are encouraged to have all clinical documentation at the time of the initial telephone authorization request.

> ***Note:*** *Obstetric (OB) services providers are no longer allowed to initiate prior authorization requests or ultrasound extension requests over the telephone.*

To initiate a new prior authorization request or to request an extension of an existing prior authorization, OB services providers are required to submit the request online using the TMHP secure provider portal or on paper by faxing or mailing the applicable prior authorization form to TMHP.

Providers can continue to use the Prior Authorization telephone line to inquire about the status of the prior authorization requests that have been submitted to TMHP online, by fax, or mail.

5.5.2.1 Prior Authorization Calls

Initial prior authorization calls are handled by the TMHP Contact Center. If the contact center representative determines that a prior authorization inquiry can be better handled by the TMHP Prior Authorization department, the TMHP Contact Center representative will transfer the call to a Prior Authorization Clinician.

> ***Note:*** *This does not impact the timeframes for the resolution of more complex issues.*

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5.5.2.2 TMHP Prior Authorization Requests by Fax

Providers who fax new prior authorization requests, resubmitted requests, or additional information to complete a request must include:

- A working fax number on the prior authorization form, so that they can receive faxed responses and correspondence from TMHP.
- The last four digits of the client's Medicaid identification number on the fax coversheet.

Note: *Prior authorization cover sheets must not contain any protected health information (PHI) per HIPAA. The faxed cover sheet is not meant to replace the appropriate prior authorization form. Providers cannot include information on a cover sheet that is needed to complete the review of a request.*

If a provider is faxing prior authorization requests for more than one client, each client request must be faxed individually with a separate cover sheet. Requests received with multiple clients will be returned to the provider for resubmission to ensure Health Insurance Portability and Accountability Act (HIPAA) compliance.

Contact	Fax Number
Ambulance Authorization Fax (includes out-of-state transfers)	512-514-4205
Home Health Services Fax	512-514-4209
CCP Fax	512-514-4212
Prior Authorization MH/SUD Fax	512-514-4211
Outpatient Psychiatric Fax	512-514-4213
Radiology Fax	833-912-1129
TMHP Special Medical Prior Authorization (SMPA) Fax (including transplants)	512-514-4213

5.5.2.3 TMHP Prior Authorization Requests by Telephone

Contact	Telephone Number
Ambulance Authorization (including out-of-state transfers)	1-800-540-0694

5.5.2.4 TMHP Prior Authorization Requests by Mail

Contact	Address
Ambulance (includes out-of-state transfers)	Texas Medicaid & Healthcare Partnership Ambulance Prior Authorizations PO Box 200735 Austin, TX 78720-0735
CCP	Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP) Prior Authorization PO Box 200735 Austin, TX 78720-0735
Dental	Texas Medicaid & Healthcare Partnership Dental Prior Authorization PO Box 204206 Austin, TX 78720-4206
Home Health Services	Texas Medicaid & Healthcare Partnership Home Health Services Prior Authorization PO Box 202977 Austin, TX 78720-2977

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Contact	Address
Radiology Services	Texas Medicaid & Healthcare Partnership Radiology Prior Authorization 12365A Riata Trace Parkway Austin, TX 78727
SMPA	Texas Medicaid & Healthcare Partnership Special Medical Prior Authorization 12365A Riata Trace Parkway Austin, TX 78727

5.5.3 Home Health Services Prior Authorizations

Home health services providers cannot initiate new prior authorization requests or request extensions over the telephone. The following home health services are affected:

- Skilled nursing and home health aide visits
- Physical and occupational therapy
- Durable medical equipment (DME)
- Expendable medical supplies

Home health services providers must initiate new prior authorization requests or request extension of existing prior authorizations online using the TMHP secure provider portal or on paper by faxing or mailing TMHP the appropriate paper prior authorization form.

Home health services providers can use telephone number 1-800-925-8957 for follow-up and status inquiry of prior authorizations.

5.5.4 Radiology Prior Authorizations

TMHP performs radiology prior authorization services.

Refer to: Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) to determine which radiology services require a prior authorization.

5.5.4.1 Retroactive Authorization Requests

Retroactive authorization requests for outpatient diagnostic computed tomography (CT), magnetic resonance (MR), positron emission tomography (PET), and cardiac nuclear imaging services for Texas Medicaid fee-for-service clients must be submitted to TMHP. The retroactive authorizations requests must be submitted to TMHP no later than 14 calendar days after the day on which the study was completed, regardless of the method of submission. If the retroactive authorization request is submitted after the allotted time, the authorization request will not be processed.

5.6 Verifying Prior Authorization Status

Prior authorizations are processed based on the date the request is received. Requests with all required information can take up to three business days after the date of receipt for TMHP to complete the authorization process.

Providers can check the status of prior authorizations requested online through the TMHP website at www.tmhp.com.

Providers may also check status of prior authorizations that are issued by TMHP by using the following numbers.

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Contact	Telephone Number
Personal Care Services (PCS) Prior Authorization Inquiry Line	1-888-648-1517
CCP and Home Health Status Line	1-800-846-7470
All other authorization requests	1-800-925-9126

5.7 Prior Authorization Notifications

TMHP sends a notification to the provider when the prior authorization is approved, denied, or modified. If TMHP receives prior authorization requests with incomplete or insufficient information, TMHP will ask the requesting provider to furnish the additional documentation needed before TMHP can make a decision on the request. If the requesting provider does not respond to the request for additional information, the prior authorization request will be denied. It is the requesting provider's responsibility to contact the appropriate provider, when necessary, to obtain the additional documentation.

5.8 Prior Authorization Denials Appeals Process

Prior authorizations that are denied by TMHP can be resubmitted to the TMHP Prior Authorization Department with new or additional information for reconsideration.

If the request is denied a second time, or if the provider has no new or additional information, the provider may file an Administrative Appeal to HHSC. Providers must include a copy of the denial letter.

It is strongly recommended that providers maintain a list that details the prior authorizations, including:

- Client's name
- Client's Medicaid number
- Date of service
- NPI
- Items submitted

This information will be required if a provider needs to file an administrative review.

5.9 Closing a Prior Authorization

When a client decides to change providers or elects to discontinue prior-authorized services before the authorization ends, that prior authorization is updated to reflect the early closure date and the reason for closure.

If a client with an active prior authorization changes providers, TMHP must receive a change of provider letter with the request for a new prior authorization in accordance with submission guidelines for the service. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

The client is responsible for notifying the previous provider that the client is discontinuing services and the effective date of the change. TMHP also notifies the previous provider by mail when a prior authorization has been closed early. The letter includes the beginning date of service, the revised ending date of the authorization, and the reason for the early closure.

If a provider submits a Change of Provider letter in the middle of an existing authorization period, the current authorization will be end-dated and the original provider will be notified. TMHP will send the new provider an authorization that begins on the next business day after the end date and lasts through the remainder of the authorization period.

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5.10 Submitting Claims for Services That Require Prior Authorization

Claims submitted for services that require prior authorization must indicate the authorization number, NPI, procedure codes, dates of service, required modifiers, number of units, and the amount for manually priced procedure codes as detailed on the authorization letter. If the prior authorization letter shows itemized details and the provider rendered all services listed, the details on the claim must match the details on the prior authorization letter.

Important: *Claims processing and payment may be delayed if the detailed information on the authorization letter and the claim details do not match exactly.*

Claims for prior authorized services must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the applicable electronic fields or in the following blocks for paper claim forms:

Paper Claim Form	Block for Prior Authorization Number
CMS-1500 (professional) claim form	Block 23
UB-04 CMS-1450 (institutional) claim form	Block 63
American Dental Association (ADA) claim form	Block 2
2017 claim form	Block 30

Refer to: Subsection 6.1.3, "TMHP Paper Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

5.10.1 Authorization and Manually Priced Claims

If prior authorization has been obtained for services that use manually priced procedure codes, providers must submit claims for them using the MSRP that was submitted with the authorization request and the following information that is listed on the authorization letter:

- Authorization number
- NPI
- Procedure codes
- Dates of service
- Types of service
- Required modifiers

If the authorization letter shows itemized details, the claim must include all rendered services as they are itemized on the authorization letter and the MSRP rate for each of those services. The procedure codes and MSRP rates that are detailed on the claim must match the procedure codes that are detailed in the authorization letter and the MSRP rates that were submitted with the authorization request. Claims processing and payment may be delayed if there is not an exact match between the detailed information on the authorization letter, the approved authorization, and the information that was submitted on the claim.

Important: *For appropriate processing and payment, the Pay Price that is indicated on the authorization letter should not be billed on the claim.*

Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

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5.11 Guidelines for Procedures Awaiting Rate Hearing

For procedure codes that require prior authorization but are awaiting a rate hearing, providers must follow the established prior authorization process as defined in the applicable provider handbook. Providers must obtain a timely prior authorization for services provided. Providers must not wait until the rate hearing process for the procedure codes is completed to request prior authorization. In this situation, retroactive prior authorization requests are not granted; the requests are denied as late submissions. Providers are also responsible for meeting the initial 95-day filing deadline and for ensuring that the prior authorization number is on the claim the first time it is submitted to TMHP for consideration of reimbursement.

Claims for procedure codes awaiting a rate hearing are denied. TMHP automatically reprocesses affected claims; providers are not required to appeal the claims unless they are denied for additional reasons after the claims reprocessing is complete. If the required prior authorization number is not on the claim at the time of reprocessing, the claim is denied for lack of prior authorization.

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Section 6: Claims Filing

Texas Medicaid Provider Procedures Manual: Vol. 1

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SECTION 6: CLAIMS FILING

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6.1 Claims Information

Providers that render services to Texas Medicaid fee-for-service and managed care clients must file the assigned claims. Texas Medicaid does not make payments to clients. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business. Providers cannot bill Texas Medicaid or Medicaid clients for missed appointments or failure to keep an appointment. Only claims for services rendered are considered for payment.

Medicaid providers are also required to complete and sign authorized medical transportation forms (e.g., Form H3017, Individual Transportation Participant [ITP] Service Record, or Form 3111, Verification of Travel to Healthcare Services by Mass Transit) or provide an equivalent (e.g., provider statement on official letterhead) to attest that services were provided to a client on a specific date. The client presents these forms to the provider.

Providers are not allowed to bill clients or Texas Medicaid for completing these forms.

All claims for Electronic Visit Verification (EVV) services, including fee-for-service and managed care claims, must be submitted electronically to TMHP using the appropriate electronic claims submission method. Paper claims for EVV services will not be accepted. The EVV aggregator will perform EVV claims matching and TMHP will forward the EVV claim with the EVV match code to the applicable payer for claims processing.

6.1.1 TMHP Processing Procedures

TMHP processes claims for services rendered to Texas Medicaid fee-for-service clients and carve-out services rendered to Medicaid managed care clients.

Note: *Claims for services rendered to a Medicaid managed care client must be submitted to the managed care organization (MCO) or dental plan that administers the client's managed care benefits. Only claims for those services that are carved-out of managed care can be submitted to TMHP.*

Claims for EVV services (Acute Care and Long Term Care Fee-For-Service and Long Term Support Services [LTSS] [managed care]) must be submitted to TMHP to perform the EVV claims matching process and forwarded to the applicable payer for adjudication.

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for more information about carve-out services.

Medicaid claims are subject to the following procedures:

- TMHP verifies all required information is present.
- Claims filed under the same National Provider Identifier (NPI) and program and ready for disposition at the end of each week are paid to the provider with an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) Report, which may be received as a downloadable portable document format (PDF) version or on paper. A Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 transaction file is also available for those providers who wish to import claim dispositions into a financial system.

  An R&S Report is generated for providers that have weekly claim or financial activity with or without payment. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist during the time period, an R&S Report is not generated for the week.
- For services that are billed on a claim and have any benefit limitations for providers, the date of service determines which provider's claims are paid, denied, or recouped. Claims that have been submitted and paid may be recouped if a new claim with an earlier date of service is submitted, depending on the benefit limitations for the services rendered.

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Services that have been authorized for an extension of the benefit limitation will not be recouped. Providers can submit an appeal with medical documentation if the claim has been denied.

6.1.1.1 Fiscal Agent

TMHP acts as the state's Medicaid fiscal agent. A fiscal agent arrangement is one of two methods allowed under federal law and is used by all other states that contract with outside entities for Medicaid claims payment. Under the fiscal agent arrangement, TMHP is responsible for paying claims, and the state is responsible for covering the cost of claims.

Note: *The fiscal agent arrangement does not affect Long Term Care (LTC) and Health and Human Services Commission (HHSC) Family Planning providers.*

Provider Designations

The fiscal agent arrangement requires that providers be designated as either public or nonpublic. By definition, public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations. In addition, any provider or agency that performs intergovernmental transfers to the state would be considered a public provider. This includes those agencies that can certify and provide state matching funds, (i.e., other state agencies). New providers self-designate (public or private) on the provider enrollment application.

The fiscal agent:

- Rejects all claims not payable under Texas Medicaid rules and regulations.
- Suspends payments to providers according to procedures approved by HHSC.
- Notifies providers of reduction in claim amount or rejection of claim and the reason for doing so.
- Collects payments made in error, affects a current record credit to the department, and provides the department with required data relating to such error corrections.
- Prepares checks or drafts to providers, except for cases in which the department agrees that a basis exists for further review, suspension, or other irregularity within a period not to exceed 30 days of receipt and determination of proper evidence establishing the validity of claims, invoices, and statements.
- Makes provisions for payments to providers who have furnished eligible client benefits.
- Withholds payment of claim when the eligible client has another source of payment.
- Employs and assigns a physician, or physicians, and other professionals as necessary, to establish suitable standards for the audit of claims for services delivered and payment to eligible providers.
- Requires eligible providers to submit information on claim forms.

6.1.1.2 Payment Error Rate Measurement (PERM)

The Improper Payments Information Act (IPIA) of 2002 directs federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review agency programs that are susceptible to significant erroneous payments and to report the improper payment estimates to the U.S. Congress.

Every three years the CMS will assess Texas Medicaid using the PERM process to measure improper payments in Texas Medicaid and the Children's Health Insurance Program (CHIP).

CMS uses PERM to measure the accuracy of Medicaid and CHIP payments made by states for services rendered to clients. Under the PERM program, CMS will use three national contractors to measure improper payments in Medicaid and CHIP:

- The statistical contractor will provide support to the program by identifying the claims to be reviewed and by calculating each state's error rate.

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- The data documentation contractor will collect medical policies from the State and medical records from providers.
- The review contractor will perform medical and data processing reviews of the selected claims in order to identify any improper payments.

Providers are required to provide medical record documentation to support the medical reviews that the federal review contractor will conduct for Texas Medicaid fee-for-service and CHIP claims.

Note: *The federal review contractor will also conduct reviews for Primary Care Case Management (PCCM) claims that were submitted to TMHP with dates of service on or before February 29, 2012.*

Past studies have shown that the largest cause of error in medical reviews is lack of documentation or insufficient documentation. It is important that information be sent in a timely and complete manner, since a provider's failure to timely submit complete records in support of the claims filed can result in a higher payment error rate for Texas, which in turn can negatively impact the amount of federal funding received by Texas for Medicaid and CHIP.

Providers must submit the requested medical records to the data documentation contractor and HHSC within 60 calendar days of the receipt of the written notice of request. If providers have not responded within 15 days, the data documentation contractor and possibly state officials will initiate reminder calls and letters to providers. The data documentation contractor and possibly state officials will also initiate reminder calls and letters to providers after 35 days. If providers have not responded in 60 days, the data documentation contractor will submit a letter to the provider and the state PERM director indicating a "no documentation error." After the provider's submittal of requested information, the data documentation contractor may request additional information to determine proper payment. In this instance, the provider is given 15 days to provide additional documentation.

If medical records are not received within 60 calendar days, the data documentation contractor will identify the claim as a PERM error and classify all dollars associated with the claim as an overpayment. Providers will be required to reimburse the overpayment in accordance with state and federal requirements.

A provider's failure to maintain complete and correct documentation in support of claims filed or failure to provide such documentation upon request can result in the provider being sanctioned under Title 1, Texas Administrative Code (TAC) Part 15, Chapter 371. Sanction actions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation. Sanctions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation.

6.1.2 Claims Filing Instructions

This manual references paper claims when explaining filing instructions. HHSC and TMHP encourage providers to submit claims electronically. TMHP offers specifications for electronic claim formats. These specifications are available from the TMHP website and include a cross-reference of the paper claim filing requirements to the electronic format.

Providers can participate in the most efficient and effective method of submitting claims to TMHP by submitting claims through the TMHP Electronic Data Interchange (EDI) claims processing system using TexMedConnect or a third party vendor. The proceeding claim filing instructions in this manual apply to paper and electronic submitters. Although the examples of claims filing instructions refer to their inclusion on the paper claim form, claim data requirements apply to all claim submissions, regardless of the media. Claims must contain the provider's complete name, physical address including the ZIP+4 code, NPI, taxonomy code, and benefit code (if applicable) to avoid unnecessary delays in processing and payment.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on accessing the TMHP website.

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6.1.2.1 Wrong Surgery Notification

Providers are required to notify TMHP when a wrong surgery or other invasive procedure is performed on a Texas Medicaid client. Notification is mandated by Senate Bill (SB) 203, Section 3, Regular Session, 81st Texas Legislature, which covers preventable adverse events (PAE) and reimbursement for services associated with PAE.

Professional, inpatient, and outpatient hospital claims that are submitted for the wrong surgery or invasive procedure will be denied. Any corresponding procedures that are rendered to the same client, on the same dates of service (for professional and outpatient hospital claims), or the same date of surgery (for inpatient hospital claims) will be denied. Claims that have already been reimbursed will be recouped.

The law requires providers that are submitting claims for services rendered to Texas Medicaid clients to indicate whether any of the following situations apply to the claim:

- The incorrect operation or invasive procedure was performed on the correct client.
- The operation or invasive procedure was performed on the incorrect client.
- The incorrect operation or invasive procedure was performed on the incorrect body part.

Providers must notify Texas Medicaid of a wrong surgery or invasive procedure by submitting one of the following nonspecific injury, poisoning and other consequences of external causes diagnosis codes or modifiers with the procedure code for the rendered service:

Code	Description	Type of Claim
Injury, Poisoning and Other Consequences of External causes Diagnosis Codes		
Y6551	Performance of wrong procedure (operation) on correct patient	Inpatient hospital
Y6552	Performance of procedure (operation) on patient not scheduled for surgery	
Y6553	Performance of correct procedure (operation) on wrong side or body part	
Modifiers		
PA	Surgical or other invasive procedure on wrong body part	Professional or outpatient hospital
PB	Surgical or other invasive procedure on wrong patient	
PC	Wrong surgery or other invasive procedure on patient	

Professional or outpatient hospital claims must include a valid diagnosis with up to seven-digit specificity, the procedure code that identifies the service rendered, and the PA, PB, or PC modifier that describes the type of "wrong surgery" performed.

Inpatient hospital claims must be submitted with type of bill (TOB) 110 as an inpatient hospital-nonpayment claim when a "wrong surgery" is reported. If other services or procedures that are unrelated to the "wrong surgery" are provided during the same stay as the "wrong surgery," the inpatient hospital must submit a claim for the "wrong surgery" and a separate claim or claims for the unrelated services rendered during the same stay as the "wrong surgery."

The "wrong surgery" claim must include TOB 110, the appropriate diagnosis code, the surgical procedure code for the surgical service rendered, and the date of surgery. The "wrong surgery" claim will be denied.

The unrelated services rendered during the same stay as the "wrong surgery" must include TOB 111, 112, 113, 114, or 115 on a claim separate from the "wrong surgery" claim. The unrelated services that are benefits of Texas Medicaid may be reimbursed by Texas Medicaid.

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A claim that is denied for wrong surgery will have one of the following EOB codes:

EOB Code	Message
01167	Claim detail denied due to wrong surgery performed on client
01168	Claim denied due to wrong surgery performed on client
01185	Claim denied due to wrong surgery claim found in history for the same PCN and DOS
01186	Claim detail denied due to wrong surgery claim found in history for the same PCN and DOS
PCN = Patient Control Number (also known as the client's Medicaid number) DOS = Date of service	

6.1.2.2 Maximum Number of Units allowed per Claim Detail

The total number of units per claim detail can not exceed 9,999. Providers who submit a claim with more than 9,999 units must bill 9,999 units on the first detail of the claim and any additional units on separate details.

6.1.2.3 Tips on Expediting Paper Claims

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

General requirements

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

Data Fields

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

Attachments

- Use paper clips on claims or appeals if they include attachments. Do not use glue, tape, or staples.
- Place the claim form on top when sending new claims, followed by any medical records or other attachments.
- Number the pages when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
- Do not total the billed amount on each claim form when submitting multi-page claims for the same client.

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- Use the CMS-approved Medicare Remittance Advice Notice (MRAN) printed from Medicare Remit Easy Print (MREP) (professional services) or PC-Print (institutional services) when sending a Remittance Advice from Medicare or the paper MRAN received from Medicare or a Medicare intermediary. You may also download the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template from the TMHP website at www.tmhp.com.
- Submit claim forms with MRANs and R&S Reports.

6.1.3 TMHP Paper Claims Submission

All paper claims must be submitted with an NPI and taxonomy code for the billing and performing provider. All other provider fields on the claim forms require an NPI only. If an NPI and taxonomy code are not included in the billing and performing provider fields, or if an NPI is not included on all other provider identifier fields, the claim will be denied. In addition to the NPI and taxonomy code for the billing provider, claim submissions will need to include the provider benefit code (if applicable) and complete physical address with ZIP + 4 code.

Refer to: Subsection 6.4, "Claims Filing Instructions" in this section for more information.

6.1.4 Claims Filing Deadlines

For claims payment to be considered, providers must adhere to the time limits described in this section. Claims received after the following claims filing deadlines are not payable because Texas Medicaid does not provide coverage for late claims.

Exception: *Unless otherwise stated, claims must be received by TMHP within 95 days of each DOS. Appeals must be received by TMHP within 120 days of the disposition date on the R&S Report on which the claim appears. A 95-day or 120-day appeal filing deadline that falls on a weekend or a holiday is extended to the next business day following the weekend or holiday.*

Only the following holidays extend the deadlines in 2026:

Date	Holiday
January 1, 2026	New Year's Day
January 19, 2026	Martin Luther King, Jr. Day
February 16, 2026	Presidents' Day
May 25, 2026	Memorial Day
June 19, 2026	Emancipation Day
July 4, 2026	Independence Day
September 7, 2026	Labor Day
October 12, 2026*	Columbus Day
November 11, 2026	Veterans Day
November 26, 2026	Thanksgiving Day
November 27, 2026	Day after Thanksgiving
December 24, 2026	Christmas Eve Day
December 25, 2026	Christmas Day
December 26, 2026	Day after Christmas
***Federal holiday, but not a state holiday. The claims filing deadline will be extended for providers because the Post Office will not be operating on this day.**	

The following are time limits for submitting claims:

- Inpatient claims that are filed by the hospital must be received by TMHP within 95 days of the discharge date or last DOS on the claim.

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  - Hospitals that are reimbursed according to diagnosis-related group (DRG) payment methodology may submit an interim claim because the client has been in the facility 30 consecutive days or longer. A total stay claim is needed after discharge to ensure accurate calculation for potential outlier payments for clients who are 20 years of age and younger.
  - Hospitals that are reimbursed according to Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital's fiscal year end.
- When medical services are rendered to a Medicaid client in Texas, TMHP must receive claims within 95 days of the DOS on the claim.
- Re-enrolling providers who are assigned their previous enrollment information must submit claims so that they are received by TMHP within 95 days of the date of service.
- Providers that are enrolling in Texas Medicaid for the first time or are making a change that requires the issuance of a new taxonomy and benefit code can submit claims within 95 days from the date their taxonomy and benefit code is issued as long as claims are submitted within 365 days of the date of service.
- Providers who are revalidating an existing enrollment can continue to file claims while they are completing the revalidation process. TMHP must receive claims within 95 days of the date of service.
- TMHP must receive claims from out-of-state providers within 365 days from the DOS. The DOS is the date the service is provided or performed.
- TMHP must receive claims on behalf of an individual who has applied for Medicaid coverage but has not been assigned a Medicaid number on the DOS within 95 days from the date the eligibility was added to the TMHP eligibility file (add date) and within 365 days of the date of service or from the discharge date for inpatient claims.
- Providers should verify eligibility and add date by contacting TMHP (Automated Inquiry System [AIS], TMHP EDI's electronic eligibility verification, or TMHP Contact Center) when the number is received. Not all applicants become eligible clients. Providers that submit claims electronically within the 365-day federal filing deadline for services rendered to individuals who do not currently have a Texas Medicaid identification number will receive an electronic rejection. Providers can use the TMHP rejection report as proof of meeting the 365-day federal filing deadline and submit an administrative appeal.

Important: *Providers should keep documentation of all Texas Medicaid client eligibility verification. Documentation of client eligibility is required for the appeal process.*

- If a client becomes retroactively eligible or loses Medicaid eligibility and is later determined to be eligible, the 95-day filing deadline begins on the date that the eligibility start date was added to TMHP files (the add date). However, the 365-day federal filing deadline must still be met.
- When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs, the claim must be filed with Medicare first. TMHP *must* receive Medicaid claims within 95 days of the date of Medicare disposition.

  Providers must submit a paper MRAN received from Medicare or a Medicare intermediary, the computer-generated MRANs from the CMS-approved software application MREP for professional services or PC-Print for institutional services, or the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template with a completed claim form to TMHP.

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- When a client is eligible for Medicare Part B only, the inpatient hospital claim for services covered as Medicaid only is sent directly to TMHP and is subject to the 95-day filing deadline (from date of discharge).

  Note: *It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send. It is also recommended that paper claims be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 95-day claims filing deadline has been met. TMHP will accept certification receipts as proof of the 95-day or 120-filing deadline. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed listing along with the Medicaid number, billed amount, DOS, and a signed claim copy. The provider needs to keep such proof of multiple claims submissions if the provider's enrollment with TMHP is pending.*

- If the provider is attempting to obtain prior authorization for services performed or will be performed, TMHP must receive the claim according to the usual 95-day filing deadline.
- The provider bills TMHP directly within 95 days from the DOS. However, if a non-third party resource (TPR) is billed first, TMHP must receive the claim within 95 days of the claim disposition by the other entity.

  Note: *The provider submits a copy of the disposition with the claim. A non-TPR is secondary to Texas Medicaid and may only pay benefits after Texas Medicaid.*

Refer to: Subsection 8.4, "Non-TPR Sources" in "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for examples of non-TPRs.

- When a service is billed to another insurance resource, the filing deadline is 95 days from the date of disposition by the other resource.
- When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. However, the 365-day federal filing deadline requirement must still be met.
- A Compass21 (C21) process allows an HHSC Family Planning claim to be paid by Title XIX (Medicaid) if the client is eligible for Title XIX when those services are provided and billed under the HHSC Family Planning Program. In this instance, the Medicaid 95-day filing deadline is in effect and must be met or the claim will be denied.
- For claims re-submitted to TMHP with additional detail changes (i.e., quantity billed), the additional details are subject to the 95-day filing deadline.

  Note: *In accordance with federal regulations, all claims must be initially filed with TMHP within 365 days of the DOS, regardless of provider enrollment status or retroactive eligibility.*

Refer to: Subsection 6.1.2, "Claims Filing Instructions" in this section.

Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for information on the provider enrollment process.

Subsection 7.1, "Appeal Methods" in "Section 7: Appeals" (*Vol. 1, General Information*) for information on the process for submitting appeals.

Subsection 6.1.4.3, "Exceptions to the 95-Day Filing Deadline" in this section.

Subsection A.12.3, "Automated Inquiry System (AIS)" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*) to learn how to retrieve client eligibility information by telephone.

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Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

Subsection 4.1.10, "Eligibility Verification" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

Subsection 6.11.6, "Provider Inquiries—Status of Claims" in this section.

6.1.4.1 Claims for Clients with Retroactive Eligibility

Claims for clients who receive retroactive eligibility must be submitted within 95 days of the date that the client's eligibility was added to the TMHP eligibility file (add date) and within 365 days of the DOS.

Title 42 of the Code of Federal Regulations (42 CFR), at 447.45 (d) (1), states "The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service." The 12-month filing deadline applies to all claims. Claims not submitted within 365 days (12 months) from the date of service cannot be considered for payment.

Retroactive eligibility does not constitute an exception to the federal filing deadline. Even if the patient's Medicaid eligibility determination is delayed, the provider must still submit the claim within 365 days of the date of service. A claim that is not submitted within 365 days of the date of service will not be considered for payment.

If a client is not yet eligible for Medicaid, providers must submit the claim using either 999999999 or 000000000 as the recipient identification number. Although TMHP will deny the claim, providers should retain the denial or electronic rejection report for proof of timely filing, especially if the eligibility determination occurs more than 365 days after the date of service. Claims denied for recipient ineligibility may be resubmitted when the patient becomes eligible for the retroactive date(s) of service. Texas Medicaid may then consider the claim for payment because the initial claim was submitted within the 365-day federal filing deadline and the denial was not the result of an error by the provider.

If the 365-day federal filing deadline requirement has passed, providers must submit the following to TMHP within 95 days from the add date:

- A completed claim form.
- One of the following dated within 365 days from the date of service:
  - A page from an R&S Report documenting a denial of the claim.
  - An electronic rejection report of the claim that includes the Medicaid recipient's name and date of service.

Providers that have submitted their claims electronically can provide proof of timely filing by submitting a copy of an electronic claims report that includes the following information:

- Client name or Medicaid identification number (PCN)
- DOS
- Total charges
- Batch identification number (Batch ID) (in correct format)

Note: *Only reports that were accepted or rejected by TMHP will be honored. The claim filed (client name or PCN, DOS and total charges) should match the information on the batch report.*

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6.1.4.2 Claims for Newly Enrolled Providers

Claims submitted by newly enrolled providers must be received within 95 days of the date that enrollment is complete and within 365 days of the date of service. Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be rejected by TMHP until enrollment is complete. Providers can use the TMHP rejection report as proof of meeting the 365-day deadline and submit an appeal.

Note: *Claims can be submitted for dates of service on or after the provider's effective date of enrollment. Providers can find the effective date for their enrollment in their Welcome Letter in PEMS.*

Refer to: Subsection 1.1.9.7, "Copy of License, Temporary License, or Certification" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

All claims for services rendered to Texas Medicaid clients who do not have Medicare benefits are subject to a filing deadline from the date of service of:

- 95 days for in-state providers.
- 365 days for out-of-state providers.

TMHP cannot issue a prior authorization before Medicaid enrollment is complete. Upon notice of Medicaid enrollment, the provider must contact the appropriate TMHP Authorization Department before providing services that require a prior authorization number to Medicaid clients. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted.

Retroactive authorizations will not be issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. For these services, providers have 95 days from the add date of the client's retroactive eligibility in TMHP's system to obtain authorization for services that have already been performed. Providers should refer to the specific manual section for details on authorization requirements, claims filing, and timeframe guidelines for authorization request submissions.

Providers who have not completed enrollment and have general claim submission questions may refer to this section for assistance with claim submission. If additional general information is needed, providers may call the TMHP Contact Center at 800-925-9126 to obtain information. Due to HIPAA privacy guidelines, specific client and claim information cannot be provided.

Providers who have completed enrollment and have questions about submitting claims may call the same number and select the option to speak with a TMHP Contact Center representative.

6.1.4.3 Exceptions to the 95-Day Filing Deadline

TMHP is not responsible for appeals about exceptions to the 95-day filing deadline. These appeals must be submitted to the HHSC Claims Administrator Operations Management. TAC allows HHSC to consider exceptions to the 95-day filing deadline under special circumstances.

6.1.4.4 Appeal Time Limits

All appeals of denied claims and requests for adjustments on paid claims must be received by TMHP within 120 days from the date of disposition, the date of the R&S Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

Refer to: Subsection 6.1.2, "Claims Filing Instructions" in this section.

Hospitals appealing final technical denials, admission denials, DRG changes, continued-stay denials, or cost/day outlier denials refer to "Section 7: Appeals" (*Vol. 1, General Information*) for complete appeal information.

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6.1.4.5 Claims with Incomplete Information and Zero Paid Claims

Claims listed on the R&S Report with $0 allowed and $0 paid may be resubmitted as electronic appeals. Previously, these claims were only accepted as paper claims and were not accepted as electronic appeals. Appeals may be submitted through a third party biller or through TexMedConnect.

Zero-paid claims that are still within the 95-day filing deadline should be submitted as new day claims, which are processed faster than appeals. Electronic appeal for these claims must be submitted within the 120-day appeal deadline. Electronic claims can be resubmitted past the 95-day deadline as new day claims if the following fields have not changed:

- NPIs
- Client Medicaid number
- Dates of service
- Total billed amount

Claims that are past the 95-day filing deadline and require changes to the fields listed above must be appealed on paper, with a copy of the R&S report. All other appeal guidelines remain unchanged.

Important: *Initial zero-paid claims and appeal submissions must meet the 95-day deadline and 120-day appeal deadline outlined in subsection 6.1.4, "Claims Filing Deadlines" in this section.*

6.1.4.6 Claims Filing Reminders

After filing a claim to TMHP, providers should review the weekly R&S Report. If within 30 days the claim does not appear in the Claims In Process section, or if it does not appear as a paid, denied, or incomplete claim, the provider should resubmit it to TMHP within 95 days of the DOS.

The provider should allow TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of deductible or coinsurance.

Electronic billers should notify TMHP about missing claims when:

- An accepted claim does not appear on the R&S Report within ten workdays of the file submittal.
- A claim or file does not appear on a TMHP Electronic Claims Submission Report within ten days of the file submission.

Certain claims, including those that were submitted for newborn services or that might be covered under Medicare, are suspended for review so that other state agencies can verify information. This review may take longer than 60 days.

These suspended claims will appear on the provider's R&S Report under "The following claims are being processed" with a message indicating that the client's eligibility is being investigated. Providers must wait until the claim is finalized and appears under "Paid or Denied" or "Adjustment to Claims" on the R&S Report before appealing the claim. If the claim does not appear on the R&S Report, providers must resubmit the claim to TMHP to ensure compliance with filing and appeal deadlines.

6.1.5 HHSC Payment Deadline

Payment deadline rules, as defined by HHSC, affect all providers with the exception of LTC and the HHSC Family Planning Program. The HHSC payment deadline rules for the fiscal agent arrangement ensure that state and federal financial requirements are met.

TMHP is required to finalize and pay claims within 24 months of:

- Each date of service on a claim.
- Discharge date for inpatient claims.

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Texas Medicaid and Children with Special Health Care Needs (CSHCN) Service Program payments, excluding crossovers, cannot be made after 24 months. Claims and appeals that are submitted after the designated payment deadlines are denied.

Note: *Providers may appeal HHSC Office of Inspector General (OIG) initiated claims adjustments (recoupments) after the 24-month deadline but must do so within 120 days from the date of the recoupment. Refer to subsection 7.1.5, "Paper Appeals" in "Section 7: Appeals" (Vol. 1, General Information) for instructions. All appeals of OIG recoupments must be submitted by paper, no electronic or telephone appeals will be accepted.*

6.1.6 Filing Deadline Calendars

The most current filing deadline calendars are available on the TMHP website at www.tmhp.com:

- Filing Deadline Calendar for 2025
- Filing Deadline Calendar for 2026

6.2 TMHP Electronic Claims Submission

TMHP uses the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 5010 file format through a Secure File Transfer Protocol (SFTP) connection for maximum security.

Claims may be submitted electronically to TMHP through TexMedConnect on the TMHP website at www.tmhp.com or through billing agents who interface directly with the TMHP EDI Gateway.

Providers must retain all claim and file transmission records. They may be required to submit them for pending research on missing claims or appeals.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*).

6.2.1 Benefit and Taxonomy Codes

Providers must submit the Benefit Code field (when applicable), Address field, and Taxonomy Code Field and all other required fields. These fields must be completed before submitting electronic claims.

Taxonomy codes do not affect pricing or the level of pricing, but rather are used to crosswalk the NPI to the billing provider. It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a provider's enrollment with TMHP is included on all electronic transactions.

Billing providers that are not associated with a group are required to submit a taxonomy code on all electronic claims. Claims submitted without a taxonomy code may be rejected.

Medicare does not require a taxonomy code for Part B claims. Therefore, some claims submitted to TMHP from Medicare for payment of deductible or coinsurance may not include the taxonomy code needed for accurate processing by TMHP.

6.2.2 Electronic Claim Acceptance

Providers should verify that their electronic claims were accepted by Texas Medicaid for payment consideration by referring to their Claim Response report, which is in the 27S batch response file (e.g., file name E085LDS1.27S). Providers should also check their Accepted and Rejected reports in the rej and acc batch response files (e.g., E085LDS1.REJ and E085LDS1.ACC) for additional information. Only claims that have been accepted on the Claim Response report (27S file) will be considered for payment and made available for claim status inquiry. Claims that are rejected must be corrected and resubmitted for payment consideration.

Refer to: Subsection 3.2, "Electronic Billing" in "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*), visit www.tmhp.com, or call the EDI Help Desk at 888-863-3638 for more information about electronic claims submissions.

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6.2.3 Electronic Rejections

The most common reasons for electronic professional claim rejections are:

- *Client information does not match.* Client information does not match the PCN on the TMHP eligibility file. The name, date of birth, sex, and nine-digit Medicaid identification number must be an exact match with the client's identification number on TMHP's eligibility record. If using TexMedConnect, send an interactive eligibility request to obtain an exact match with TMHP's record. If not using TexMedConnect, verify through the TMHP website or call AIS at 800-925-9126 to verify client information. A lack of complete client eligibility information causes a rejection and possibly delayed payment. To prevent delays when submitting claims electronically:
  - Always include the first and last name of the client on the claim in the appropriate fields.
  - Always enter the client's complete, valid nine-digit Medicaid number. Valid Medicaid numbers begin with 1, 2, 3, 4, 5, 6 or 7. CSHCN Services Program client numbers begin with a 9.
  - When submitting claims for newborns, use the guidelines in the following section.
- *Referring/Ordering Physician field blank or invalid.* The referring physician's NPI must be present when billing for consultations, laboratory, or radiology. Consult the software vendor for this field's location on the electronic claims entry form.
- *Performing Physician ID field blank or invalid.* When the billing NPI is a *group* practice, the performing NPI for the physician who performed the service must be entered. Consult the software vendor for this field's location on the electronic claim form.
- *Facility Provider field blank or invalid.* When place of service (POS) is anywhere other than home or office, the facility's NPI must be present. If the NPI is not known, enter the name and address of the facility. Consult the software vendor for this field's location on the electronic claims entry form.
- *Invalid Type of Service or Invalid Type of Service/Procedure code combination.* In certain cases some procedure codes will require a modifier to denote the procedure's type of service (TOS).

  Note: *The C21 claims processing system can accept only 40 characters (including spaces) in the Comments section of electronic submissions for ambulance and dental claims. If providers include more than 40 characters in that field, C21 will accept only the first 40 characters; the other characters will not be imported into C21. Providers must ensure that all of the information that is required for the claim to process appropriately is included in the first 40 characters.*

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in this section for TMHP EDI modifier information.

6.2.3.1 Newborn Claim Hints

The following are to be used for newborns:

- If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. *Always* use "boy" or "girl" first and then the mother's full name. An exact match must be submitted for the claim to process.
- Do not use "NBM" for newborn male or "NBF" for newborn female.

The following are the most common reasons for electronic hospital UB-04 CMS-1450 claim rejections:

- *Admit hour outside allowable range* (such as 24 hours).
- *Billed amount blank.*

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- *Health coverage ID blank or invalid.* This number *must* be the valid nine-digit Medicaid client number. *Incorrect data* includes: a number less than nine digits; PENDING; 999999999; and Unknown.
- *Referring physician information on outpatient claim is blank* when laboratory/radiology services are ordered or a surgical procedure is performed. The referring physician's NPI is required in Fields 78–79. Consult the software vendor for the location of this field on the electronic claims entry form.

6.2.4 TMHP EDI Batch Numbers, Julian Dates

All electronic transactions are assigned an eight-character Batch ID immediately upon receipt by the TMHP EDI Gateway. The batch ID format allows electronic submitters to determine the exact day and year that a batch was received. The batch ID format is JJJYSSSS, where each character is defined as follows:

- *JJJ – Julian date.* The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where I = 0, J = 1, K = 2, and L = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date. For example, a Julian date of 143 would be J43.
- *Y – Year.* The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a "2" in this position indicates the year 2012.
- *SSSS* = The unique 4-character sequence number assigned by EDI to the batch filed.

6.2.5 Modifier Requirements for TOS Assignment

Modifiers for TOS assignment are not required for Texas Health Steps (THSteps) Dental claims (claim type 021) and Inpatient Hospital claims (claim type 040). Additionally, procedures submitted by specific provider types such as genetics, eyeglass, and THSteps medical checkup are assigned the appropriate TOS based on the provider type or specific procedure code, and will not require modifiers.

Most procedure codes do not require a modifier for TOS assignment, but modifiers are required for some services submitted on professional claims (claim type 020) and outpatient hospital claims (claim type 023). Services that require a modifier for TOS assignment are listed in the following sections.

6.2.5.1 Assistant Surgery

For assistant surgical procedures, use one of the following modifiers: 80, 81, 82, and AS. Using these modifiers results in TOS 8 being assigned to the procedure.

6.2.5.2 Anesthesia

For anesthesia procedures, use one of the following modifiers: AA, AD, QK, QS, QX, QY, and QZ. Using these modifiers results in TOS 7 being assigned to the procedure.

6.2.5.3 Interpretations

For interpretations or professional components of laboratory, radiology, or radiation therapy procedures, use modifier 26. Using modifier 26 results in TOS I being assigned to the procedure.

Note: *Procedure codes that only have a TOS I are not required to use modifier 26.*

6.2.5.4 Technical Components

For technical components of laboratory, radiology, or radiation therapy procedures, use modifier TC. Using this modifier results in TOS T being assigned to the procedure.

Exception: *Outpatient hospitals do not include the TC modifier when they provide technical components of lab and radiology services. These services automatically have TOS 4 or 5 assigned and are subject to the facility's interim reimbursement rate or the clinical lab rate.*

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6.2.6 Electronic Visit Verification (EVV)

All claims for Electronic Visit Verification (EVV) services, including fee-for-service and managed care claims, must be submitted electronically to TMHP using the appropriate electronic claims submission method. Paper claims for EVV services will not be accepted. The EVV aggregator will perform EVV claims matching and TMHP will forward the EVV claim with the EVV match code to the applicable payer for claims processing.

6.3 Coding

Electronic billers must code all claims. TMHP encourages all providers to code their paper claims. Claims are processed fast and accurately if providers furnish appropriate information. By coding claims, providers ensure precise and concise representation of the services provided and are assured reimbursement based on the correct code. If providers code claims, a narrative description is not required and does not need to be included unless the code is a not an otherwise classified code.

Important: *Claims for anesthesia must have the CPT anesthesia procedure code narrative descriptions or CPT surgical codes; if these codes are not included, the claim will be denied.*

The carrier for the Texas Medicare Program has coding manuals available for physicians and suppliers with codes not available in CPT. To order a CPT Coding Manual, write to the following address:

American Medical Association
Book and Pamphlet Fulfillment
PO Box 2964
Milwaukee, WI 53201

6.3.1 Diagnosis Coding

Texas Medicaid requires providers to provide *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) diagnosis codes on their claims. The *only* diagnosis coding structure accepted by Texas Medicaid is the ICD-10-CM. Diagnosis codes must be to the highest level of specificity available. In most cases a written description of the diagnosis is not required.

All diagnosis codes that are submitted on a claim must be appropriate for the age of the client as identified in the ICD-10-CM description of the diagnosis code. Claims that are denied because one or more of the diagnosis codes submitted on the claim are not appropriate for the age of the client may be appealed with the correct diagnosis code or documentation of medical necessity to justify the use of the diagnosis code.

Diagnosis codes in the following categories are not valid as primary or referenced diagnosis:

- Nonspecific injury, poisoning and other consequences of external causes
- Diagnosis in the International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)
- Factors influencing health status and contact with health services, unless otherwise directed in this manual.
- External causes of morbidity

6.3.1.1 Place of Service (POS) Coding

The POS identifies where services are performed. Indicate the POS by using the appropriate code for each service identified on the claim.

Important: *Attention ambulance providers: POS 41 and 42 are accepted by Texas Medicaid for ambulance claims processing. The two-digit origin and destination codes are still required for claims processing.*

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Use the following codes for POS identification where services are performed:

POS	2-Digit Numeric Codes	1-Digit Numeric Codes
Office	02, 10, 11, 15, 17, 20, 49, 50, 60, 65, 71, 72	1
Home	12, 27	2
Inpatient hospital	21, 51, 52, 56, 61	3
Outpatient hospital	19, 22, 23, 24, 55, 57, 58, 62	5
Birthing center	25	7
Other location	01, 03, 04, 05, 06, 07, 08, 16, 18, 26, 34, 41, 42, 53, 99	9
Skilled nursing facility or intermediate care facility for individuals with an intellectual disability or related conditions	13, 31, 32, 54	4
Extended care facility (rest home, domiciliary or custodial care, nursing facility boarding home)	14, 33	8
Independent lab	81	6
Destination of ambulance	Indicate destination using above codes	Indicate destination using above codes

Note: *Family planning and THSteps medical services performed in a rural health clinic (RHC) are billed using national POS code 72.*

6.3.2 Type of Service (TOS)

The TOS identifies the specific field or specialty of services provided.

To determine the TOS payable for each procedure code, providers may refer to the online fee lookup (OFL) or the static fee schedules, both are available on the TMHP website at www.tmhp.com.

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in this section for TMHP EDI modifier information.

6.3.2.1 TOS Table

Important: *TOS codes are not used for claim submissions, but they do appear on R&S Reports.*

TOS	Description
0	Blood
1	Medical Services
2	Surgery
3	Consultations
4	Radiology (total component)
5	Laboratory (total component)
6	Radiation Therapy (total component)
7	Anesthesia
8	Assistant surgery

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TOS	Description
9	Other medical items or services
C	Home health services
D	TB clinic
E	Eyeglasses
F	Ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC)
G	Genetics
I	Professional component for radiology, laboratory, or radiation therapy
J	DME purchase new
L	DME rental
R	Hearing aid
S	THSteps medical
T	Technical component for radiology, laboratory, or radiation therapy
W	THSteps dental

6.3.3 Procedure Coding

Texas Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS provides health-care providers and third-party payers a common coding structure that uses codes designed around a five-character numeric or alphanumeric base. The procedure codes are updated annually and quarterly.

HCPCS consists of two levels of codes:

- Level I—Current Procedural Terminology (CPT®) Professional Edition
  - Numeric, five digits
  - Makes up 80 percent of HCPCS
  - Maintained by AMA, which updates it annually
  - Updates by the AMA are coordinated with CMS before modifications are distributed to third-party payers
  - Anesthesia codes from CPT
- Level II—HCPCS
  - Approved and released by CMS
  - Codes for both physician and non-physician services not contained in CPT (for example, ambulance, DME, prosthetics, and some medical codes)
  - Maintained and updated by the CMS Maintenance Task Force
  - Alphanumeric, a single alpha character (A through V) followed by four digits
  - The single alpha character represents one of the following:

Alpha	Description
A	Supplies, ambulance, administrative, miscellaneous
B	Enteral and parenteral therapy
E	DME and oxygen

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Alpha	Description
G	Procedures/professional (temporary)
H	Rehab and behavioral health services
J	Drugs (administered other than orally)
K	Durable Medical Equipment Regional Carriers (DMERC)
L	Orthotic and prosthetic procedures
M	Medical
P	Laboratory
Q	Temporary procedures
R	Radiology
S	Private payer
T	State Medicaid agency
V	Vision and hearing services

6.3.3.1 HCPCS Updates

TMHP updates HCPCS codes on both an annual and quarterly basis. Major updates are made annually and minor updates are made quarterly.

Most of the procedure codes that do not replace a discontinued procedure code must go through the rate hearing process. HHSC conducts public rate hearings to provide an opportunity for the provider community to comment on the Medicaid proposed payment rate, as required by Chapter 32 of the Human Resources Code, §32.0282, and Title 1 of the Texas Administrative Code, §355.201.

6.3.3.1.1 Annual HCPCS

Annual HCPCS updates apply additions, changes, and deletions that include the program and coding changes related to the annual HCPCS, Current Dental Terminology (CDT), and CPT updates. These updates ensure that the coding structure is up-to-date by using the latest edition of the CPT and the nationally established HCPCS codes that are released by CMS.

6.3.3.1.2 Quarterly HCPCS

Quarterly HCPCS updates apply HCPCS additions, changes, and deletions that are released by CMS.

6.3.3.1.3 Rate Hearings for New HCPCS Codes

HHSC holds rate hearings for new HCPCS codes on a regular basis. Rate hearings are announced on the HHSC website at www.hhs.texas.gov/providers/medicaid-business-resources/texas-medicaid-chip-rate-analysis.

Claims for services that are provided before the rates are adopted through the rate hearing process are denied as pending a rate hearing (EOB 02008) until the applicable reimbursement rate is adopted. The client cannot be billed for these services.

Providers are responsible for meeting the initial 95-day filing deadline. Providers must submit the procedure codes that are most appropriate for the services provided, even if the procedure codes have not yet completed the rate hearing process and are denied by Texas Medicaid as pending a rate hearing.

Once the reimbursement rates are established in the rate hearing and applied, TMHP automatically reprocesses affected claims. Providers are not required to appeal the claims unless they are denied for other reasons after the claims reprocessing is complete.

Refer to: Subsection 5.11, "Guidelines for Procedures Awaiting Rate Hearing" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about the authorization guidelines for procedure codes that are awaiting a rate hearing.

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6.3.4 National Drug Code (NDC)

The NDC is an 11-digit number on the package or container from which the medication is administered. All Texas Medicaid fee-for-service and Family Planning providers must submit an NDC for professional or outpatient claims submitted with physician-administered prescription drug procedure.

N4 must be entered before the NDC on claims.

National Drug Unit of Measure: The submitted unit of measure should reflect the volume measurement administered. Refer to the NDC Package Measure column on the Texas NDC-to-HCPCS Crosswalk.

The valid units of measurement codes are:

- F2—International unit
- GR—Gram
- ME—Milligram
- ML—Milliliter
- UN—Unit

Note: *Unit quantities are required.*

6.3.4.1 Paper Claim Submissions

UB-04 CMS 1450

Block No.	Description	Guidelines
43	Revenue codes and description	This block should include the following elements in the following order: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). • The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME (e.g., GR). • The unit quantity with a floating decimal for fractional units (limited to 3 digits, e.g., 0.025). ***Example:*** *N400409231231GR0.025*

CMS-1500

Block No.	Description	Guidelines
24A	Dates of service	In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). ***Example:*** *N400409231231*

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Block No.	Description	Guidelines
24D	Procedures, services, or supplies	In the shaded area, enter the NDC quantity of units administered (up to 12 digits, including the decimal point.). A decimal point must be used for fractions of a unit (e.g., 0.025).
24G	Days or units	In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME.

2017 Claim Form

Block No.	Description	Guidelines
32A	Dates of service	In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). ***Example:*** *N400409231231*
32D	Procedures, services, or supplies Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Modifier	In the shaded area, enter the NDC quantity of units administered (up to 12 digits, including the decimal point.). A decimal point must be used for fractions of a unit (e.g., 0.025).
32F	Days or units	In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME.

National Drug Unit

Claims will be edited for the value submitted in the NDC quantity field. In order to convert the HCPCS units submitted into the NDC quantity; use the Texas NDC-to-HCPCS Crosswalk to review the "HCPCS Description" and the "NDC Label" description to identify the quantity.

The Texas NDC-to-HCPCS Crosswalk identifies relationships between HCPCS codes and National Drug Codes (NDC). The Texas file is published at least quarterly. The Texas NDC-to-HCPCS Crosswalk can be found at www.txvendordrug.com/formulary/clinician-administered-drugs. Clinician-administered drugs that do not have an appropriate NDC to HCPCS combination for the procedure code that is submitted are not payable.

6.3.4.2 NDC Requirements for Dual Eligible Clients

The 11-digit NDC, NDC quantity, and NDC Unit of measure information is required on all professional and outpatient clinician-administered drug claims for dual-eligible clients. These drug claims are submitted to Medicare, which will cross over to Medicaid for consideration of coinsurance and deductible liabilities.

Important: *Claims which cross over without this required information may be denied due to missing, incomplete, or invalid NDC information. This information applies to all Medicaid providers who serve Medicare-Medicaid dual-eligible clients.*

Providers may refer to subsection 6.3.4, "National Drug Code (NDC)" in this section for more information on NDC requirements. The Texas NDC-to-HCPCS Crosswalk identifies relationships between HCPCS codes.

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6.3.4.3 Drug Rebate Program

Texas Medicaid will reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the Centers for Medicare & Medicaid Services (CMS) Drug Rebate Program and that show as active on the CMS list for the date of service the drug is administered.

CMS maintains a list of participating manufacturers and their rebate-eligible drug products, which is updated quarterly on the CMS website. TMHP will republish this list quarterly in a more accessible format.

When providers submit claims for clinician-administered drug procedure codes, they must include the National Drug Code (NDC) of the administered drug as indicated on the drug packaging. While 340B purchased claims are not eligible for drug rebates, NDCs are required to receive federal funding to pay the claim.

TMHP will deny claims for drug procedure codes under the following circumstances:

- The NDC submitted with the drug procedure code is not on the CMS drug rebate list that was current on the date of service.
- The NDC submitted with the drug procedure code has been terminated.
- The drug procedure code is submitted with a missing or invalid NDC.

To avoid claim denials, providers must speak with the pharmacy or wholesaler with whom they work to ensure the product purchased is on the current CMS list of participating manufacturers and their drugs.

> ***Note:*** *Texas Medicaid managed care organizations (MCOs) have their own policies and procedures regarding clinician-administered drugs. Providers must contact the client's MCO for benefit and limitation information.*

Providers can find a complete, downloadable list of procedure codes and the corresponding descriptions on the Vendor Drug Program website at www.txvendordrug.com.

Vitamins and minerals procedure codes will be listed on a separate tab of the supplemental file.

6.3.5 Modifiers

Modifiers describe and qualify the services provided by Texas Medicaid. A modifier is placed after the five-digit procedure code. Up to two modifiers may apply per service. Examples of frequently used modifiers are listed in the following table. Refer to the service-specific sections for additional modifier requirements.

Modifier	Special Instructions/Notes (if applicable)
340B Drug Rebate Program	
U8	All eligible organizations and covered entities that are enrolled in the federal 340B Drug Pricing Program to purchase 340B discounted drugs must use modifier U8 when submitting claims for 340B clinician-administered drugs. Non-compliance with this new requirement to use modifier U8 on all claims submitted for 340B clinician-administered drugs may jeopardize a covered entity's 340B status with the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). Providers can refer to the HRSA website at www.hrsa.gov/opa/index.html for more information about the 340B Drug Pricing Program.
Ambulance	
ET	Use for all emergency transport services.
GY	Use to indicate that no medical necessity existed for a transport.
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

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Modifier	Special Instructions/Notes (if applicable)
Surgeons	
53	Use for physician reporting of a discontinued procedure. For outpatient/ASC reporting of a discontinued procedure, see modifier 73 and 74.
54+	Surgeon who performs the surgical procedure only must bill the surgical code with modifier 54 and is reimbursed 70% of the global fee.
55+	Provider who performs the postoperative care only must bill the surgical code with modifier 55 and is reimbursed 20% of the global fee.
56+	Providers who perform the preoperative care only must bill the surgical code with modifier 56 and is reimbursed 10 percent of the global fee.
58+	Staged or related procedure or services by the same physician during the postoperative period.
62+	Cosurgery. Two surgeons perform the specific procedure(s).
76+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
77+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
78+	Return to the operating room for a related procedure during the postoperative period.
79+	Unrelated procedure or service by the same physician during the postoperative period.
Assistant Surgeons	
80 *and* KX+	Use modifier 80 and KX together to indicate an assistant surgeon in a teaching facility: • In a case involving exceptional medical circumstances such as emergency or life-threatening situations requiring immediate attention. • When the primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his or her patients. • In a case involving a complex surgical procedure that qualifies for more than one physician.
AS	Use when the physician assistant is not enrolled as an individual provider and provides assistance at surgery.
Sterilizations	
PM	Use to indicate post-menopausal.
PS	Use to indicate previously sterilized.
Excision of Lesions/Masses	
KX+	Use modifier KX if the excision/destruction is due to one of the following signs or symptoms: inflamed, infected, bleeding, irritated, growing, limiting motion or function. Use of this modifier is subject to retrospective review.
Injections	
AT	Use to indicate acute conditions.
JA	Administered intravenously.
JB	Administered subcutaneously.

+ Modifier is required for accurate claims processing.
*** Description is defined by the state.**

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Modifier	Special Instructions/Notes (if applicable)
KX+	Use modifier KX to indicate the injection was due to: • Oral route contraindicated or an acceptable oral equivalent is not available. • Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available. • Patient has a temperature over 102 degrees (documented on the claim) and a high level of antibiotic is needed quickly. • Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare up of a chronic condition.
Visits	
76+	Use to indicate the repeated non-clinical procedure.
FP+	Use to indicate that the service was part of an annual family planning examination.
TH+	Use with external causes of injury and poisoning (E Codes) procedures and morphology of neoplasms (M Codes) procedures to specify antepartum or postpartum care.
25	Use to describe circumstances in which an office visit was provided at the same time as other separately identifiable services. Refer to the CMS NCCI website for additional information.
Anesthesia	
One of the following modifier combinations must be used by anesthesiologists directing non-CRNA qualified professionals.	
AA and U1	Use to indicate that the anesthesia services were performed personally by the anesthesiologist.
AD and U1 (Emergency circumstances only)	Use when directing five or more concurrent procedures provided by non-CRNA qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.
QK an U1	Use when directing two, three, or four concurrent procedures provided by non-CRNA qualified professionals.
QY and U1	Use when directing one procedure provided by a non-CRNA qualified professional.
One of the following modifier combinations must be used by anesthesiologists directing CRNAs.	
AD and U2 (Emergency circumstances only)	Use when directing five or more concurrent procedures involving CRNA (s). Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.
QK and U2	Use when directing two, three, or four concurrent procedures involving CRNAs.
QY and U2	Use when directing one procedure by a CRNA.
One of the following modifier combinations must be used by CRNAs.	
QX and U2	Use to indicate the anesthesia was medically directed by the anesthesiologist.
QZ and U1	Use to indicate the anesthesia was directed by the surgeon.
DME	
For DME, use one of the following modifiers:	
NU	For DME purchase new
RR	For DME rental- monthly
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

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Modifier	Special Instructions/Notes (if applicable)
UE	For DME other-purchase-used
FQHC and RHC	
Services provided by a health-care professional require one of the following modifiers:	
AH	Use to indicate that the services were performed by a clinical psychologist.
AJ	Use to indicate that the services were performed by a clinical social worker.
AM	Use to indicate that the services were performed by a physician or team member service (includes clinical psychiatrist).
SA	Use to indicate that the services were performed by an advanced practice registered nurse (APRN) or CNM rendering services in collaboration with a physician.
TD	For home services performed by a RN and provided in areas with a shortage of home health agencies.
TE	For home services performed by an LVN and provided in areas with a shortage of home health agencies.
TS	Use to indicate a case management follow-up service.
U1	Licensed professional counselor
U2	Licensed marriage and family therapist
U7*	Physician assistant services for other than assistant at surgery
The following modifiers may be used in addition to the modifier identifying the health-care professional that rendered the service:	
EP	Use to indicate THSteps services (FQHC only).
FP	Use to indicate that the service was part of an annual family planning examination.
TH	Use to indicate the encounter is for antepartum care or postpartum care.
U5*	State-defined modifier for use with case management services.
Abortion	
G7	Use by performing physicians, facilities, anesthesiologists, and CRNAs (with appropriate procedure code) when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid.
Vision	
RB	Use modifier RB to indicate replacement of prosthetic or nonprosthetic eyeglasses or contact lenses.
VP+	Use when billing prosthetic eyeglasses or contact lenses with a diagnosis of aphakia.
Laboratory/Radiology	
26+	Use for laboratory interpretations and radiological procedures.
59-	Code to indicate the procedure or service was independent from other services performed on the same day. Refer to the CMS NCCI website for additional information.
91+	Use for repeat laboratory clinical test.
76	Use for repeat laboratory nonclinical test.
SU+	Indicates necessary equipment is in physician's office for RAST/MAST testing or Pap smears.
TC+	The modifier TC is used for technical radiological procedures.
Q4+	Use for lab/radiology/ultrasound interps by other than the attending physician.
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

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Modifier	Special Instructions/Notes (if applicable)
Therapy	
AT+	Must be used to indicate the necessity of an acute condition for occupational therapy (OT), physical therapy (PT), osteopathic manipulation treatment (OMT), or chiropractic services.
GN	Use to indicate outpatient speech language pathology.
GO	Use to indicate outpatient occupational therapy.
GP	Use to indicate outpatient PT.
U4*	Reassessment
THSteps Medical	
AM	Physician, team member service
EP	FQHCs must use modifier EP for services provided under THSteps.
SA	Nurse practitioner rendering service in collaboration with a physician
U5*	Intermediate oral examination with dental varnish
U7*	Physician assistant services for other than assistant at surgery
TD	Registered nurse
THSteps Exceptions to Periodicity	
SC	Medically necessary service or supply
23	Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier *23* to the procedure code of the basic service or by use of the separate five-digit modifier code 09923
32	Mandated Services: Services related to mandated consultation or related services (e.g., peer review organization [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 five digit modifier 09932
Physicians	
Q5	Informal reciprocal arrangement (period not to exceed 14 continuous days)
Q6	Locum tenens or temporary arrangement (up to 90 days)
Radiology Services	
U6	CT, CTA, MRI, MRA, Cardiac Nuclear Imaging, and PET Scan studies provided in the emergency department. Obstetric ultrasounds provided in the emergency department or during a hospital observation stay.
Durable Medical Equipment	
NU	Use to indicate purchased equipment.
RR	Use to indicate leased equipment.
Telemedicine/Telehealth	
95	Use with appropriate evaluation and management codes.

+ Modifier is required for accurate claims processing.
*** Description is defined by the state.**

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Other Common Modifiers									
AE	AF	AG	AK	AR	CB	CD	CE	CF	CG
KC	KD	KF	LT	M2	RD	RT	SW	SY	TL
U1	U2	U3	UN	UP	UQ	UR	US		

The following modifiers may appear on R&S Reports (they are not entered by the provider):

- *PT.* The DRG payment was calculated on a per diem basis for an inpatient stay because of patient transfer.
- *PS.* The DRG payment was calculated on a per diem basis because the patient exhausted the 30-day inpatient benefit limitation during the stay.
- *PE.* The DRG payment was calculated on a per diem basis because the patient was ineligible for Medicaid during part of the stay. Also used to adjudicate claims with adjustments to outlier payments.

6.3.6 Benefit Code

A benefit code is an additional data element used to identify state programs.

Providers that participate in the following programs must use the associated benefit code when submitting claims and authorizations:

Program	Benefit Code
Comprehensive Care Program (CCP)	CCP
THSteps Medical	EP1
THSteps Dental	DE1
Family Planning Agencies*	FP3
Hearing Aid Dispensers	HA1
Maternity	MA1
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) Providers	EC1
Tuberculosis (TB) Clinics	TB1
IDD case management providers	MH2
***Agencies only—Benefit codes should not be used for individual family planning providers.**	

6.4 Claims Filing Instructions

This section contains instructions for completion of Medicaid-required claim forms. When filing a claim, providers should review the instructions *carefully* and complete *all* requested information. A correctly completed claim form is processed faster.

This section provides a sample claim form and its corresponding instruction table for each acceptable Texas Medicaid claim form.

All providers, except those on prepayment review, should submit paper claims to TMHP to the following address:

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

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Providers on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

Texas Medicaid & Healthcare Partnership
Attention: Prepayment Review MC–A11 SURS
PO Box 203638
Austin, TX 78720-3638

6.4.1 National Correct Coding Initiative (NCCI) Guidelines

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims that are submitted to TMHP be filed in accordance with the NCCI guidelines, including claims for services that have been prior authorized or authorized with medical necessity documentation.

The following NCCI MUE limitations have been deactivated as approved by CMS:

Procedure Codes	Description	Deactivated Limitation (per date of service)	Approved Limitations
A4281, A4282, A4284, A4286	Breast pump replacement parts	1	2 of each part per rolling year
H0005	Group therapy for substance use disorder treatment	1	135 units per calendar year

The CMS NCCI and MUE guidelines can be found on the CMS website at www.cms.gov.

The NCCI guidelines consist of HCPCS or CPT procedure code pairs that must not be reported together and MUEs that determine whether procedure codes are submitted in quantities that are unlikely to be correct.

The NCCI and MUE spreadsheets are published and updated by CMS and are available on the CMS Medicaid NCCI Coding web page under "NCCI and MUE Edits" as follows:

- NCCI edit spreadsheets. The website contains the Medicaid NCCI edit spreadsheet for hospital services and the Medicaid NCCI edit spreadsheet for practitioner services. The spreadsheets list the procedure code pairs that will not be reimbursed separately if they are billed by the same provider with the same date of service. Column 1 procedure codes may be reimbursed and Column 2 procedure codes will be denied. The spreadsheets also contain a column that indicates whether or not a modifier is allowed for services that may be reimbursed separately.
- MUE edit spreadsheets. The website contains the Medicaid MUE edit spreadsheets for hospital services, practitioner services, and supplier services. The spreadsheets list procedure codes and the number of units that may be reimbursed for each procedure code. Units that are submitted beyond these limitations will be denied.

Note: *Providers are required to comply with NCCI and MUE guidelines as well as the guidelines that are published in the Texas Medicaid Provider Procedures Manual, all currently published website articles, fee schedules, and all other application information published on the TMHP website at www.tmhp.com. In instances when Texas Medicaid medical policy is more restrictive than NCCI or MUE guidance, Texas Medicaid medical policy prevails.*

HHSC continue to implement and enforce correct coding initiatives. Providers may see additional claim denials related to NCCI and MUE edits including those services that were prior authorized or authorized with medical necessity documentation.

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If a rendered service does not comply with a guideline as defined by NCCI, medical necessity documentation may be submitted with the claim for the service to be considered for reimbursement; however, medical necessity documentation does not guarantee payment for the service.

Important: *Prior authorization and authorization based on documentation of medical necessity is a condition for reimbursement; it is not a guarantee of payment.*

Claims that were submitted with dates of service from October 1, 2010, through June 30, 2013, will not be reprocessed in accordance with the NCCI guidelines; however, any claims with dates of service on or after October 1, 2010, that are appealed or reprocessed for reasons other than NCCI auditing will be subject to NCCI auditing guidelines.

6.4.1.1 NCCI Processing Categories

The following coding rule categories are applied to claims that are submitted with dates of service on or after October 1, 2010:

Coding Rule Category	Description
Maximum units	CMS has assigned to all procedure codes a maximum number of units that may be submitted for a client per day, regardless of the provider. The maximum number of units for each procedure code is based on the following criteria: • Procedure code description • Anatomical site • CMS sources • Clinical guidelines ***Important:*** *If the maximum number of units has been exceeded on a particular line item, the line item will be denied. The line item will not be cut back to the allowable quantity. The line item may be appealed with the appropriate quantity for consideration.*
NCCI	NCCI is a collection of bundling edits created and sponsored by CMS that are separated into two major categories: Column I and Column II procedure code edits (previously referred to as "Comprehensive" and "Component") and Mutually Exclusive procedure code edits. NCCI edits are applied to services that are performed by the same provider on the same date of service only and do not apply to services that are performed within the global surgical period. Each NCCI code pair edit is associated with a policy as defined in the *National Correct Coding Initiative Policy Manual*. Effective dates apply to code pairs in NCCI and represent the date when CMS added the code pair combination to the NCCI edits. Code combinations are processed based on this effective date. Termination dates also apply to code pairs in NCCI. This date represents the date when CMS removed the code pair combination from the NCCI edits. Code combinations are refreshed quarterly.

6.4.1.2 CPT and HCPCS Claims Auditing Guidelines

Claims with dates of service on or after October 1, 2010, must be filed in accordance with *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) guidelines as defined in the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) coding manuals. Claims that are not filed in accordance with CPT and HCPCS guidelines may be denied, including claims for services that were prior authorized or authorized based on documentation of medical necessity.

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If a rendered service does not comply with CPT or HCPCS guidelines, medical necessity documentation may be submitted with the claim for the service to be considered for reimbursement; however, medical necessity documentation does not guarantee payment for the service.

Important: *Prior authorization and authorization based on documentation of medical necessity is a condition for reimbursement; it is not a guarantee of payment.*

The following coding rule categories apply to claims submissions:

Coding Rule Category	Description
Add-on codes	Certain services are commonly carried out in addition to the rendering of the primary procedure and are associated with the primary procedures. These additional or supplemental procedures are referred to as "add-on" procedures. Add-on codes are identified in the CPT Manual with a plus mark ("+") symbol and are also listed in Appendix D of the CPT Manual. Add-on codes are always performed in addition to a primary procedure, and should never be reported as a stand-alone service. When an add-on code is submitted and the primary procedure has not been identified on either the same or different claim, then the add-on code will be denied as an inappropriately-coded procedure. If the primary procedure is denied for any reason, then the add-on code will be denied also.
Deleted HCPCS codes	Procedure codes undergo revision by the AMA and CMS on a regular basis. Revisions typically include adding new procedure codes, deleting procedure codes, and redefining the description of existing procedure codes. These revisions are normally made on an annual basis by the governing entities with occasional quarterly updates. Claims that are received with deleted procedure codes will be validated against the date of service. If the procedure code is valid for the date of service, the claim will continue processing. If the procedure code is invalid for the date of service, the invalid procedure code will be denied.
Diagnosis validity	ICD-10-CM diagnosis codes undergo revision by the Centers for Disease Control and Prevention (CDC) and CMS on a regular basis. Revisions typically include adding new diagnosis codes, deleting diagnosis codes, and redefining the description of existing diagnosis codes. These revisions are normally made on an annual basis. Claims that are received with invalid diagnosis codes will be validated against the date of service. If the diagnosis code is valid for the date of service, the claim will continue processing. If the diagnosis code is invalid for the date of service, the procedure that is referenced to the invalid diagnosis code will be denied.
Diagnosis-age	Certain diagnosis codes are age-specific. If a diagnosis code that is billed does not match the age of the client on that date of service, all services associated with that diagnosis code will be denied.
Diagnosis-gender	Certain diagnosis codes are gender-specific. If the diagnosis code that is billed does not match the gender of the client, all services associated with that diagnosis code will be denied.
Duplicate claim	A duplicate claim is defined as a claim or procedure code detail that exactly matches a claim or procedure code detail that has been reimbursed to the same provider for the same client. Duplicate claims or details include the same date of service, procedure code, modifier, and number of units. Duplicate claims or procedure code details will be denied. ***Note:*** *Modifiers may be used to identify separate services.*

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Coding Rule Category	Description
Evaluation and Management (E/M) services	The AMA defines new and established patients as follows: • A new patient is "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." • An established patient is "one who has received a professional service from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." Only one E/M procedure code may be reimbursed for a single date of service by the same provider group and specialty, regardless of place of service. Providers may refer to subsection 9.2.60, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information about physician E/M services.
Procedure code definition	The CPT manual assigns each procedure code a specific description or definition to describe the service that is rendered. In order to support correct coding, the procedure code definition rules will deny procedure codes based on the appropriateness of the code selection as directed by the definition and nature of the procedure code.
Procedure code guideline	The CPT manual includes specific reporting guidelines that are located throughout the manual and at the beginning of each section. In order to ensure correct coding, these guidelines provide reporting guidance and must be followed when submitting specific procedure codes.
Procedure-age	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group. For example, procedure code 99382 is limited to clients who are 1 through 4 years of age.
Procedure-gender	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of one gender. For example, hysterectomy procedure code 58150 is limited to female clients.
Total, professional interpretation, and technical services	Diagnostic tests and radiology services are procedure codes that include two components: professional interpretation and technical. The professional interpretation component describes the physician's interpretation and report services and is billed with modifier 26. The technical component describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service, and is billed with modifier TC. If the professional interpretation and technical components are rendered by the same provider, the total component may be billed using the appropriate procedure code without modifiers 26 and TC. Reimbursement of diagnostic tests and radiology services is limited to no more than the amount for the total component. Providers must refer to the appropriate Texas Medicaid fee schedules to determine payable components for diagnostic and radiology services. Procedure codes that are submitted with an inappropriate modifier will be denied.

6.4.2 Claim Form Requirements

6.4.2.1 Provider Signature on Claims

Every paper CMS-1500, American Dental Association (ADA) Dental Claim Form, and 2017 Claim Form must be submitted with the provider's or an authorized representative's handwritten signature (or signature stamp) in the appropriate block of the claim form. Signatory supervision of the authorized

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representative is required. Providers delegating signature authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment. Initials are only acceptable for first and middle names. The last name must be spelled out. An acceptable example is J.A. Smith for John Adam Smith. An unacceptable example is J.A.S. for John Adam Smith. Typewritten names must be accompanied by a handwritten signature; in other words, a typewritten name with signed initials is not acceptable. The signature must be contained within the appropriate block of the claim form. Claims prepared by computer billing services or office-based computers may have "Signature on File" printed in the signature block, but it must be in the same font that is used in the rest of the form. For claims prepared by a billing service, the billing service must retain a letter on file from the provider authorizing the service.

Printing the provider's name instead of "Signature on File" is unacceptable. Because space is limited in the signature block, providers should not type their names in the block. Claims not meeting these specifications appear in the "Paid or Denied Claims" sections of the R&S Reports.

6.4.2.2 Group Providers

Providers billing as a group must give the performing provider NPI on their claims as well as the group provider NPI. This requirement excludes THSteps medical providers.

6.4.2.3 Supervising Physician Provider Number Required on Some Claims

The supervising physician provider number is required on claims for services that are ordered or referred by one provider at the direction of or under the supervision of another provider, and the referral or order is based on the supervised provider's evaluation of the client.

If a referral or order for services to a Texas Medicaid client is based on a client evaluation that was performed by the supervised provider, the billing provider's claim must include the names and NPIs of both the ordering provider and the supervising provider. The billing provider must obtain all of the required information from the ordering or referring provider before submitting the claim to TMHP.

Providers who submit TexMedConnect electronic claims for professional, ambulance, or vision services can provide the claim information in the designated field for the supervising provider of the referring or ordering provider.

Providers can refer to TexMedConnect instructions on the TMHP website at www.tmhp.com for details about the "Referring/Other Supervising Provider" field for professional, ambulance, and vision electronic claims.

Note: *Pharmacy claims are currently excluded from this requirement.*

6.4.2.4 Ordering or Referring Provider NPI

All Texas Medicaid claims for services that require a physician order or referral must include the ordering or referring provider's NPI:

- If the ordering or referring provider is enrolled in Texas Medicaid as a billing or performing provider, the billing or performing provider NPI must be used on the claim as the ordering or referring provider.
- If the ordering or referring provider is not currently enrolled in Texas Medicaid as a billing or performing provider, the provider must enroll to receive an ordering or referring-only taxonomy and benefit code. After the ordering or referring provider is enrolled, the ordering or referring provider's NPI must be used on the claim as the ordering or referring provider.

Important: *The billing provider is responsible for confirming that the ordering or referring provider is enrolled as an ordering or referring-only provider.*

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Claims that are submitted without the ordering or referring provider's NPI and claims submitted with an NPI for a provider who is not enrolled in Texas Medicaid may be subject to retrospective review and denial for a missing or invalid NPI.

Note: *Providers who enroll in Texas Medicaid as ordering- and referring-only providers can use their NPI for orders and referrals for Texas Medicaid clients and CSHCN Services Program clients.*

6.4.2.5 Attending Provider NPI Requirements

The attending provider is the individual who would normally be expected to certify and re-certify the medical necessity of the number of services rendered or who has primary responsibility for the patient's medical care and treatment.

Note: *Outpatient claim providers may be instructed to submit the ordering provider name and NPI number in the attending provider field.*

6.4.2.6 Prior Authorization Numbers on Claims

Claims filed to TMHP must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the appropriate electronic field or on the paper claim forms in the indicated block:

- CMS-1500—Block 23
- UB-04 CMS-1450—Block 63
- ADA—Block 2
- Family Planning—Block 30

6.4.2.7 Newborn Clients Without Medicaid Numbers

If a Medicaid eligible newborn has not been assigned a Medicaid number on the DOS, the provider may temporarily submit claims using the mother's Medicaid identification number until the newborn's individual Medicaid number has been assigned. Once the newborn's Medicaid number is assigned, the provider must use the newborn's number for all subsequent claims.

All claims must be filed within 95 days of the DOS. Providers verify eligibility through TexMedConnect or by calling the AIS or the TMHP Contact Center at 800-925-9126.

6.4.2.8 Multipage Claim Forms

6.4.2.8.1 Professional Claims

The approved electronic claims format is designed to list 50 line items. The total number of details allowed for a professional claim by the TMHP claims processing system (C21) is 28. If the services provided exceed 28 line items on an approved electronic claims format or 28 line items on paper claims, the provider must submit another claim for the additional line items.

The CMS-1500 paper claim form is designed to list six line items in Block 24. If more than six line items are billed on a paper claim, a provider may attach additional forms (pages) totaling no more than 28 line items. The first page of a multipage claim must contain all the required billing information. On subsequent pages of the multipage claim, the provider should identify the client's name, diagnosis, information required for services in Block 24, and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form and indicate "continued" in Block 28. The combined total charges for all pages should be listed on the last page in Block 28.

Note: *Providers who submit professional claims for inpatient services are required to include only the facility's NPI on the CMS-1500 paper claim form or electronic equivalent.*

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6.4.2.8.2 Institutional Claims

The total number of details allowed for an institutional claim by the TMHP claims processing system (C21) is 28. C21 merges like revenue codes together for inpatient claims to reduce the lines to 28 or less. If the C21 merge function is unable to reduce the lines to 28 or less, the claim will be denied, and the provider will need to reduce the number of details and resubmit the claim.

An EDI approved electronic format of the UB-04 CMS-1450 is designed to list 71 lines. C21 merges like revenue codes together to reduce the lines to 28 or less.

Providers submitting electronic claims using TexMedConnect may not submit more than 28 lines. If the services exceed the 28 lines, the provider may submit another claim for the additional lines or merge codes.

The paper UB-04 CMS-1450 is designed to list 23 lines in Block 43. If services exceed the 23-line limitation, the provider may attach additional pages. The first page of a multipage claim must contain all required billing information. On subsequent pages, the provider identifies the client's name, diagnosis, all information required in Block 43, and the page number of the attachment (e.g., page 2 of 3) in the top right-hand corner of the form and indicate "continued" on Line 23 of Block 47. The combined total charges for all pages should be listed on the last page on Line 23 of Block 47.

When splitting a claim, all pages must contain the required information. Usually, there are logical breaks to a claim. For example, the provider may submit the surgery charges in one claim and the subsequent recovery days in the next claim.

TEFRA hospitals are required to submit all charges.

6.4.2.8.3 Inpatient Hospital Claims

Medicaid present-on-admission (POA) reporting is required for all inpatient hospital claims that are paid under prospective payment basis methodology. No hospitals are exempt from this POA requirement.

Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators are denied. POA values are:

POA Value	Description	Payment
Y	Diagnosis was present at the time of admission.	Payment will be made by Texas Medicaid when a hospital acquired condition (HAC) is present.
N	Diagnosis was not present at the time of admission.	No payment will be made by Texas Medicaid when an HAC is present.
U	Documentation was insufficient.	No payment will be made by Texas Medicaid when an HAC is present.
W	Clinically undetermined.	Payment will be made by Texas Medicaid when an HAC is present.
Blank	Exempt from POA Reporting	Exempt from POA Reporting

Note: *Texas Medicaid follows Medicare guidelines for payments referenced in the above table.*

Depending on the POA indicator value, the DRG may be recalculated, which could result in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a POA DRG recalculation, the lesser of the number of days is reimbursed.

Refer to: *Federal Register*, Vol. 76, No. 108 (for CMS).

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6.4.2.9 Attachments to Claims

To expedite claims processing, providers must supply all information on the claim form itself and limit attachments to those required by TMHP or necessary to supply information to properly adjudicate the claim. The following claim form attachments are required when appropriate:

- All claims for services associated with an elective sterilization must have a valid Sterilization Consent Form attached or on file at TMHP.
- Nonemergency ambulance transfers must have documentation of medical necessity including out-of-locality transfers.
- For fee-for-service clients, providers filing to TMHP for Medicaid payment of Medicare coinsurance and deductible according to current payment guidelines must attach the paper MRAN received from Medicare or a Medicare intermediary or the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services. Providers that submit paper crossover claims must submit only one of the approved MRAN formats.
- For MAP clients, providers filing to TMHP for Medicaid payment of Medicare coinsurance and deductible according to current payment guidelines must submit with the paper claim the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template with the MAP EOB. If the template and MAP EOB contain conflicting information, the claim will not be processed and will be returned to the provider.
- Medically necessary abortions performed (on the basis of a physician's professional judgement, the life of the mother is endangered if the fetus were carried to term), or abortions provided for pregnancy related to rape or incest must have a signed and dated physician certification statement. Elective abortions are *not* benefits of Texas Medicaid.
- Hysterectomies must have a Hysterectomy Acknowledgment Statement attached or on file at TMHP.

Refer to: Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

- Claims for services that were paid by an MCO and then recouped must contain the recoupment EOB from the MCO for consideration of payment. The claims must meet the 95-day deadline from the recoupment disposition date.

Note: *Letter requests for refunds will not be accepted. A recoupment EOB with a disposition date is required.*

6.4.2.10 Clients with a Designated or Primary Care Provider

Claims for clients with a primary care provider or designated provider (i.e., Texas Medicaid fee-for-service clients enrolled as Limited Program clients) must indicate the primary care provider or designated provider NPIs in the billing or performing provider fields.

When clients receive services from a different provider, such as a specialist, the primary care provider or designated provider's information must be included in the referring provider fields on the claim.

6.5 CMS-1500 Paper Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 5010 electronic specifications or the CMS-1500 paper claim form:

Providers
Ambulance
ASC (freestanding)

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Providers
Case Management for Blind and Visually Impaired Children (BVIC), Case Management for Early Childhood Intervention (ECI), and Case Management for Children and Pregnant Women
Certified nurse-midwife (CNM)
Certified registered nurse anesthetist (CRNA)
Certified respiratory care practitioner (CRCP)
Chemical dependency treatment facilities
Chiropractor
Clinical nurse specialist (CNS)
Dentist (doctor of dentistry practicing as a limited physician)
DME
Family planning agency that does not also receive funds from the HHSC Family Planning Program
FQHC
Genetic service agency
Hearing aid
IDD case management
In-home total parenteral nutrition (TPN) supplier
Laboratory
Licensed dietitian (CCP only)
Licensed clinical social worker (LCSW)
Licensed professional counselor (LPC)
Maternity service clinic (MSC)
Mental health (MH) targeted case management
Mental health (MH) rehabilitative services
Nurse practitioner (NP)
Occupational therapist (CCP only)
Optician/optometrist/ophthalmologist
Orthotic and prosthetic supplier (CCP only)
Pharmacy
Physical therapist
Physician (group and individual)
Physician assistant (PA)
Podiatrist
Private duty nurse (PDN) (CCP only)
Psychologist
Radiology
Rural Health Clinics rendering services to THSteps clients
School Health and Related Services (SHARS)
Speech language pathologist (CCP only)
THSteps medical
Tuberculosis clinic

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Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice; TMHP does not supply them.

6.5.1 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 paper claim forms with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/topics/edi. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 888-863-3638.

Refer to: Subsection 3.2, "Electronic Billing" in "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic billing.

6.5.2 CMS-1500 Claim Form (Paper) Billing

Claims must contain the billing provider's complete name, physical address with ZIP +4 code, taxonomy, and benefit code (if applicable). Claims without this information cannot be processed. Each claim form must have the appropriate signatory evidence in the signature certification block.

Refer to: The Professional Paper Claim Form (CMS-1500) page of the CMS website at www.cms.gov for more information about the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. Providers can find examples of completed claim forms on the Claim Form Examples page of the TMHP website at www.tmhp.com.

Important: *When completing a CMS-1500 paper claim form, all required information must be included on the claim in the appropriate block. Information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.*

6.5.3 CMS- 1500 Provider Definitions

The following definitions apply to the provider terms used on the CMS-1500 paper claim form:

Referring Provider

The referring provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form.

Examples include, but are not limited to the following:

- A primary care provider referring to a specialist
- An orthodontist referring to an oral and maxillofacial surgeon
- A physician referring to a physical therapist
- A provider referring to a home health agency

Ordering Provider

The ordering provider is the individual who requested the services or items listed in Block D of the CMS-1500 paper claim form.

Examples include, but are not limited to, a provider ordering diagnostic tests, medical equipment, or supplies.

Rendering Provider

The rendering provider is the individual who provided the care to the client. In the case where a substitute provider was used, that individual is considered the rendering provider.

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An individual such as a lab technician or radiology technician who performs services in a support role is not considered a rendering provider.

Supervising Provider

The supervising provider is the individual who provided oversight of the rendering provider and the services listed on the CMS-1500 paper claim form.

An example would be the supervision of a resident physician.

Purchased Service Provider

A purchased service provider is an individual or entity that performs a service on a contractual or reassignment basis.

Examples of services include the following:

- Processing a laboratory specimen
- Grinding eyeglass lenses to the specifications of the referring provider
- Performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's antimarkup rule

In the case where a substitute provider is used, that individual is not considered a purchased service provider.

6.5.4 CMS-1500 Instruction Table

The instructions describe what information must be entered in each of the block numbers of the CMS-1500 paper claim form. Block numbers *not* referenced in the table may be left blank. They are *not* required for claim processing by TMHP.

Block No.	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the client's nine-digit patient number from the Medicaid identification form. For other property & casualty claims: Enter the Federal Tax ID or SSN of the insured person or entity.
2	Patient's name	Enter the client's last name, first name, and middle initial as printed on the Medicaid identification form. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client's gender by checking the appropriate box. Only one box can be marked.
5	Patient's address	Enter the client's complete address as described (street, city, state, and ZIP code).
8	Benefit code	Enter the benefit code (if applicable) for the billing provider.
9	Other insured's name	For special situations, use this space to provide additional information such as: If the client is deceased, enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.

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Block No.	Description	Guidelines
10a 10b 10c	Is patient's condition related to: a. Employment (current or previous)? b. Auto accident? c. Other accident?	Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b.
11 11a 11b	Other health insurance coverage	• If another insurance resource has made payment or denied a claim, enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. • If the client is enrolled in Medicare attach a copy of the MRAN to the claim form. • For Workers Compensation and other property and casualty claims: (Required if known) Enter Workers' Compensation or property and casualty claim number assigned by the payer.
11c	Insurance plan or program name	Enter the benefit code, if applicable, for the billing or performing provider.
12	Patient's or authorized person's signature	Enter "Signature on File" or the patient's or authorized person's legal signature. When the legal signature is entered, enter the date signed in eight-digit format (MMDDYYYY). TMHP will process the claim without the signature of the patient.
14	Date of current	Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.
17	Name of referring physician or other source	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supplies on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas within the name. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. DN = Referring Provider DK = Ordering Provider DQ = Supervising Provider Supervising Physician for Referring Physicians: If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.

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Block No.	Description	Guidelines
17b	NPI	Enter the NPI number of the referring, ordering, or supervising provider.
19	Additional claim information	**Ambulance transfers of multiple clients** If the claim is part of a multiple transfer, indicate the other client's complete name and Medicaid number. **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility **Supervising Physician for Referring Physicians:** If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.
20	Outside lab	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the provider identifier of the facility that performed the service in block 32.
21	Diagnosis or nature of illness or injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.
23	Prior authorization number	Enter the PAN issued by TMHP. For Workers Compensation and other property and casualty claims, this is required when prior authorization, referral, concurrent review, or voluntary certification was received.
24	(Various)	General notes for blocks 24a through 24j: • Unless otherwise specified, all required information should be entered in the unshaded portion. • If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim. • For multi-page claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form.

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Block No.	Description	Guidelines
24a	Date(s) of service	Enter the date of service for each procedure provided in a MM/DD/YYYY format. If more than one date of service is for a single procedure, each date must be given on a separate line. **NDC** In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4). • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). ***Example:*** *N400409231231* ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24b	Place of service	Select the appropriate POS code for each service from the table under subsection 6.3.1.1, "Place of Service (POS) Coding" in this section.
24c	EMG (THSteps medical checkup condition indicator)	Enter the appropriate condition indicator for THSteps medical checkups. ***Refer to:*** Subsection 4.3.6, "THSteps Medical Checkups" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
24d	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. **NDC** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit (e.g., 0.025). ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24e	Diagnosis pointer	In 24 E, enter the diagnosis code reference letter (pointer) as shown in Form Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. Diagnosis codes must be entered in Form Field 21 only. Do not enter diagnosis codes in Form Field 24E.
24f	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.

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Block No.	Description	Guidelines
24g	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). ***Note:*** *The maximum number of units per detail is 9,999.* **NDC** In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24j	Rendering provider taxonomy code (performing)	Enter the taxonomy code of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the taxonomy code in the shaded area of the field. Entered the NPI in the unshaded area of the field.
26	Patient's account number	**Optional:** Enter the client identification number if it is different than the subscriber/insured's identification number. Used by provider's office to identify internal client account number.
27	Accept assignment	**Required** All providers of Texas Medicaid must accept assignment to receive payment by checking **Yes**.
28	Total charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician, supplier, or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. ***Refer to:*** Subsection 6.4.2.1, "Provider Signature on Claims" in this section.

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Block No.	Description	Guidelines
32	Service facility location information	If services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP+4 code of the facility where the service was provided. This is a required field for services provided in a facility. The facility provider number, name, and address are not optional.
32A	NPI	Enter the NPI of the service facility location.
33	Billing provider info & PH #	Enter the billing provider's name, physical address, city, state, ZIP+4 code, and telephone number.
33A	NPI	Enter the NPI of the billing provider.
33B	Other ID #	Enter the taxonomy code of the billing provider.

6.6 UB-04 CMS-1450 Paper Claim Filing Instructions

The following provider types may bill electronically or use the UB-04 CMS-1450 paper claim form when requesting payment:

Provider Types
ASCs (hospital-based)
Comprehensive outpatient rehabilitation facilities (CORFs) (CCP only)
FQHCs ***Note:*** *Must use CMS-1500 when billing THSteps.*
Home health agencies
Hospitals • Inpatient (acute care, rehabilitation, military, and psychiatric hospitals) • Outpatient
Indian Health
Renal dialysis center
Personal Care Services (PCS)
RHCs (freestanding and hospital-based) ***Note:*** *Must use CMS-1500 when billing THSteps.*

If a service is rendered in the facility setting but the facility's medical record does not clearly support the information submitted on the facility claim, the facility may request additional information from the physician before submitting the claim to ensure the facility medical record supports the filed claim.

> ***Note:*** *In the case of an audit, facility providers will not be allowed to submit an addendum to the original medical records for finalized claims.*

6.6.1 UB-04 CMS-1450 Electronic Billing

Electronic billers must submit UB-04 CMS-1450 claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837I 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, field locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 888-863-3638.

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Refer to: Subsection 3.2, "Electronic Billing" in "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for more information about electronic billing.

Note: *The maximum number of electronic claim details that will be accepted electronically is 71. Only 28 details will be processed.*

6.6.2 UB-04 CMS-1450 Claim Form (Paper) Billing

Providers obtain the UB-04 CMS-1450 paper claim forms from a vendor of their choice.

Note: *To avoid claim denial, only the provider's NPI should be placed in form locators 76-79 of the UB-04 CMS-1450 paper claim form or in the referring provider field on the electronic claim unless the client is a limited client.*

Completed UB-04 CMS-1450 claims must contain the billing provider's full name, physical address, including the ZIP+4 Code, NPI, taxonomy and benefit code (if applicable). Claims *without* this information in the appropriate fields *cannot* be processed.

Refer to: The Institutional paper claim form (CMS-1450) CMS website at www.cms.gov for more information about the CMS-1450 paper claim form. Providers can purchase CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms. Providers can find examples of completed claim forms on the Claim Form Examples page of the TMHP website at www.tmhp.com.

Subsection 6.6.3, "UB-04 CMS-1450 Instruction Table" in this section.

6.6.3 UB-04 CMS-1450 Instruction Table

The instructions describe what information must be entered in each of the block numbers of the UB-04 CMS-1450 paper claim form. Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.

Block No.	Description	Guidelines
1	Unlabeled	Enter the hospital name, street, city, state, ZIP+4 Code, and benefit code (if applicable).
3a	Patient control number	**Optional:** Any alphanumeric character (limit 16) entered in this block is referenced on the R&S Report.
3b	Medical record number	Enter the patient's medical record number (limited to ten digits) assigned by the hospital.
4	Type of bill (TOB)	Enter a TOB code. First Digit—Type of Facility: 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC]) 8 Special facility Second Digit—Bill Classification (except clinics and special facilities): 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 7 Intermediate care

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Block No.	Description	Guidelines
		Second Digit—Bill Classification (clinics only): 1 Rural health 2 Hospital-based or independent renal dialysis center 3 Free standing 5 CORFs Third Digit—Frequency: 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim 5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim
6	Statement covers period	Enter the beginning and ending dates of service billed.
8a	Patient identifier	**Optional:** Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by providers office to identify internal patient account number.
8b	Patient name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid identification form.
9a–9b	Patient address	Starting in 9a, enter the patient's complete address as described (street, city, state, and ZIP+4 Code).
10	Birthdate	Enter the patient's date of birth (MM/DD/YYYY).
11	Sex	Indicate the patient's gender by entering an "M" or "F."
12	Admission date	Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.
13	Admission hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.
14	Priority (Type) of Admission or Visit	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Priority (Type) of Admission or Visit codes.
15	Point of Origin for Admission or Visit	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Point of Origin for Admission or Visit codes.
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank.
17	Patient Discharge Status	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Patient Discharge Status Codes.
18–28	Condition codes	Enter the two-digit condition code "05" to indicate that a legal claim was filed for recovery of funds potentially due to a patient.
29	ACDT state	**Optional:** Accident state.
31-34	Occurrence codes and dates	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Occurrence Codes.

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Block No.	Description	Guidelines
35-36	Occurrence span codes and dates	For inpatient claims, enter code "71" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay. For inpatient claims, enter occurrence span code 82 for the "from" and "through" dates of the hospital-at-home care. For charges of the at-home care room and board, enter revenue code 0161.
39-41	Value codes	Accident hour–For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.
42-43	Revenue codes and description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. **NDC** This block should include the following elements in the following order: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). • The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME (e.g., GR). • The unit quantity with a floating decimal for fractional units (limited to 3 digits, e.g., 0.025). ***Example:*** *N400409231231GR0.025* ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.

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Block No.	Description	Guidelines
44	HCPCS/rates	**Inpatient:** Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. **Home Health Services** Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. ***Refer to:*** Subsection 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on which revenue codes require HCPCs codes. **Outpatient:** Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. ***Refer to:*** Subsection 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on which revenue codes require HCPCs codes. Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. ***Note:*** *The UB-04 CMS-1450 paper claim form is limited to 28 items per inpatient and outpatient claim.* *If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.*
45	Service date	Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.
45 (line 23)	Creation date	Enter the date the bill was submitted.
46	Serv. units	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation.
47	Total charges	Enter the total charges for each service provided.
47 (line 23)	Totals	Enter the total charges for the entire claim. ***Note:*** *For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*

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Block No.	Description	Guidelines
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.
50	Payer Name	Enter the health plan name.
51	Health Plan ID	Enter the health plan identification number.
54	Prior payments	Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and 80 as required: • Block 32 - Occurrence code and date. • Block 61 - Insured group name • Block 62 - Insurance group number • Block 80 - Remarks. This section is used for requesting the 110-day rule for a third party insurance.
56	NPI	Enter the NPI of the billing provider.
57	Code code (CC)	**Optional:** Area to capture additional information necessary to adjudicate the claims. Required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere on the claim data set.
58	Insured's name	If other health insurance is involved, enter the insured's name.
60	Medicaid identification number	Enter the patient's nine-digit Medicaid identification number.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number if one was issued.
65	Employer name	Enter the name of the patient's employer if health care might be provided.
66	Diagnosis/ Procedure Code Qualifier	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM
67	Principal diagnosis (DX) code and present on admission (POA) indicator	Enter the ICD-10-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. **Required:** POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.8.3, "Inpatient Hospital Claims" in this section for POA values.

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Block No.	Description	Guidelines
67A-67Q	Secondary DX codes and POA indicator	Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141"). ***Exception:*** *A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein.* ***Note:*** *ICD-10-CM diagnosis codes entered in 67K–67Q are not required for systematic claims processing.* **Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.8.3, "Inpatient Hospital Claims" in this section for POA values.
69	Admit DX code	Enter the ICD-10-CM diagnosis code indicating the cause of admission or include a narrative ***Note:*** *The admitting diagnosis is only for inpatient claims.*
70a-70c	Patient's reason DX	**Optional:** New block indicating the patient's reason for visit on unscheduled outpatient claims.
71	Prospective Payment System (PPS) code	**Optional:** The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a-72c	External cause of injury (ECI) and POA indication	**Optional:** Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. **Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.8.3, "Inpatient Hospital Claims" in this section for POA values.
74	Principal procedure code and date	Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
74a-74e	Other procedure codes and dates	Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
76	Attending provider	Enter the attending provider name and NPI. Outpatient claims require an attending provider. Inpatient claims, services that require an attending provider are defined as those listed in the ICD-10-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures.
77	Operating	Enter operating provider's name (last name and first name) and NPI number of the operating provider.

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Block No.	Description	Guidelines
78-79	Other	Other provider's name (last name and first name) and NPI. NPI number of the referring and prescribing provider. Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. Rendering provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure. ***Important:*** *Qualifier 82 is required to identify the rendering provider for acute care inpatient and outpatient institutional services.* ***Note:*** *If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.*
80	Remarks	This block is used to explain special situations such as the following: • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. • If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician. • If services are the result of an accident, the cause and location of the accident must be entered in this block. The time must be entered in Block 39. • If laboratory work is sent out, the name and address or the provider identifier of the facility where the work was forwarded must be entered in this block. • If the services resulted from a family planning provider's referral, write "family planning referral." • If services were provided at another facility, indicate the name and address of the facility where the services were rendered. • Request for 110-day rule for a third party insurance.
81A-81D	Other identification (ID) number	Enter the taxonomy code (non-NPI number) of the billing provider.

6.6.4 Filing Tips for Outpatient Claims

The following are outpatient claim filing tips:

- Use HCPCS codes in Block 44 when available and give a narrative description in Block 43 for all services and supplies provided.

Important: *Services and supplies that exceed the 28 items per claim limitation must be submitted on an additional UB-04 CMS-1450 paper claim form and will be assigned a different claim number by TMHP.*

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- Combine central supplies and bill as one item. IV supplies may be combined and billed as one item. Include appropriate quantities and total charges for each combined procedure code used. Using combination procedure codes conserves space on the claim form.
- The 28-item limitation per claim: a UB-04 CMS-1450 paper claim form submitted with 28 or fewer items is given an internal control number (ICN) by TMHP. Multipage claim forms are processed as one claim for that client *if all* pages contain 28 or fewer items.
- Itemized Statements: Itemized statements are not used for assignment of procedure codes. HCPCS codes or narrative descriptions of procedures *must* be reflected on the face of the UB-04 CMS-1450 paper claim form. Attachments will only be used for clarification purposes.

Refer to: Subsection 6.3.3, "Procedure Coding" in this section.

6.7 American Dental Association (ADA) Dental Claim Filing Instructions

Providers billing for dental services and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) dental services may bill electronically or use the ADA claim form.

Note: *TMHP is responsible for reimbursing all THSteps dental services provided by dentists.*

6.7.1 ADA Dental Claim Electronic Billing

Electronic billers must submit THSteps dental claims using TexMedConnect or an approved vendor software that uses the ANSI ASC X12 837D 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, block locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 888-863-3638.

Note: *Dental providers who submit American National Standards Institute, Accredited Standards Committee X12 (ANSI ASC X12N) 837D transactions through the TMHP Electronic Data Interchange (EDI) are required to include the header date of service (HDOS) to comply with International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) claims processing guidelines.*

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for more information about electronic filing.

6.7.2 ADA Dental Claim Form (Paper) Billing

All participating THSteps dental providers are required to submit a ADA Dental claim form for paper claim submissions to Texas Medicaid. These forms may be obtained by contacting the ADA at 800-947-4746.

Claims must contain the billing provider's complete name, physical address, NPI, and taxonomy code. Claims without a provider name, physical address, NPI, and taxonomy code cannot be processed.

6.7.3 ADA Dental Claim Form

Samples of the ADA Dental Claim form can be found on the ADA website at www.ada.org.

6.7.4 ADA Dental Claim Form Instruction Table

The following table is an itemized description of the questions appearing on the form. Thoroughly complete the ADA Dental claim form according to the instructions in the table to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

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ADA Block No.	ADA Description	Instructions
1	Type of Transaction	For Texas Medicaid, check the Statement of Actual Services Box. The other two boxes are not applicable. Do not use the ADA Dental Claim Form as a Texas Medicaid Prior Authorization form. ***Refer to:*** THSteps Dental Mandatory Prior Authorization Request Form on the TMHP website at www.tmhp.com.
2	Predetermination/ Preauthorization Number	Enter prior authorization number if assigned by Medicaid.
3	Company/Plan Name, Address, City, State, ZIP Code	Enter TMHP and the address. ***Refer to:*** Subsection A.11, "Written Communication With TMHP" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).
4	Other Dental or Medical Coverage	Check applicable box. If both "Dental" and "Medical" are marked, complete blocks 5–11 for dental only.
5-11	Other Coverage Information	General notes: • Enter the information for non-Medicaid insurance coverage. • Enter the information for the policyholder or subscriber, not necessarily the patient. May be a parent or legal guardian of the patient receiving treatment.
5	Name of Policyholder/ Subscriber in # 4	Enter the policyholder/subscriber name.
6	Date of Birth (MM/DD/ CCYY)	Enter policyholder/subscriber eight-digit date of birth (MM/ DD/YYYY).
7	Gender	Check the appropriate box for the policyholder/subscriber gender
8	Policyholder/Subscriber ID	Enter policyholder/subscriber identifier.
9	Plan/Group Number	Enter policyholder/subscriber plan/group number.
10	Patient's Relationship to Person Named in # 5	Enter the patient's relationship to policyholder/subscriber.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	Enter the contact information for the insurance company providing the non-Medicaid coverage.
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Enter the Medicaid patient's last name, first name, and middle initial as printed on the Medicaid identification form.
13	Date of Birth (MM/DD/ CCYY)	Enter the Medicaid patient's date of birth (MM/DD/YYYY).

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ADA Block No.	ADA Description	Instructions
14	Gender	Check the appropriate box for the Medicaid patient's gender.
15	Policyholder/Subscriber ID	Enter nine-digit patient number from the Medicaid identification form.
16	Plan/Group/Number	Enter the billing provider's benefit code, if applicable.
17	Employer Name	Not applicable to Texas Medicaid.
18	Relationship to Policyholder/ Subscriber in # 12 Above	Not applicable to Texas Medicaid.
19	Reserved for Local Use	Leave blank and skip to Item 20. (Field was previously used to report "Student Status") Include the appropriate modifier.
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
21	Date of Birth (MM/DD/CCYY)	Not applicable to Texas Medicaid.
22	Gender	Not applicable to Texas Medicaid.
23	Patient ID/Account # (Assigned by Dentist)	**Optional**: Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by dental office to identify internal patient account number.
24	Procedure Date (MM/DD/CCYY)	Enter the eight-digit date of service (MM/DD/YYYY).
25	Area of Oral Cavity	Not applicable to Texas Medicaid.
26	Tooth System	Not applicable to Texas Medicaid.
27	Tooth Number(s) or Letter(s)	Enter the Tooth ID as required for procedure code. ***Refer to:*** Subsection 3.2.14, "Tooth Identification (TID) and Surface Identification (SID) Systems" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
28	Tooth Surface	Enter Surface ID as required for procedure code. ***Refer to:*** Subsection 3.2.14, "Tooth Identification (TID) and Surface Identification (SID) Systems" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
29	Procedure Code	Use an appropriate Current Dental Terminology (CDT) procedure code.
29a	Diagnosis Code Pointer	Enter the letter(s) from Box 34 that identified the diagnosis code(s)applicable to the dental procedure. List the primary diagnosis pointer first.
29b	Procedure Quantity	Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in item 24. The default value is "01".
30	Description	Provide a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).

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ADA Block No.	ADA Description	Instructions
31	Fee	Enter usual and customary charges for each service listed. Charges must not be higher than the fees charged to private pay clients.
31a	Other Fee(s)	When other changes applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies. Identify the source of each payment date in Block 11. If the client makes a payment, the reason for the payment must be identified in Block 11.
32	Total Fee	Enter the sum of all fees in Block 31. For multi-page claims, enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
33	Missing Teeth Information	Mark an "X" on each missing tooth. For identifying missing permanent dentition only. Report missing teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant services procedures on a particular claim.
34	Diagnosis Code List Qualifier	Enter "AB= ICD-10" to identify the diagnosis code source.
34a	Diagnosis Codes(s)	Enter up to four applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter "A".
35	Remarks	Use this space for: • Explanation of exception to periodicity. • The facility name and address and NPI if the place of treatment indicated in Block 38 is not the provider's office. • Explanation of emergency if indicated in Block 45. • To provide more information such as reports for local orthodontia codes, 999 codes, multiple supernumerary teeth, or remarks.
36	Patient/Guardian signature	Not applicable to Texas Medicaid.
37	Subscriber signature	Not applicable to Texas Medicaid.

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ADA Block No.	ADA Description	Instructions
38	Place of Treatment	Enter the 2-digit place of service (POS) code for professional claims, which is a Health Insurance Portability and Accountability Act (HIPAA) standard. Frequently used POS codes include the following: • 11=Office • 12=Home • 21=Inpatient hospital • 22= Outpatient hospital • 31=Skilled nursing facility • 32= Nursing facility
39	Enclosures	Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).
40	Is Treatment for Orthodontics?	Check Yes or No as appropriate.
41	Date Appliance Placed	Not applicable to Texas Medicaid.
42	Months of Treatment Remaining	Not applicable to Texas Medicaid.
43	Replacement of Prosthesis?	Not applicable to Texas Medicaid.
44	Date Prior Placement	Not applicable to Texas Medicaid.
45	Treatment Resulting from (Check applicable box)	Providers are required to check the Other Accident box for emergency claim reimbursement. If the Other Accident box is checked, information about the emergency must be provided in Block 35.
46	Date of Accident (MM/DD/CCYY)	Not applicable to Texas Medicaid.
47	Auto Accident State	Not applicable to Texas Medicaid.
48	Name, Address, City, State, ZIP Code	Enter the name and physical address of the billing group or individual provider. Do not enter the name and address of a provider employed within a group.
49	NPI	Enter the billing provider's NPI for a group or an individual. Do not enter the NPI for a provider employed within a group.
50	License Number	Not applicable to Texas Medicaid.
51	Social Security Number (SSN) or Tax Identification Number (TIN)	Not applicable to Texas Medicaid.
52	Telephone Number	Enter the area code and number for the billing group or individual Do not enter the telephone number of a provider employed within a group.
52A	Additional Provider ID	Enter the taxonomy code assigned to the billing dentist or dental entity. Do not enter the taxonomy code for a provider employed within a group.

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ADA Block No.	ADA Description	Instructions
53	Signed (Treating Dentist)	Required-Signature of treating dentist or authorized personnel. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. ***Refer to:*** Subsection 6.4.2.1, "Provider Signature on Claims" in this section.
54	NPI	Enter the NPI for the dentist enrolled as part of a group who treated the patient. Does not apply to individual providers.
55	License Number	Not applicable to Texas Medicaid.
56	Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
56A	Provider Specialty Code	This block is optional.
57	Telephone Number	Not applicable to Texas Medicaid.
58	Additional Provider ID	**Required:** Enter the taxonomy code for the dentist's enrolled as part of a group who treated the patient. Does not apply to individual providers.

6.8 Family Planning Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 5010 electronic specifications or the CMS-1500 paper claim form:

Providers
Clinical nurse specialist (CNS)
Family Planning title agencies contracted with HHSC
Federally Qualified Health Center (FQHC)
Nurse practitioner (NP)
Physician
Physician assistant (PA)

6.8.1 Family Planning Electronic Billing

Electronic billers must submit family planning claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/topics/edi. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 888-863-3638.

Refer to: Subsection 3.2, "Electronic Billing" in "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic billing.

6.9 Family Planning Claim Form (Paper Billing)

Claims must contain the billing providers complete name, physical address, NPI, and taxonomy code. Claims without a provider name, physical address, NPI, and taxonomy code cannot be processed.

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6.9.1 2017 Claim Form

A copy of a blank 2017 Claim Form and copies of example completed claim forms are available on the Claim Form Examples page of the TMHP website at www.tmhp.com.

6.9.2 2017 Claim Form Instruction Table

The instructions describe what information must be entered in each of the block numbers of the 2017 Claim Form.

Block No.	Description	Guidelines	Required (Paper)
1	Program	Check the box for the specific program to which these services are billed: • Family Planning Program: XIX (Check this box for Title XIX family planning services and for Healthy Texas Women (HTW) program services) • DSHS Family Planning Program (DFPP)	XIX, DFPP (All)
2a	Billing provider NPI	Enter the billing provider's ten-digit NPI.	All
2b	Billing provider taxonomy code	Enter the billing provider's taxonomy code.	All
3	Provider name	Enter the provider's name as enrolled with TMHP.	All
4	Eligibility date (DFPP)	Enter the date (MM/DD/CCYY) this client was designated eligible for DFPP services. For DFPP, the eligibility date can be found on the following forms: • INDIVIDUAL Eligibility Form (EF05-14215) • HOUSEHOLD Eligibility Form (EF05-14214) • HOUSEHOLD Eligibility Worksheet (EF05-13227) • An approved DSHS substitute	DFPP
5	DSHS Client no. (Medicaid PCN if XIX)	If previous DFPP, claims or encounters have been submitted to TMHP, enter the client's nine-digit DSHS client number, which begins with "F." If the client has Title XIX Medicaid, enter the client's nine-digit client number from the Medicaid Identification form. If this is a new client, without Medicaid, leave this block blank and TMHP will assign a DSHS client number for the client.	XIX
6	Patient's name (last name, first name, middle initial)	Enter the client's last name, first name, and middle initial as printed on the Medicaid Identification Form, if Title XIX, or as printed in the provider's records, if DFPP.	All
7	Address (street, city, state)	Enter the client's complete home address as described by the client (street, city, and state). This reflects the location where the client lives.	All
7a	ZIP Code	Enter the client's ZIP Code.	All
8	County of residence	Enter the county code that corresponds to the client's address. Please use the HHSC county codes.	All

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Block No.	Description	Guidelines	Required (Paper)
9	Date of birth	Enter numerically the month, day, and year (MM/DD/CCYY) the client was born.	All
10	Sex	Indicate the client's sex by checking the appropriate box.	All
11	Patient status	Indicate if this is the client's first visit to this provider (new patient) or if this client has been to this provider previously (established patient). If the provider's records have been purged and the client appears to be new to the provider, check "New Patient."	All
12	Patient's Social Security number	Enter the client's nine-digit Social Security number (SSN). If the client does not have a SSN, or refuses to provide the number, enter 000-00-0001.	All
13	Race (code #)	Indicate the client's race by entering the appropriate race code number in the box. Aggregate categories used here are consistent with reporting requirements of the Office of Management and Budget Statistical Direction. Race is independent of ethnicity and all clients should be self-categorized as White, Black or African American, American Indian or Native Alaskan, Asian, Native Hawaiian or other Pacific Islander, or Unknown or Not Reported. An "Hispanic" client must also have a race category selected.	All
13a	Ethnicity	Indicate whether the client is of Hispanic descent by entering the appropriate code number in the box. Ethnicity is independent of race and all clients should be counted as either Hispanic or non-Hispanic. The Office of Management and Budget defines Hispanic as "a person of Mexican, Puerto Rican, Cuban, Central, or South American culture or origin, regardless of race."	All
14	Marital status	Indicate the client's marital status by entering the appropriate marital code number in the box.	All
15	Family income (all)	DFPP: Use the gross monthly income calculated and reported on the INDIVIDUAL Eligibility Form (EF05-14215), the HOUSEHOLD Eligibility Form (EF05-14214), or the HOUSEHOLD Eligibility Worksheet (EF05-13227). Title XIX: Enter the gross monthly income reported by the client. Be sure to include all sources of income If income is received in a lump sum, or if it is for a period of time greater than a month (e.g., for seasonal employment), divide the total income by the number of months included in the payment period. If income is paid weekly, multiply weekly income by 4.33. If paid every two weeks, multiply amount by 2.165. If paid twice a month, multiply by 2. Enter $1.00 for clients not wishing to reveal income information.	All

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Block No.	Description	Guidelines	Required (Paper)
15a	Family size	DFPP: Use the family size reported on the eligibility assessment tool. Title XIX providers: Enter the number of family members supported by the income listed in Box 15. Must be at least "one."	All
16	Number times pregnant	Enter the number of times this client has been pregnant. If male, enter zero.	XIX
17	Number live births	Enter the number of live births for this client. If male, enter zero.	XIX
18	Number living children	Enter the number of living children this client has. This also must be completed for male clients.	XIX
19	Primary birth control method before initial visit	Enter the appropriate code letter (a through r) in the box.	XIX
20	Primary birth control method at end of this visit	Enter the appropriate code letter (a through r) in the box.	XIX
21	If no method used at end of this visit, give reason (required only if #20=r)	If the primary birth control method at the end of the visit was "no method" (r), you must complete this box with an appropriate code letter from this block (a through g).	XIX (only if #20=r)
22	Is there other insurance available?	Check the appropriate box.	Optional
23	Other insurance name and address	Enter the name and address of the health insurance carrier.	Optional
24a	Insured's policy/ group no.	Enter the insurance policy number or group number.	Optional
24b	Provider benefit code	Benefit code, if applicable for the billing provider.	Optional
25	Other insurance paid amount	Enter the amount paid by the other insurance company. If payment was denied, enter "Denied" in this block.	Optional
25a	Date of notification	Enter the date of the other insurance payment or denial in this block. This must be in the format of MM/DD/CCYY.	Optional
26	Name of referring provider	If a non-family planning service is being billed, and the service requires a referring provider, enter the provider's name.	XIX (if available)
27b	Referring NPI	If a non-family planning service is being billed and the service requires a referring provider identifier, enter the referring provider's NPI.	XIX

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Block No.	Description	Guidelines	Required (Paper)
28	Level of practitioner	Enter the level of practitioner that performed the service. Primary care or generalist physicians and specialists are correctly classified as "Physicians." Certified nurse-midwives, nurse practitioners, clinical nurse specialists, and physician assistants providing encounters are correctly categorized as "Midlevel." Encounters provided by a registered nurse or a licensed vocational nurse would be categorized as "Nurse." Encounters provided by staff not included in the preceding classifications would be correctly categorized as "Other." If a client has encounters with staff members of different categories during one visit, select the highest category of staff with whom the client interacted. Optional for agencies not receiving any DFPP funding.	DFPP
29	Diagnosis code (Relate Items A-L to service line 32E)	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.	All
30	Authorization number	Enter the authorization number for the client, if appropriate.	Optional
31	Date of occurrence	Use this section when billing for complications related to sterilizations, contraceptive implants, or intrauterine devices (IUDs). This block should contain the date (MM/DD/CCYY) of the original sterilization, implant, or IUD procedure associated with the complications currently being billed.	All, if billing complications
32A	Dates of service	Enter the dates of service (DOS) for each procedure provided in a MM/DD/CCYY format. If more than one DOS is for a single procedure, each date must be given (such as 3/16, 17, 18/2010). Electronic Billers Medicaid does not accept multiple (to-from) dates on a single-line detail. Bill only one date per line. **NDC** In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). ***Example:*** *N400409231231*	All

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Block No.	Description	Guidelines	Required (Paper)
32B	Place of service	Enter the appropriate POS code for each service from the POS table in the Texas Medicaid Provider Procedures Manual. If the client is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.	All
32C	Reserved for local use	Leave this block blank. ***Note:*** *TOS codes are no longer required for claims submission.*	Optional
32D	Procedures, services, or supplies CPT/ HCPCS modifier	Enter the appropriate CPT or HCPCS procedure codes for all procedures/services billed. **NDC** In the shaded area, enter the NDC quantity of units administered (up to 12 digits, including the decimal point.). A decimal point must be used for fractions of a unit.	All
32E	Dx. ref. (29)	Enter the diagnosis line item reference (A-L) for each service or procedure as it relates to each ICD diagnosis code identified in Block 29. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. Diagnosis codes must be entered in Form Field 29 only. Do not enter diagnosis codes in Form Field 32E.	All
32F	Units or days (quantity)	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). **NDC** In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME.	All
32G	$Charges	Indicate the charges for each service listed (quantity multiplied by reimbursement rate). Charges must not be higher than fees charged to private-pay clients.	All
32H (a)	Performing provider taxonomy code	Members of a group practice (except pathology and renal dialysis groups) must identify the taxonomy code of the provider within the group who performed the service. ***Note:*** *To avoid unnecessary denials, DFPP providers should include the performing provider's taxonomy code on the claim. Although not required for DFPP claims, if a claim or encounter that was submitted through DFPP is later determined eligible to be paid under Title XIX, the claim will be denied if the performing provider information is missing.*	XIX

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Block No.	Description	Guidelines	Required (Paper)
32H (b)	Performing provider number (XIX only)-NPI	**Optional:** Members of a group practice (except pathology and renal dialysis groups) must identify NPI of the provider within the group who performed the service. ***Note:*** *To avoid unnecessary denials, DFPP providers should include the performing provider's taxonomy code on the claim. Although not required for DFPP claims, if a claim or encounter that was submitted through DFPP is later determined eligible to be paid under Title XIX, the claim will be denied if the performing provider information is missing.*	XIX
33	Federal tax ID number/EIN (optional)	Enter the federal TIN (Employer Identification Number [EIN]) that is associated with the provider identifier enrolled with TMHP. ***Note:*** *To avoid unnecessary denials, PHC and EPHC providers should include the federal tax ID on the claim. Although not required for PHC and EPHC claims, if a claim or encounter that was submitted through PHC or EPHC is later determined eligible to be paid under Title XIX, the claim will be denied if the tax ID information is missing.*	XIX, DFPP
34	Patient's account number (optional)	Enter the client's account number that is used in the provider's office for its payment records.	Optional
35	Patient copay assessed (DFPP)	If the client was assessed a copayment (DFPP), enter the dollar amount assessed. If no copay was assessed, enter $0.00. Copay cannot be assessed for Title XIX clients. Copayment must not exceed $30.00 for DFPP patients.	DFPP
36	Total charges	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multipage claim.	All
37	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on file" in place of the provider's signature if the billing service obtains and retains on file a letter signed and dated by the provider authorizing this practice. When providers enroll to be an electronic biller, the "Signature on file" requirement is satisfied during the enrollment process.	All

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Block No.	Description	Guidelines	Required (Paper)
38	Name and address of facility where services were rendered (if other than home or office)	If the services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP Code, of the facility (such as the hospital or birthing center) where the service was provided. Independently practicing health-care professionals must enter the name and number of the school district/cooperative where the child is enrolled (SHARS). For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address of the outside laboratory should be entered. The laboratory should bill Texas Medicaid for the services performed.	XIX
38a	NPI	Enter the NPI of the provider where services were rendered (if other than home or office).	XIX
39	Physician's, supplier's billing name, physical address, ZIP Code, and telephone number	Enter the billing provider name, physical address, city, state, ZIP Code, and telephone number.	Optional

6.10 Vision Claim Form

All vision services must be billed on a CMS-1500 paper claim form or the appropriate electronic formats. Vision claims submitted on other forms are denied with EOB 01145, "Claim form not allowed for this program."

For eyewear claims beyond program benefits, (e.g., replacing lost or destroyed eye wear), providers must have the patient sign the "Patient Certification Form" and retain in their records. Do not submit form to TMHP.

Refer to: Medicaid Vision Eyewear Client Certification Form on the TMHP website at www.tmhp.com.

The following table shows the blocks required for vision claims on a CMS-1500 paper claim form.

Block No.	Description
1a	Enter the patient's nine-digit client number from the Your Texas Benefits Medicaid card.
2	Enter the patient's last name, first name, and middle initial as printed on the Your Texas Benefits Medicaid card.
3	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Enter the patient's complete address as described (street, city, state, and ZIP Code).
9 and 9a–9d	Other insurance or government benefits

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Block No.	Description
10	Was condition related to: a. Patient's employment b. Auto accident c. Other accident
11	Medicare number
12	Patient's or authorized person's signature
13*	Insured or authorized person's signature
17 Name of referring physician or other source 17b NPI	Name, provider identifiers, and address of prescribing medical doctor or doctor of optometry
21	Diagnosis or nature of illness or injury
24A	DOS
24B	POS
24D	Describe procedures, medical services, or supplies furnished for each date given
24D, Line "5" for new prescription 24D, Line "6" for old prescription	Prescription/description of lenses and frames
24E	Diagnosis pointer
24F	Charges
26*	The account number for the patient that is used in the provider's office for its billing records.
27 Check "YES" or "NO"	Accept assignment
28	Total charges
29	Amount paid by other insurance
31	Signature of physician or supplier
32	Name and address of facility where services were rendered if other than home or office
33	Telephone number
33	Physician's or supplier's name, physical address, city, state, and ZIP code
No longer used	Referral from screening program (THSteps)

6.11 Remittance and Status (R&S) Report

The R&S Report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP. The R&S Report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same NPI and program processed for payment are paid at the end of the week, either by a single check or with

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Electronic Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S Report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

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

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

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

6.11.1 R&S Report Delivery Options

TMHP offers two options for the delivery of the R&S Report:

- A PDF version that is available on the TMHP website through the secure provider portal.
- An Electronic Remittance and Status (ER&S) Report that is available through EDI.

The PDF version of the R&S Report is available through TexMedConnect, and can be downloaded by registered users of the TMHP website at www.tmhp.com. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S Report are released the next Friday following the weekly claims cycle. Newly-enrolled providers are initially set up to receive the PDF version of the R&S Report.

The EDI delivery method is also available. Using HIPAA-compliant EDI standards, the (ER&S 835 file) can be downloaded through the TMHP EDI Gateway using third party software. The ER&S Report is available on Thursday the week the provider payments are released.

Note: *In rare instances, payments and R&S delivery may be delayed due to a system outage or holiday.*

In addition to the PDF R&S Report, an optional R&S Report delivery method is also available. Using HIPAA-compliant EDI standards, the ER&S Report can be downloaded through the TMHP EDI Gateway using TexMedConnect or third party software. The ER&S Report is also available each Monday after the completion of the claims processing cycle.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for more information about EDI formats and enrollment for the ER&S Report.

6.11.2 Banner Pages

Banner pages serve two purposes:

- They identify the provider's name and address.
- They are used to inform providers of new policies and procedures.

The title pages include the following information:

- TMHP address for submitting paper appeals
- Provider's name, address, and telephone number
- Unique R&S Report number specific to each report
- Provider identifier (NPI, and atypical provider identifier [API])
- Report sequence number (indicates the week number of the year)
- Date of the week being reported on the R&S Report

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- Tax Identification Number
- Page number (R&S Report begins with page 1)
- AIS telephone number
- Taxonomy code

6.11.3 R&S Report Field Explanation

- *Patient name.* Lists the client's last name and first name, as indicated on the eligibility file.
- *Claim number.* The 24-digit Medicaid ICN for a specific claim. The format for the TMHP claim number is expanded to PPP/CCC/MMM/CCYY/JJJ/BBBBB/SSS.

Acronym	Description
PPP	Program
CCC	Claim type
MMM	Media source (region)
CCYY	Year in which the claim was received
JJJ	Julian date on which the claim was received
BBBBB	TMHP internal batch number
SSS	TMHP internal claim sequence within the batch

Program Type

PPP	Program
001	Long Term Care
100	Medicaid
200	Managed Care (for carve-out services administered by TMHP and PCCM claims with dates of service before March 1, 2012)
300	Family Planning (DSHS Family Planning Program)
400	CSHCN Services Program
999	Default/summary for all media regions

Claim Type

Claim Type	Description
020	Physician/supplier (Medicaid only) (genetics agencies, THSteps [medical only], FQHC, optometrist, optician)
021	THSteps (dental)
023	Outpatient hospital, home health, RHC, FQHC
030	Physician crossovers
031	Hospital outpatient crossovers, home health crossovers, RHC crossovers
040	Inpatient hospital
050	Inpatient crossover
056	DSHS Family Planning Program
058	Family Planning Title XIX

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Media Source (MMM)

Region	Description
010	Paper
011	Paper adjustment
030	Electronic (including TexMedConnect)
031	Electronic adjustment (including TexMedConnect)
041	AIS adjustment
051	Mass adjustment
061	Crossover adjustment
071	Retroactive eligibility adjustment
080	State Action Request
081	State Action Request adjustment
090	Telephone
100	Fax
110	Mail
120	Encounter
121	Encounter Adjustment

- *Medicaid #.* The client's Medicaid number.
- *Patient Account #.* If a patient account number is used on the provider's claim, it appears here.
- *Medical Record #.* If a medical record number is used on the provider's claim, it appears here.
- *Medicare #.* If the claim is a result of an automatic crossover from Medicare, the last ten digits of the Medicare claim number appears directly under the TMHP claim number.
- *Diagnosis.* Primary diagnosis listed on the provider's claim.
- *Service Dates.* Format MMDDYYYY (month, day, year) in "From" and "To" dates of service.
- *TOS/Proc.* Indicates by code the specific service provided to the client. The one-digit TOS appears first followed by a HCPCS procedure code. A three-digit code represents a hospital accommodation or ancillary revenue code. For claims paid under prospective payment methodology, it is the code of the DRG.
- *Billed Quantity.* Indicates the quantity billed per claim detail.
- *Billed Charge.* Indicates the charge billed per claim detail.
- *Allowed Quantity.* Indicates the quantity TMHP has allowed per claim detail.
- *Allowed Charge.* Indicates the charges TMHP has allowed per claim detail. For inpatient hospital claims, the allowed amount for the DRG appears.
- *POS Column*. The R&S Report includes the POS to the left of the Paid Amount. A one-digit numeric code identifying the POS is indicated in this column. Refer to subsection 6.3.1.1, "Place of Service (POS) Coding" in this section for the appropriate cross-reference among the two-digit numeric POS codes (Medicare), and one-digit numeric code on the R&S Report. Providers using electronic claims submission should continue using the same POS codes.
- *Paid Amt.* The final amount allowed for payment per claim detail. The total paid amount for the claim appears on the claim total line.

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- *EOB Codes and Explanation of Pending Status (EOPS) Codes.* These codes explain the payment or denial of the provider's claim. The EOB codes are printed next to or directly below the claim. The EOPS codes appear only in "The Following Claims Are Being Processed" section of the R&S Report. The codes explain the status of pending claims and are not an actual denial or final disposition. An explanation of all EOB and EOPS codes appearing on the R&S Report are printed in the Appendix at the end of the R&S Report. Up to five EOB codes are displayed.
- *Total TEFRA Billed and Allowed Charges.* Indicates claim details that have been denied or reduced.
- *Benefit.* Indicates the three digit benefit code associated with the claim.
- *Modifier.* Modifiers have been developed to describe and qualify services provided. For THSteps dental services two modifiers are printed. The first modifier is the TID and the second is the SID.

6.11.4 R&S Report Section Explanation

6.11.4.1 Claims – Paid or Denied

The heading "Claims – Paid or Denied Claims" is centered on the top of each page in this section. Claims in this section finalized the week before the preparation of the R&S Report. The claims are sorted by claim status, claim type, and by order of client names. The reported status of each claim will not change unless further action is initiated by the provider, HHSC, or TMHP.

The following information is provided on a separate line for all inpatient hospital claims processed according to prospective payment methodology:

- *Age.* Client's age according to TMHP records
- *Sex.* Client's sex according to TMHP records: M = Male, F = Female, U = Unknown
- *Pat-Stat.* Indicates the client's status at the time of discharge or the last DOS on the claim (refer to instructions for UB-04 CMS-1450 paper claim form, Block 17)
- *Proc.* ICD-10-PCS code indicates the primary surgical procedure used in determining the DRG

Important: *Only paper claims appear in this section of the R&S Report. Claims filed electronically without required information are rejected. Users are required to retrieve the response file to determine reasons for rejections.*

TMHP cannot process incomplete claims. Incomplete claims may be submitted as original claims only if the resubmission is received by TMHP within the original filing deadline.

Refer to: Subsection 6.1, "Claims Information" in this section for a description of different claim types.

6.11.4.2 Adjustments to Claims

Adjustments – Paid or Denied is centered at the top of each page in this section. Adjustments are sorted by claim type and then patient name and Medicaid number. Media types 011, 021, 031, 041, 051, 061, 071, and 081 appear in this section. An adjustment prints in the same format as a paid or denied claim.

The adjusted claim is listed first on the R&S Report. EOB 00123, "This is an adjustment to previous claim XXXXXXXXXXXXXXXXXXXXXXXX which appears on R&S Report dated XX/XX/XX" follows this claim. Immediately below is the claim as originally processed. An accounts receivable is created for the original claim total as noted by EOB 00601, "A receivable has been established in the amount of the original payment: $XXX,XXX,XXX.XX. Future payments will be reduced or withheld until such amount is paid in full." prints below the claim indicating the amount to be recouped. This amount appears under the heading, "Financial Transactions Accounts Receivable." EOB 06065, "Account Receivable is due to the adjusted claim listed. For details, refer to your R&S Report for the date listed within the original date field."

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Claims adjusted as a result of a rate change will be listed on the R&S Report with EOB 01154 "This adjustment is a result of a rate change."

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in this section for a list of the most commonly used modifiers.

6.11.4.3 Financial Transactions

All claim refunds, reissues, voids/stops, recoupments, backup withholdings, levies, and payouts appear in this section of the R&S Report. The Financial Transactions section does not use the R&S Report form headings. Additional subheadings are printed to identify the financial transactions. The following descriptions are types of financial items.

6.11.4.3.1 Accounts Receivable

This label identifies money subtracted from the provider's current payment owed to TMHP. Specific claim data are not given on the R&S Report unless the accounts receivable control number is provided which should be referenced when corresponding with TMHP. Accounts receivable appear on the R&S Report in the following format:

- *Control Number.* A number to reference when corresponding with TMHP.
- *Recoupment Rate.* The percentage of the provider's payment that is withheld each week unless the provider elects to have a specific amount withheld each week.
- *Maximum Periodic Recoupment Amount.* The amount to be withheld each week. This area is blank if the provider elects to have a percentage withheld each week.
- *Original Date.* The date the financial transaction was processed originally.
- *Original Amount.* The total amount owed TMHP.
- *Prior Date.* The date the last transaction on the accounts receivable occurred.
- *Medical Record Number.* A number assigned by the provider, if available. This area is blank for purged claims.
- *Prior Balance.* The amount owed from a previous R&S Report.
- *Applied Amount.* The amount subtracted from the current R&S Report.
- *Balance.* Indicates the total outstanding accounts receivable (AR) balance that remains due to TMHP.
- *FYE.* The fiscal year end (FYE) for cost reports.
- *EOB.* The EOB code that corresponds to the reason code for the accounts receivable.
- *Patient Name.* The name of the patient on the claim, if the accounts receivable are claim-specific.
- *Claim Number.* The ICN of the original claim, if the accounts receivable are claim-specific.
- *Backup Withholding Penalty Information.* A penalty assessed by the Internal Revenue Service (IRS) for noncompliance due to a B-Notice. Although the current payment amount is lowered by the amount of the backup withholding, the provider's 1099 earnings are not lowered.
- *Control Number.* TMHP control number to reference when corresponding with TMHP.
- *Original Date.* The date the backup withholding was set up originally.
- *Withheld Amount.* Amount withheld (31 percent) of the provider's checkwrite.

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6.11.4.3.2 IRS Levies

The payments withheld from a provider's checkwrite as a result of a notice from the IRS of a levy against the provider appear in the "IRS Levy Information" section of the R&S Report. Payments are withheld until the levy is satisfied or released. Although the current payment amount is lowered by the amount of the levy payment, the provider's 1099 earnings are not lowered. IRS levies are reported in the following format:

- *Control Number.* TMHP control number to reference when corresponding with TMHP.
- *Maximum Recoupment Rate.* The percentage of the provider's payment that is withheld each week, unless the provider elects to have a specific amount withheld each week.
- *Maximum Recoupment Amount.* The amount to be withheld periodically.
- *Original Date.* The date the levy was set up originally.
- *Original Amount.* The total amount owed to the IRS.
- *Prior Balance.* The amount owed from a previous R&S Report.
- *Prior Date.* The date the last transaction on the levy occurred.
- *Current Amount.* The amount subtracted from the current R&S Report and paid to the IRS.
- *Remaining Balance.* The amount still owed on the levy. (This amount becomes the "previous balance" on the next R&S Report.)

6.11.4.3.3 Refunds

Refunds are identified by EOB 00124, "Thank you for your refund; your 1099 liability has been credited." This statement is verification that dollars refunded to TMHP for incorrect payments have been received and posted. The provider's check number and the date of the check are printed on the R&S Report. Claim refunds appear on the R&S Report in the following format:

- Claim Specific:
  - *ICN.* The claim number of the claim to which the refund was applied this cycle.
  - *Patient Name.* The first name, middle initial, and last name of the patient on the applicable claim.
  - *Medicaid Number.* The patient's Medicaid or CSHCN Services Program number.
  - *Date of Service.* The format MMDDCCYY (month, day, and year) in "From" DOS.
  - *Total Billed.* The total amount billed for the claim being refunded.
  - *Amount Applied This Cycle.* The refund amount applied to the claim.
  - *EOB.* Corresponds to the reason code assigned.
- Nonclaim Specific:
  - *Control Number.* A control number to reference when corresponding with TMHP.
  - *FYE.* The fiscal year for which this refund is applicable.
  - *EOB.* Corresponds to the reason code assigned.

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6.11.4.3.4 Payouts

Payouts are dollars TMHP owes to the provider. TMHP processes two types of payouts: system payouts that increase the weekly check amount and manual payouts that result in a separate check being sent to the provider. Specific claim data are not given on the R&S Report for payouts. A control number is given, which should be referenced when corresponding with TMHP. System and manual payouts appear on the R&S Report in the following format:

- *Payout Control Number.* A control number to reference when corresponding with TMHP.
- *Payout Amount.* The amount of the payout.
- *FYE.* The fiscal year for which the payout is applicable.
- *EOB.* Corresponds to the reason code assigned.
- *Patient Name.* Name of the patient (if available).
- *PCN.* Medicaid number of the patient (if available).
- *DOS.* Date of service (if available).

6.11.4.3.5 Reissues

The provider's 1099 earnings are not affected by reissues. A messages states, "Your payment has been increased by the amount indicated below":

- *Check Number.* The number of the original check.
- *Check Amount.* The amount of the original check.
- *R&S Number.* The number of the original R&S Report.
- *R&S Date.* The date of the original R&S Report.

6.11.4.3.6 Voids and Stops

The provider's 1099 earnings are credited by the amount of the voided/stopped payment.

- *Check Number.* The number of the voided/stopped payment.
- *Check Amount.* The amount of the voided/stopped payment.
- *R&S Number.* The number of the voided/stopped payment.
- *R&S Date.* The date of the voided/stopped payment.

6.11.4.4 Claims Payment Summary

This section summarizes all payments, adjustments, and financial transactions listed on the R&S Report. The section has two categories: one for amounts "Affecting Payment This Cycle" and one for "Amount Affecting 1099 Earnings."

If the provider is receiving a check on this particular R&S Report, the following information is given: "Payment summary for check XXXXXXXXX in the amount of XXX,XXX,XXX.XX." If the payment is EFT: "Payment summary for direct deposit by EFT XXXXXXXXX in the amount of XXX,XXX,XXX.XX." The check number also is printed on the check that accompanies the R&S Report.

Headings for the Payment Summary for "Affecting Payment This Cycle" and "Amount Affecting 1099 Earnings"

- *Claims Paid.* Indicates the number of claims processed for the week and the year-to-date total.
- *System Payouts.* The total amount of system payouts made to the provider by TMHP.
- *Manual Payouts (Remitted by separate check or EFT).* The total amount of manual payouts made to the provider by TMHP.

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- *Amount Paid to IRS for Levies.* The amount remitted to IRS and withheld from the provider's payment due to an IRS levy.
- *Amount Paid to IRS for Backup Withholding.* The amount paid to the IRS for backup withholding.
- *Accounts Receivable Recoupments.* The total amount withheld from the provider's payment due to accounts receivable.
- *Miscellaneous Levies.* The amount withheld from the provider's payment and remitted to HHSC for a SHARS Admin Fee levy.
- *Amounts Stopped/Voided.* The total amount of the payment that was voided or stopped with no reissuance of payment.
- *System Reissues.* The amount of the reissued payment.
- *Claim Related Refunds.* The total amount of claim-related refunds applied during the weekly cycle.
- *Nonclaim Related Refunds.* The total amount of nonclaim-related refunds applied during the weekly cycle.
- *Approved to Pay/Deny Amount.* The total amount of claim payments that were approved to pay/deny within the week. (This column will not be used at this time.)
- *Pending Claims.* The total amount billed for claims in process as of the cutoff date for the report.

6.11.4.5 The Following Claims are Being Processed

In the "Following Claims are Being Processed" section, the R&S Report may list up to five EOPS codes per claim. The claims listed in this section are in process and *cannot be appealed for any reason* until they appear in either the "Claims Paid or Denied," or "Adjustments Paid and Denied" sections of the R&S Report. TMHP is listing the pending status of these claims for informational purposes only. *The pending messages should not be interpreted as a final claim disposition.* Weekly, all claims and appeals on claims TMHP has "in process" from the provider are listed on the R&S Report. The Following Claims are Being Processed claim prints in the same format as a paid or denied claim.

6.11.4.6 Explanation of Benefit Codes Messages

This section lists the descriptions of all EOBs that appeared on the R&S Report. EOBs appear in numerical order.

EDI ANSI X12 5010 835 files display the appropriate Claims Adjustment Reason Code (CARC), Claims Adjustment Group Code (CAGC), and Remittance Advice Remarks Code (RARC) explanation codes that are associated with EOB denials.

The 835 file includes the CARC, CAGC, and RARC explanation codes that are associated with the highest priority detail EOB to provide a clearer explanation for the denial.

6.11.4.7 Explanation of Pending Status Codes Appendix

This section lists the description of all EOPS codes that appeared on the R&S Report. EOPS appear in numerical order.

EOB and EOPS codes may appear on the same pending claim because some details may have already finalized while others may have questions and are pending.

6.11.5 R&S Report Examples

Examples of R&S Reports are available on the TMHP website at www.tmhp.com.

R&S Report Examples
Accounts Receivables R&S Report (For purposes of example, accounts receivables, void, and stop pay appear together.)

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R&S Report Examples
Adjustments R&S Report
Appendix R&S Report
Backup Withholding Penalty Information R&S Report
Banner Page R&S Report
Claims in Process R&S Report
IRS Levy R&S Report
Manual Payouts R&S Report
Paid or Denied Claims (Hospital) R&S Report
Paid or Denied Claims (Physician) R&S Report
Refunds for Managed Care R&S Report
Refunds for Medicaid R&S Report
Reissues R&S Report
Sub-Owner Recoupments R&S Report
Summary R&S Report
System Payouts R&S Report
Void and Stop Pay R&S Report

6.11.6 Provider Inquiries—Status of Claims

TMHP provides several effective mechanisms for researching the status of a claim. Weekly, TMHP provides the R&S Report reflecting all claims with a paid, denied, or pending status. Providers verify claim status using the provider's log of pending claims.

Electronic billers allow ten business days for a claim to appear on their R&S Reports. If the claim does not appear on an R&S Report as paid, pending, or denied, a transmission failure, file rejection, or claims rejection may exist. Providers check records for transmission reports correspondence from the TMHP EDI Help Desk.

The provider allows at least 30 days for a Medicaid paper claim to appear on an R&S Report after the claim has been submitted to TMHP. If a claim has not been received by TMHP and must be submitted a second time, the second claim must also meet the 95-day filing deadline.

The provider allows TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of coinsurance or deductible according to current payment guidelines. Claims that fail to cross over from Medicare may be filed to TMHP by submitting a paper MRAN received from Medicare or a Medicare intermediary, the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services or, for MAP clients, TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template with the completed claim form.

If the claim does not appear on an R&S Report as paid, pending, or denied, providers can use any of the following procedures to inquire about the status of the claim:

- The provider can use the claim status inquiry function of TexMedConnect on the TMHP website at www.tmhp.com.
- The provider can call AIS at 800-925-9126 to determine if the claim is pending, paid, denied, or if TMHP has no record of the claim.
- If any of the three options above indicates that TMHP has no record of the claim, the provider can call the TMHP Contact Center at 800-925-9126 and speak to a TMHP contact center representative.

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- If the TMHP Contact Center has no record of a claim that was submitted within the original filing deadline, the provider can submit a copy of the original claim to TMHP for processing. Electronic billers may refile the claim electronically. For claims submitted by a hospital for inpatient services, the filing deadline is 95 days from the discharge date or the last DOS on the claim. For all other types of providers, the filing deadline is 95 days from each DOS on the claim.
- If the 95-day filing deadline has passed and the claim is still within 120 days of the date of the rejection report or the R&S Report, the provider can submit a signed copy of the claim and all of the documentation that supports the original claim submission, including any electronic rejection reports, to:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not send original R&S Reports back with appeals. Providers must submit one copy of the R&S Report to TMHP per appeal.

Refer to: Subsection A.12.3, "Automated Inquiry System (AIS)" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

6.12 Filing Medicare Primary Claims

When a service is a benefit of both Medicare and Medicaid, the claim must be filed to Medicare first.

Providers should not file a claim with Medicaid until Medicare has dispositioned the claim unless the service is a Medicaid-only service.

All Medicare providers and suppliers who offer services and supplies to Qualified Medicaid Beneficiaries (QMB) or Medicaid Qualified Medicare Beneficiaries (MQMB) must not bill dual eligible clients for Medicare cost-sharing. This includes deductible, coinsurance, and copayments for any Medicaid covered items and services.

Medicaid claims for Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients can be filed to Medicaid for consideration of coinsurance and deductible payment as follows:

- Medicare primary claims filed to Medicare Administrative Contractors (MACs) may be transferred electronically to TMHP through a Benefit Coordination and Recovery Center (BCRC).
- Providers can submit crossover claims directly to TMHP using a paper claim form only for the specific circumstances indicated in the following section.
- MAP providers can submit crossover claims directly to TMHP using EDI.

Note: *These guidelines do not apply to services that are rendered to clients who are living in a nursing facility.*

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about reimbursement for QMBs and MQMBs.

Subsection 4.9, "Medicare and Medicaid Dual Eligibility" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for information about MQMBs and QMBs eligibility.

6.12.1 Electronic Crossover Claims

Medicare primary claims filed to MACs may be transferred electronically to TMHP through a BCRC for claims that are processed as assigned. Providers should contact their MAC for more information.

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This electronic crossover process allows providers to receive disposition from both carriers while only filing the claim once. Providers must allow 60 days from the date of Medicare's disposition for a claim to appear on the Medicaid R&S Report.

If all services on the claim are denied by Medicare, the claim is not automatically transferred to TMHP by the MAC through the BCRC. Providers must submit the denied crossover claims to TMHP on paper.

Claims that are submitted to Medicare must include the facility's NPI. Medicare crossover claims must comply with the Medicaid requirement to include a facility NPI. If a Medicare crossover claim includes a service for which Medicaid requires a facility NPI but the claim does not include the facility's NPI number, the claim will be denied by Texas Medicaid. TMHP accepts electronic Medicare Advantage Plan (MAP) crossover claims electronically using EDI.

Important: *TMHP accepts only electronic crossover claims that are automatically transferred to TMHP by the MAC through the BCRC, or through the provider as New Day electronic Medicare Advantage Plans (MAPs) Part C claims. All other New Day crossover claims and all appeals, including Medicare Advantage Plan Part Cs, must be submitted as paper claims. TMHP accepts only paper appeals.*

6.12.1.1 Type of Bills Values for Medicare Crossover Claims

Type of bills (TOB) values in the 12x series may be billed to Medicare for Medicare Inpatient Part B services as appropriate, but TOB values in the 12x series are not valid for Medicaid claims.

Reminder: *Texas Medicaid only allows interim billing and late changes to be submitted on inpatient claims*

6.12.1.2 Medicare Copayments

Claims for Medicare copayments can also be submitted to TMHP. TMHP processes and pays Medicare HMO and Medicare PPO copayments for dual-eligible clients according to Medicaid guidelines.

TMHP may reimburse the copayment in addition to a service the HMO or PPO has denied if the client is eligible for Texas Medicaid and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.

An office or emergency room (ER) visit (the ER physician is paid only when the ER is not staffed by the hospital) is reimbursed a maximum copayment of $10 per visit. The hospital ER visit is reimbursed at a maximum of $50 to the facility. TMHP pays up to four copayments per day, per client. ER visits are limited to one per day, per client, and are considered one of the four copayments allowed per day.

Refer to: Subsection 2.7.5.2, "Nephrology (Hemodialysis, Renal Dialysis) and Renal Dialysis Facility Providers" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about claims for nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers for Medicare crossover Claims.

Subsection 2.7.5, "Exceptions" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about exceptions for Medicare Part A, Part B, and Part C (noncontracted MAPs) reimbursement.

6.12.1.3 Requirement for Group Billing Providers – Professional Claims

The performing provider NPI must be included on the professional electronic claim if the billing provider is a group. Claims are processed using the performing provider NPI that is submitted on the Medicare claim.

Important: *The performing provider who is identified on the claim must be a member of the billing provider's group. If the performing provider is not a member of the billing provider group, the detail line item will be denied.*

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A claim is denied if the performing provider NPI is missing, invalid, or is not a member of the billing provider's group. Denied claims may be appealed on paper with the appropriate performing provider information.

6.12.2 Paper Crossovers Claims

TMHP accepts only paper crossover claims or appeals from providers and other entities.

Note: *Electronic crossover claims will only be accepted for Medicare Part C New Day claims.*

The following paper crossover claims may be submitted to TMHP:

- For QMB and MQMB clients, if a crossover claim is not transferred to TMHP electronically through the BCRC, the provider can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration.
- For MQMB clients, if a claim is denied by Medicare because the services are not a benefit of Medicare or because Medicare benefits have been exhausted, the provider can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration, and reimbursement consideration for the Medicaid-only services that were denied by Medicare. The Medicare EOB that contains the relevant claim denial must be submitted to TMHP with the completed claim from within 95 days from the Medicare disposition date and 365 days from the date of service. The denied services are processed as Medicaid-only services.

Claims that are submitted to Medicare must include the facility's NPI. Medicare crossover claims must comply with the Medicaid requirement to include a facility NPI. If a Medicare crossover claim includes a service for which Medicaid requires a facility NPI but the claim does not include the facility's NPI number, the claim will be denied by Texas Medicaid.

Important: *Claims that are denied by Medicare for administrative reasons must be appealed to Medicare before they are submitted to Texas Medicaid.*

The paper submission must include all of the following:

- The Medicare Remittance Advice (RA) or Remittance Notice (RN), using the CMS-approved software MREP, for professional services, or PC-Print or a paper MRAN from Medicare.
- The appropriate, completed paper CMS-1500 or UB-04 CMS-1450 paper claim form.

  Note: *Although it is not required, it is strongly recommended that providers send claim forms with their Medicare appeals in case one is needed for further processing.*
- The appropriate TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template for Medicare Advantage Plan only. The template must be submitted with the claims form and the MAP EOB.

Providers that receive Remittance Advice Notices from a Medicare intermediary may submit these in place of the MRAN to TMHP which must contain the following required information:

- Client name
- Medicare number
- NPI
- Dates of service
- Procedure code (Professional and Outpatient claims)
- Billed amount
- Medicare allowed amount or non-covered amount
- Deductible amount

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- Co-insurance amount
- Medicare paid amount
- Medicare ICN
- Quantity billed

6.12.2.1 Deductible or Coinsurance Amount Balancing

The Texas Medicaid claims processing system validates that the total Medicare deductible and coinsurance amounts on the claim header match the sum of the detail Medicare deductible and coinsurance amounts.

For paper crossover claims, providers must submit the same information to Texas Medicaid that was received from Medicare.

Texas Medicaid will reimburse Medicare crossover claims up to the Texas Medicaid allowed amount for Medicaid-covered services. System enhancements have been identified to ensure appropriate age restrictions are enforced applicable to the services rendered.

Example: *For a Medicare service provided to an adult client, if that service is only payable to Medicaid for clients who are 20 years of age and younger, the age restriction will be applied and the Medicaid allowed amount will be zero. Since the Medicare payment exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid will not make a payment for coinsurance liabilities.*

Because Medicare reimbursed more than Medicaid allowed, the client has no liability for any balance or Medicare coinsurance related to the rendered services.

6.12.2.2 TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template

The TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template must be submitted for paper MAP claims only. The template must be submitted with the claim form and the MAP EOB.

Note: *Providers must not submit the template for traditional Medicare crossover claims.*

The following guidelines apply for the submission of the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Templates:

- The Medicare ICN must be included on the form. Claims are denied if the Medicare ICN is omitted.
- For the TMHP Crossover Professional Claim Type 30 form, the performing provider NPI and taxonomy code must be submitted on each detail line item. A detail line item is denied if the performing provider NPI or taxonomy code is omitted, or if the performing provider is not a member of the group billing provider.
- For the TMHP Crossover Outpatient Facility Claim Type 31 form, the detail line items are required. Claims are denied if the details are omitted.
- The TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template must be submitted with a completed claim form and MAP EOB, must be legible, and must identify only one client per page. Providers must not submit handwritten MAP templates.

Claims that do not meet these standards are not processed and are returned to the provider.

By submitting the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Templates to TMHP, the provider attests that the information included in the template matches the EOB that was received from the MAP. If the information on the template does not exactly match the information on the RA or RN, the claim may be denied.

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Refer to: Subsection 6.20, "Forms" in this section for the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Templates and instructions.

Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

6.12.2.3 Crossover Paper Claims Filing Deadlines

The paper crossover claim with all required, EOBs, templates, and forms must be received by TMHP within 95 days of the Medicare date of disposition and 365 days from the date of service in order to be considered for processing.

6.12.3 Filing Medicare-Adjusted Claims

TMHP accepts crossover appeals only on paper.

Providers may submit Medicare-adjusted claims by submitting the adjusted Medicare RA/RNs (paper or electronic) and the appropriate TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template. The information on the Medicare RA/RN must exactly match the information submitted on the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template.

Refer to: Subsection 3.7.1, "Medicaid Relationship to Medicare" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on hospital Medicare claims filing requirements.

Important: *TMHP does not accept electronic crossover appeals.*

6.13 Medically Needy Claims Filing

TMHP must receive claims for unpaid bills not applied toward spend down within 95 days from the date eligibility was added to the TMHP client eligibility file (add date). These bills must be on the appropriate claim form (for example, CMS-1500 or UB-04 CMS-1450). Providers are allowed to submit completed CMS claim forms directly to the Medically Needy Clearinghouse (MNC) or to applicants for the Medically Needy Program (MNP) to be used to meet spend down. The completed CMS claim forms used to meet spend down are held for ten calendar days by the MNC, then forwarded to TMHP claims processing. Claims for services provided after the spend down is met must be received within 95 days from the date eligibility is added. Inpatient hospital facility claims must be received within 95 days from the date of discharge or last DOS on the claim. This applies when eligibility is not retroactive.

The client's payment responsibilities are as follows:

- If the entire bill was used to meet spend down, the client is responsible for payment of the entire bill.
- If a portion of one of the bills was used to meet the spend down, the client is responsible for paying the portion applied toward the spend down, unless it exceeds the Medicaid allowable amount.
- The claim must show the *total* billed amount for the services provided. Charges for ineligible days or spend down amounts should *not* be deducted or noncovered on the claim.
- A client's payment toward spend down is *not* reflected on the claim submitted to TMHP.
- A client is not required to pay the spend down amount before a claim is filed to Medicaid.
- Payments made by the client for services not used in the spend down but were incurred during an eligible period must be reimbursed to the client before the provider files a claim to TMHP.
- Services that require prior authorization and are provided before the client becomes eligible for Medicaid by meeting spend down are not reimbursable by Texas Medicaid.
- If a bill or a completed CMS claim form was not used to meet spend down and the dates of service are within the client's eligible period, submit the total bill to TMHP.

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When eligibility has been established, a type program (TP) 56 with spend down client can receive the same care and services available to all other Medicaid clients. If eligibility is established through TP 32 with spend down, the client's Medicaid eligibility is restricted to coverage for an emergency medical condition only. Emergency medical condition is defined under subsection 4.3.2.2, "Exceptions to Lock-in Status" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

6.14 Claims Filing for Consumer-Directed Services (CDS)

Clients who participate in the CDS option for both PCS and a waiver program, through HHSC are required to choose one Financial Management Services Agency (FMSA) to provide services through both programs. FMSAs are permitted to file only the financial management services (FMS) fee, also known as the monthly administrative fee, through one program. The FMSA should file the FMS claim through the program with the highest reimbursement rate. Currently, the waiver programs have a higher reimbursement rate for the FMS fee than the Texas Medicaid PCS benefit, so a FMSA should file claims for the monthly FMS fee through the waiver programs.

The U8 modifier, which is used when submitting claims for the monthly PCS administrative fee, must be prior authorized. The DSHS case managers have two options when sending a prior authorization request for PCS to TMHP:

- If a client is only using the CDS option for Texas Medicaid PCS, a case manager will submit a prior authorization request to TMHP that approves the U8 modifier and either the U7 or UB modifier. In this case, the provider authorization notification letter will include the U8 modifier and the U7 or UB modifier.
- If a client is using the CDS option for both Texas Medicaid PCS and a waiver program, a case manager will submit a prior authorization request to TMHP that approves either the U7 or UB modifier. The U8 modifier will not be prior authorized in this situation.

When a provider authorization notification letter is received by a FMSA, the provider should verify that the correct modifiers have been prior authorized for each PCS client. Providers who think that the approved modifiers are incorrect should contact the DSHS case manager and ask for the correct modifiers to be submitted to TMHP for prior authorization.

6.15 Claims Filing for Home Health Agency Services

Providers must use only type of bill (TOB) 321 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and will result in a claim denial. Home Health Services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic claims submissions.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in this section for instructions on how to complete paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in this section.

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding Healthcare Common Procedure Coding System (HCPCS) code or narrative description. The prior authorization number must appear on the CMS-1500 paper claim form in Block 23 and in Block 63 of

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the UB-04 CMS-1450 paper claim form. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

6.16 Claims for Medicaid Hospice Clients Not Related to the Terminal Illness

When the services are unrelated to the terminal illness, providers must submit a claim for Medicaid services to TMHP. The claim must include a statement and documentation from the hospice that the services billed are not related to the client's terminal illness.

If TMHP denies the claim, the following information must be submitted with the providers appeal.

- A copy of the R&S Report, with the client or claim number in question circled
- Clinical records, which may be obtained from the hospice provider
- Supporting documentation giving reasons the services billed are not related to the terminal illness

Refer to: Subsection 4.3.3, "Hospice Program" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information related to Medicaid hospice client benefits and eligibility.

6.16.1 Medical Services When Client is Discharged From Hospice

Submit claims to TMHP for Medicaid services with a statement that the services billed were provided after the client was discharged from the Hospice Program. The provider must obtain a copy of Form 3071, Medicaid Hospice Cancellation, from the Hospice Program to support the discharge.

If TMHP denies the claim, the provider may appeal the decision with the following information:

- A copy of the R&S Report, with the client or claim number in question circled
- Supporting documentation stating that the client was not in hospice at the time

6.16.2 Claims Address for Medicaid Hospice Clients Not Related to the Terminal Illness

Mail paper claims to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200105
Austin, TX 78720-0105

Appeal claims by writing to the following address:

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

6.16.3 Lab and X-Ray

Submit claims for services unrelated to the terminal illness to TMHP. Submit claims for services related to the terminal illness to the hospice provider.

6.17 Claims for Texas Medicaid and CSHCN Services Program Eligible Clients

The CSHCN Services Program is the payer of last resort when clients have other insurance, including Texas Medicaid and private carriers. The CSHCN Services Program does not supplement a client's Texas Medicaid benefits; however, services that are not a benefit of Texas Medicaid, such as hospice and medical foods, may be covered by the CSHCN Services Program.

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6.17.1 New Claim Submissions

New claims that are submitted for clients who are eligible for both Texas Medicaid and CSHCN Services Program benefits during the same eligibility period will be processed through the appropriate program and may result in a separate claim for each program. The Medicaid claim number and disposition will be listed under the "Claims – Paid or Denied" section of the Medicaid/Managed Care R&S Report. If the claim includes services that are not benefits of Texas Medicaid but are benefits of the CSHCN Services Program, a claim will be created with a unique claim number that will be listed under the "Claims – Paid or Denied" section of the CSHCN Services Program R&S Report.

Note: *If all of the services that are submitted on the claim are Texas Medicaid benefits, a CSHCN Services Program claim will not be created. Only a Texas Medicaid claim will be created, and the claim number will appear on the provider's Medicaid/Managed Care R&S Report.*

6.17.2 CSHCN Services Program Claims Reprocessing for Retroactive Texas Medicaid Eligibility

Claims that have already been paid by the CSHCN Services Program for clients who received retroactive Texas Medicaid eligibility for dates of service covered on the paid claims will be reprocessed to pay under the appropriate program. The reprocessed CSHCN Services Program claim number will appear under the "Adjustments – Paid or Denied" section of the CSHCN Services Program R&S Report. An accounts receivable will be created for services covered by Texas Medicaid that will be reflected on the "Financial Transactions" page under the "Accounts Receivable" section of the CSHCN Services Program R&S Report. The claim will be reprocessed to Texas Medicaid and given a new claim number. The new Texas Medicaid claim number and disposition will appear under the "Claims – Paid or Denied" section of the Medicaid/Managed Care R&S Report.

TMHP will contact providers when it reprocesses claims for services that require a Texas Medicaid prior authorization. Providers will be informed that a Texas Medicaid prior authorization must be submitted within a specified time frame for the claim to be considered for processing through Texas Medicaid.

6.18 Claims for State Supported Living Center Residents (SSLC)

Medicaid providers who render off-campus acute care services to Medicaid-eligible State Supported Living Center (SSLC) residents must submit claims directly to Medicaid. This is applicable only to residents of the SSLCs operated by HHSC.

Claims and prior authorization requests for acute care services rendered to these individuals must be submitted to Medicaid. These requests must be submitted according to guidelines for acute care services as indicated in this manual.

Refer to: "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information on prior authorizations.

6.19 Children's Health Insurance Program (CHIP) Perinatal Claims

Claims for services provided to CHIP Perinatal Program clients are submitted to and considered for reimbursement as follows:

- For women with income at or below 198 percent FPL:
  - Hospital facility charges are paid through Emergency Medicaid and processed by TMHP.
  - Professional service charges are paid through the CHIP Perinatal Program and processed through CHIP.

Note: *Delivery-related professional services claims denied by the CHIP Perinatal health plan will be considered for reimbursement through Emergency Medicaid and will require the CHIP Perinatal health plan denial notice. These claims should be submitted through the existing*

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Medicaid appeals process within 95 days from the date of the CHIP Perinatal Health plan denial notice. The provider must provide a copy of the complete explanation of benefits that includes the complete description of the reason for denial.

- For newborns with a family income at or below 198 percent FPL:
  - Hospital facility charges are paid through Medicaid and processed by TMHP.
  - Professional service charges are paid through Medicaid and processed by TMHP.

Inpatient services (limited to labor with delivery) for unborn children and women with income at or below 202 of FPL will be covered under CHIP Perinatal, and these claims will be paid by the CHIP Perinatal health plan.

6.19.1 CHIP Perinatal Newborn Transfer Hospital Claims

TMHP processes CHIP Perinatal newborn transfer hospital claims even if the claim from the initial hospital stay has not been received.

The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay. This change applies only to CHIP Perinatal newborns with a family income at or below 198 percent of the FPL.

Transfer claims must be filed with TMHP on an electronic institutional claim or the UB-04 CMS-1450 paper claim form using admission type 1, 2, 3, or 5 in block 14, source of admission code 4 or 6 in block 15, and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.

6.20 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
MRAN Form Crossover Claim Type 30 Form and Instructions
MRAN Form Crossover Claim Type 31 Form and Instructions
MRAN Form Crossover Claim Type 50 Form and Instructions
Sample Letter XUB Computer Billing Service Inc

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Section 7: Appeals

Texas Medicaid Provider Procedures Manual: Vol. 1

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TEXAS
Health and Human Services

SECTION 7: APPEALS

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7.1 Appeal Methods

An appeal is a request for reconsideration of a previously dispositioned claim.

Providers may use three methods to appeal Medicaid fee-for-service and carve-out service claims to Texas Medicaid & Healthcare Partnership (TMHP): electronic, Automated Inquiry System (AIS), or paper.

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

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

1) A first-level appeal is a provider's initial standard administrative or medical appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all required information to be considered.
2) A second-level appeal is a provider's final medical or standard administrative appeal to HHSC of a claim that meets all of the following requirements:
   - It has been denied or adjusted by TMHP.
   - It has been appealed as a first-level appeal to TMHP.
   - It has been denied again for the same reason(s) by TMHP.

This appeal is submitted by the provider to HHSC, which may subsequently require TMHP to gather information related to the original claim and the first-level appeal. HHSC is the sole adjudicator of this final appeal.

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

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

TMHP is not responsible for managing appeals resulting from utilization review (UR) decisions by the HHSC Office of Inspector General (OIG) UR Unit. These must be submitted to HHSC Medical and UR Appeals.

Note: *Appeals for managed care claims must be submitted to the managed care organization (MCO) or dental plan that administers the client's managed care benefits. The only managed care appeals administered by TMHP are those for carve-out services.*

Refer to: Subsection 7.3.3, "Utilization Review Appeals" in this section.

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care appeals.

7.1.1 Electronic Appeal Submission

Electronic appeal submission is a method of submitting appeals using a personal computer. The electronic appeals feature can be accessed by a business organization (e.g., billing agents) interfacing directly with the TMHP Electronic Data Interchange (EDI) Gateway or through TexMedConnect, the free web-based application available from TMHP.

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The Health Insurance Portability and Accountability Act (HIPAA) standard American National Standards Institute (ANSI) ASC X12 837 format is accepted by TMHP EDI.

For other information, contact the TMHP EDI Help Desk at 888-863-3638.

7.1.1.1 Advantages of Electronic Appeal Submission

Using electronic appeal submission provides the following advantages to the users:

- Increased accuracy of appeals filed to potentially improve cash flow.
- Maintained audit trails through print and download capabilities.
- Appeal submission windows can be automatically filled in with electronic R&S (ER&S) Report information, thereby reducing data entry time.

7.1.1.2 Disallowed Electronic Appeals

The following claims may not be appealed electronically:

- Claims that require supporting documentation (e.g., operative report, medical records, home health, hearing aid, and dental X-rays).
- Diagnosis-related group (DRG) assignment.
- Medicare crossovers.
- Claims listed as *pending* or *in process* with explanation of pending status (EOPS) messages.
- Claims denied as *past filing deadline* except when retroactive eligibility deadlines apply.
- Claims denied as *past the payment deadline*.
- Claims with quantity billed changes in the claims details.
- Claims that are the result of a mass adjustment.

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed electronically if the requested form has been faxed according to the instructions in the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.*

7.1.2 Resubmission of TMHP Electronic Data Interchange (EDI) Rejections

TMHP EDI transactions that fail HIPAA edits will be rejected, and the submitter will receive a 277CA claim response file. The 277CA claims response file lists activity by submitter, provider, and payer.

The 277CA claims response file includes member identifier, patient last name and first initial, patient control number (PCN), type of bill or place of service, charge, transaction from and to dates, receipt date, rejection code, and rejection description.

Providers must send the batch ID, PCN, date of service, transaction from and to dates, receipt date, and rejection codes from the 277CA claims response file to TMHP when appealing denied claims.

The batch ID is located in the file name of the returned 277CA claims response, and not within the file. Providers must include the batch ID in all electronic response files submitted to TMHP for appeals to denied claims. Handwritten batch IDs are not acceptable for submission to TMHP. Providers who cannot identify or retrieve the batch ID from the 277CA claims response file name should contact the clearinghouse or vendor to have the filename included in the response document. If not, the provider must request a copy of the response file that contains the filename from the clearinghouse.

Providers who receive a rejection on the 277CA claims response file may resubmit an electronic claim within 95 days of the date of service.

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A paper appeal may also be submitted with a copy of the response document within 120 days of the 277CA claims response file rejection to meet the filing deadline. A copy of the electronic response file rejection to include the batch ID must accompany each corrected claim that is submitted on paper.

7.1.3 Automated Inquiry System (AIS) Appeals

The following appeals may be submitted using AIS:

- *Client eligibility.* The client's correct Medicaid number, name, and date of birth are required.
- *Provider information (excluding Medicare crossovers).* The correct NPI is required for the billing provider, performing provider, referring provider, and limited provider. The name and address of the provider are required for the facility and outside laboratory.
- *Claim corrections.* Providers may correct the:
  - Patient control number (PCN).
  - Date of birth.
  - Date of onset.
  - X-ray date.
  - Place of service (POS).
  - Quantity billed.
  - Prior authorization number (PAN).
  - Beginning date of service (DOS), as long as the new date is within the filing deadline for the claim.
  - Ending date of service, as long as the new date is within the filing deadline for the claim.

The following appeals may not be appealed through AIS:

- Claims listed on the R&S Report as Incomplete Claims
- Claims listed on the R&S Report with $0 allowed and $0 paid
- Claims requiring supporting documentation (for example, operative report, medical records, home health, hearing aid, and dental X-rays)
- DRG assignment
- Procedure code, modifier, or diagnosis code
- Medicare crossovers
- Claims listed as *pending* or *in process* with EOPS messages
- Claims denied as *past filing deadline* except when retroactive eligibility deadlines apply
- Claims denied as *past the payment deadline*
- Inpatient hospital claims that require supporting documentation
- Third party liability (TPL)/other insurance

Providers may appeal these denials either electronically or on paper.

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Refer to: Subsection 7.1.1.2, "Disallowed Electronic Appeals" in this section to determine whether these appeals can be billed electronically. If these appeals cannot be billed electronically, a paper claim must be submitted.

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed if the requested form has been faxed according to the instructions in subsection 6.13, "Hysterectomy Services" in the Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks).*

7.1.4 Automated Inquiry System Automated Appeals Guide

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

7.1.5 Paper Appeals

Claim appeal requests that cannot be appealed electronically or by using AIS may be appealed on paper. Completed claim forms are not required to be submitted with paper appeals. Providers who submit paper appeals must clearly document on the attached R&S Report the information that is being appealed and identify the claim being appealed.

If a provider determines that a claim cannot be appealed electronically or through AIS, the claim may be appealed on paper by completing the following:

1) Submit a copy of the R&S Report page on which the claim is paid or denied. A copy of other official notification from TMHP may also be submitted.
2) Submit one copy of the R&S Report for each claim appealed.
3) Circle only one claim per R&S Report page.
4) Identify the reason for the appeal.
5) If applicable, indicate the incorrect information and provide the corrected information that should be used to appeal the claim.
6) Attach a copy of any supporting medical documentation that is required or has been requested by TMHP. Supporting documentation must be on a separate page and not copied on the opposite side of the R&S Report.

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

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

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

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

Exception: *Hospitals appealing HHSC OIG UR Unit final technical denials, admission denials, DRG revisions, continued-stay denials for Tax Equity and Fiscal Responsibility Act (of 1982) (TEFRA) Hospitals, or cost/day outliers must appeal to HHSC at the following address:*

Texas Health and Human Services Commission
Medical and UR Appeals, H-230
4601 W Guadalupe ST
Austin, TX 78751

All other provider fields on the claim forms (referring, facility, admitting, operating, and other) require only an NPI.

Providers that choose to appeal the claim with NPI information must continue submitting an NPI until the claim is finalized.

7.1.5.1 Texas Medicaid Fee-for-Service DRG Adjustment Appeal

Texas Medicaid fee-for-service hospital providers who are appealing a DRG adjustment (higher weight DRG) must provide the original and revised UB-04 CMS-1450 paper claim form, the complete medical record, and a statement defining the reason for the requested change. Hospitals have 120 days from the date of the R&S Report to request an addition of a diagnosis or procedure resulting in a DRG adjustment. Providers appealing a DRG that has not been revised by the OIG Utilization Review Unit should appeal to TMHP.

Refer to: Subsection 7.3.3, "Utilization Review Appeals" in this section.

7.1.5.2 Medical Necessity Denial Appeals

Appeals of denials relating to medical necessity decisions made for all medical services with the exception of HHSC Inpatient UR cases may be submitted for further review if providers find denials are inappropriate. All necessary documentation must accompany the request for review. Incomplete appeals and adjustment requests are denied by TMHP with an explanation of benefits (EOB) code requesting additional information.

TMHP reviews each appeal (DRG adjustment and medical necessity) and forwards written notice of final action in the form of a letter or an adjustment transaction on the R&S Report.

7.1.5.3 Other Insurance Appeals

To appeal a claim denial due to other insurance coverage, the provider must submit complete other insurance information including the disposition date. The disposition date indicates when the other insurance company processed the payment or denial. An appeal submitted without this information will be denied.

If submitting a paper appeal the provider must submit EOBs containing disposition dates. If the disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being appealed is on a subsequent page, the provider must also include the first page of the EOB that shows the disposition date.

7.1.6 Appeals Submitted Incorrectly

If an incomplete appeal is received, it is returned to the sender with further appeal instructions and a request for more information. Documentation (either by letter or facsimile) that does not clearly indicate the reason for submission is returned to the sender for clarification.

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If an appeal is received that may be more appropriately addressed in another department, the appeal is forwarded to the appropriate department for research and response.

If the TMHP Medical Director or designee identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.

7.2 Refunds to TMHP

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments when any of the following occur: overpayment, duplicate payment, payment to incorrect providers, and overlapping payments by Medicaid and a third party resource (TPR).

Providers have the option of refunding payments by issuing a check to TMHP or requesting a recoupment through the paper appeal process. The paper appeal process does not require a provider to issue a check because the refund amount is reduced on the R&S Report. To accurately process claim refunds, the TMHP Cash Reimbursement Unit requests that the refund check be accompanied by Texas Medicaid Refund Information Form, with the following information:

- Refunding provider's name and NPI.
- Client's name and Medicaid ID number.
- Date of service.
- A copy of the R&S Report showing the claim to which the refund is being applied.
- The specific reason for the refund.
- Name and address of the attorney or casualty insurance company (including the policy and claim number).
- TPR subscriber information.
- Amount of insurance payment.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for additional TPL information.

7.3 Appeals to HHSC Texas Medicaid Fee-for-Service

7.3.1 Administrative Claim Appeals

An administrative appeal is a request for review of (not a hearing on) claims that are denied by TMHP or claims processing entity for technical and nonmedical reasons. There are two types of administrative appeals:

- *Exception requests to the 95-day filing deadline or 120-day appeal deadline.* A provider's formal written request for review of (not a hearing on) a claim that is denied or adjusted by TMHP for failure to meet the 95-day filing deadline or 120-day appeal deadline. Exception requests to the 95-day filing deadline should meet one of the five exceptions in subsection 7.3.1.2, "Exceptions to the 95-Day Filing Deadline" in this section. Exceptions to the 120-day appeal deadline should meet one of the situations in subsection 7.3.1.3, "Exceptions to the 120-day Appeal Deadline" in this section.
- *Standard Administrative Appeal.* A provider's formal written request for review of (not a hearing on) a claim or prior-authorization that is denied by TMHP for technical or non-medical reasons.

An administrative claims appeal is a request for a review as defined in Title 1 TAC §354.2201(2).

An administrative appeal must be:

- Submitted in writing to HHSC Claims Administrator Operations Management by the provider delivering the service or claiming reimbursement for the service.

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- Received by HHSC Claims Administrator Operations Management after the appeals process with TMHP or the claims processing entity has been exhausted, and must contain evidence of appeal dispositions from TMHP or the claims processing entity:
  - All correspondence and documentation from the provider to TMHP or the claims processing entity including copies of supporting documentation submitted during the appeal process.
  - All correspondence from TMHP or the claims processing entity to the provider including TMHP's final decision letter or such from the claims processing entity.
- Complete and contain all of the information necessary for consideration and determination by HHSC Claims Administrator Operations Management to include the following:
  - A written explanation specifying the reason/request for appealing the claim.
  - Supporting documentation for the request.
  - All R&S Reports identifying the claims/services in question.
  - Identification of the incorrect information and the corrected information that is to be used to appeal the claim.
  - A copy of the original claim, if available. Claim copies are helpful when the appeal involves medical policy or procedure coding issues. Also provide a corrected signed claim.
  - A copy of supporting medical documentation that is necessary or requested by TMHP.
  - Provider's internal notes and logs or ticket numbers from the TMHP Contact Center when pertinent (cannot be used as proof of timely filing).
  - Memos from HHSC, TMHP, or claims processing entity indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the appeal.
  - Other documents, such as receipts (i.e., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, if relevant to the appeals. Receipts can be helpful when the issue is late filing.
- Received by HHSC Claims Administrator Operations Management within 120 days from the date of disposition by TMHP or the claims processing entity as evidenced by the weekly R&S Report.

Administrative appeals can be submitted electronically through the My Account page on the TMHP portal. Once an appeal has been submitted, providers can login to My Account to view the following information:

- The status of administrative appeals that were submitted electronically or on paper
- Communications from TMHP and Texas HHSC

Providers who have submitted their claims electronically must identify the batch submission ID with the date on the electronic claims report. This report must indicate the TMHP assigned batch ID. In addition, this report must include the individual claim that is being appealed. The claim information on the batch report, including date of service and billed amount, must match the information on the claim that is being appealed. This required information constitutes proof of timely filing.

Note: *Only reports accepted or rejected from TMHP or the claims processing entity to the vendor will be honored unless the provider is a direct submitter (TexMedConnect). Office notes indicating claims were submitted on time or personal screen prints of claim submissions are not considered proof of timely filing.*

HHSC Claims Administrator Operations Management only reviews appeals that are received within 18 months from the DOS. All claims must be paid within 24 months from the DOS as outlined in 1 TAC §354.1003.

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Providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Operations Management. The filing and appeal deadlines are described in 1 TAC §354.1003.

Additional information requested by HHSC Claims Administrator Operations Management must be returned to HHSC Claims Administrator Operations Management within 21 calendar days from the date of the letter from HHSC Claims Administrator Operations Management. If the information is not received within 21 calendar days, the case is closed.

A determination made by HHSC Claims Administrator Operations Management is the final decision for claim appeals. No additional consideration is available. Therefore, ensure that all documents pertinent to the appeal are submitted. New evidence is required for an additional appeal to HHSC Claims Administrator Operations Management.

Mail appeal requests to the following address:

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

Providers may request the status of an administrative appeal by sending an email to HHSC at MedicaidClaims@hhs.texas.gov. The email must include the NPI number, client name, Medicaid number, date of service, and, if available, the case review number.

7.3.1.1 Requirements for Exception Requests

HHSC Claims Administrator Operations Management makes the final decision on whether claims fall within one of the exceptions to the 95-day or 120-day filing deadlines.

Providers must submit the following documentation for all exception requests:

- Exception requests must be in writing and mailed directly to HHSC.
- Adequate back-up documentation must accompany the exception request. Failure to provide adequate documentation results in the case being closed. Providers are notified of the reason for denial.
- All claims that are to be considered for an exception must accompany the request. HHSC will consider only the claims that are attached to the request.
- Additional claims cannot be added to an exception request after the exception request has been completed by HHSC. Additional claims must be submitted as a separate request and must include all required documentation. Information from a previous request will not be linked by HHSC to process additional claims.
- All exception requests must include an affidavit or statement from the provider stating the details of the cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. This affidavit or statement must be made by the person with personal knowledge of the facts.
- Multiple requests submitted simultaneously must be sorted by NPI first, and then alphabetically by client name. The orderly submission of exception requests facilitates the review process. Exception requests are returned to the provider if not submitted in the required format.

HHSC may request additional information which must be received within 21 calendar days from the date of the letter from HHSC. If the information is not received within 21 calendar days, the case will remain closed.

HHSC notifies providers about the outcome of the case upon completion of an exception request review.

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7.3.1.2 Exceptions to the 95-Day Filing Deadline

HHSC Claims Administrator Operations Management is responsible for reviewing requests for exceptions to the 95-day filing deadline for Texas Medicaid fee-for-service. Only providers can submit exception requests. Requests from billing companies, vendors, or clearinghouses are not accepted unless accompanied by a signed authorization from the provider (with each appeal). Without provider authorization, these requests are returned without further action.

HHSC will only consider exceptions to the 95-day filing deadline for claims that are submitted within the 365-day federal filing deadline from the date of service as outlined in 1 TAC §354.1003.

Exceptions to the filing deadline are considered when one of the following situations exists:

- Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including, but not limited to, fire, flood, or earthquake; or damage or destruction of the provider's business office or records by circumstances that are clearly beyond the control of the provider, including, but not limited to, criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these persons are presumed to be within the control of the provider. The presumption can only be rebutted when the intentional acts of the employee or agent lead to termination of employment and filing of criminal charges against the employee or agent.

  Providers requesting an exception for catastrophic events must include independent evidence of insurable loss; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.

- Delay or error in the eligibility determination of a client, or delay due to erroneous written information from HHSC, its designee, or another state agency.

  Providers requesting an exception for the delay or error in the eligibility determination of a client or delay due to erroneous written information from HHSC, its designee, or another state agency must include the written document from HHSC or its designee that contains the erroneous information or explanation of the delayed information.

- Delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid providers.

  Providers requesting an exception for the delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid providers must include the written repair statement, invoice, computer or modem generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems.

  The documentation must include a detailed explanation made by the person making the repairs or installing the system, specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.

  If the provider is requesting an exception based upon an electronic claim or system implementation problem experienced by HHSC or its designee, the provider must submit a written statement outlining the details of the electronic claim or system implementation problems experienced by HHSC or its designee that caused the delay in the submission of claims by the provider, any steps taken to notify the state or its designee of the problem, and a verification that the delay was not caused by the neglect, indifference, or lack of diligence on the part of the provider or its employees or agents.

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- Submission of claims occurred within the 365-day federal filing deadline, but the claim was not filed within 95 days from the date of service because the service was determined to be a benefit of the Medicaid program, and an effective date for the new benefit was applied retroactively.

  Providers requesting an exception for claims that were submitted within the 365-day federal filing deadline, but were not filed within the 95-days of the date of service because the service was determined to be a benefit of Texas Medicaid and an effective date for the new benefit was applied retroactively, must include a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline for the benefit was met.

- Client eligibility is determined retroactively and the provider is not notified of retroactive coverage.

  Providers requesting an exception for client eligibility determined retroactively and the provider is not notified of retroactive coverage must include a written, detailed explanation of the facts and activities illustrating the provider's efforts in requesting eligibility information for the client. The explanation must contain dates, contact information, and any responses from the client.

7.3.1.3 Exceptions to the 120-day Appeal Deadline

HHSC must receive a written exception request within 120 days of TMHP's final action. HHSC shall consider exceptions to the 120-day appeal deadline for the following listed situations. This is a one-time exception request; therefore, all claims that are to be considered within the request for an exception must accompany the request. Claims submitted after HHSC's determination has been made for the exception will be denied consideration because they were not included in the original request.

- An exception request must be received by HHSC within 18 months from the date of service to be considered. This requirement will be waived for the exceptions listed in the following bullets (b) and (c), as well as the situation listed under "Exceptions to the 24-month deadline."
- The following exceptions to the 120-day appeal deadline are considered if the criteria in the previous bullet is met and there is evidence to support one of the following bullets:
  - (a) Errors made by a third party payor that were outside the control of the provider. The provider must submit a statement outlining the details of the cause for the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence of the provider, the provider's employee, or agent. This affidavit or statement should be made by the person with personal knowledge of the facts. In lieu of the above affidavit or statement from the provider, the provider may obtain an affidavit or statement from the third party payor including the same information, and provide this to HHSC as part of the request for appeal.
  - (b) Errors made by the reimbursement entity that were outside the control of the provider. The provider must submit a statement from the original payor outlining the details of the cause of the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence on the part of the provider, the provider's employee, or agent. In lieu of the above reimbursement entity's statement, the provider may submit a statement including the same information and provide this to HHSC as part of the request for appeal.
  - (c) Claims were adjudicated, but an error in the claim's processing was identified after the 120-day appeal deadline. The error is not the fault of the provider. An error occurred in the claims processing system that is identified after the 120-day appeal deadline has passed.

7.3.1.4 Exceptions to the 24-Month Payment Deadline

HHSC shall consider exceptions to the 24-month claims payment deadline for the following listed situations. The final decision about whether a claim falls within one of the following exceptions will be made by HHSC.

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- Refugee Eligible Status: The payable period for all Refugee Medicaid eligible recipient claims is the federal fiscal year in which each date of service occurs plus one additional Federal Fiscal year. The date of service for inpatient claims is the discharge date.
- Medicare/Medicaid Eligible Status: The payable period for Medicaid/Medicare eligible recipient claims filed electronically is 24 months from the date the file is received from Medicare by the claims administrator for Medicaid. The payable period for Medicaid/Medicare eligible recipient claims filed on paper is 24 months from the date listed on the Medicare Remittance Advice.
- Retroactive Supplemental Security Income Eligible: The payable period for Supplemental Security Income (SSI) Medicaid eligible recipients when the Medicaid eligibility is determined retroactively is 24 months from the date the Medicaid eligibility is added to the eligibility file. This date is referred to as the "add date."
- Other HHSC approved situations: To the extent permitted by state and federal laws, rules, and regulations, HHSC may, at its sole discretion, consider other situations as exceptions to the provider 24-month time limit if the provider shows good cause.

Mail exception requests to HHSC at the following address:

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

7.3.2 Medical Necessity Appeals

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

Medical necessity appeals related to UR decisions made by the HHSC OIG UR Unit must be appealed to HHSC not TMHP.

When filing appeals to HHSC, providers must submit copies of all supporting documentation, including information sent to TMHP.

Refer to: Subsection 7.1.5.1, "Texas Medicaid Fee-for-Service DRG Adjustment Appeal" in this section.

7.3.3 Utilization Review Appeals

Hospitals may appeal adverse UR decisions made by the HHSC OIG UR Unit to the HHSC Medical and UR Appeals Unit. The written appeal request, with complete medical record and approved Business Records Affidavit Form must be received by the Medical and UR Appeals Unit within 120 days of the date of the original HHSC OIG UR decision letter. If the appeal request with all required documentation is not received within 120 days, the appeal is not conducted, and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request and submitting all of the required documentation. The procedures and specific requirements for appealing these decisions can be found in the sections that follow.

Hospitals may appeal adverse HHSC OIG UR Unit determinations to the following address:

HHSC Medical and UR Appeals
Mail Code H-230
4601 W Guadalupe ST
Austin, TX 78751

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7.3.3.1 Admission Denials, Continued Stay Denials for TEFRA Hospitals, DRG Revisions, and Cost/Day Outlier Denials

If a hospital is dissatisfied with the original retrospective review conducted by the HHSC OIG UR Unit, it may submit a written request for an appeal to the HHSC Medical and Utilization Review Appeals Unit.

The request for an appeal must include a copy of the complete medical record, a letter explaining the reasons why the HHSC OIG UR decision is incorrect, a copy of the HHSC OIG UR decision letter, and an original, properly completed, and notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document.

Refer to: Business Records Affidavit Form.

Complete medical records must be provided to HHSC at no charge. A complete medical record must include, but is not limited to, a discharge summary, history and physical, emergency room record, operative report, pathology report, anesthesia record, consultation reports, physician progress notes, physician orders, laboratory reports, X-ray reports, special diagnostic reports, nurses' notes, and medication records.

Any additional information requested by the HHSC Medical and UR Appeals Unit must be returned to the HHSC Medical and UR Appeals Unit within 21 calendar days of the request. If the requested documentation is not received within this time frame, the case is closed without an opportunity for further review and the original HHSC OIG UR decision is considered the final decision.

If a hospital is notified that it failed to submit any required documentation with the initial appeal request, the required information must be returned to the HHSC Medical and UR Appeals Unit within 21 calendar days of the date of notification, or within 120 days of the date of the original HHSC OIG UR decision letter, whichever is sooner. If the required documentation is not received within the time frames, the case is closed without an opportunity for further review and the original HHSC OIG UR decision is considered the final decision. Extensions of time are not granted for filing the written appeal request and submitting all required documentation.

The HHSC Medical and UR Appeals Unit is responsible for conducting an independent review in response to a provider's appeal. The professional staff uses only the documentation submitted in the medical record to determine whether an inpatient admission was appropriate and whether the diagnoses and procedures were correct. The HHSC UR and Medical Appeals physician or designee performs a complete review for the medical necessity of inpatient admission, DRG validation, quality of care, continued stay medical necessity, and ancillary charges (TEFRA cases) using the medical record documentation submitted on appeal. After completion of the review, the physician or designee renders a final decision on the case. The final decision may include determinations regarding multiple aspects of the admission. The hospital is notified in writing of the final decision. Inpatient admission denials cannot be rebilled as outpatient claims except as noted in subsection 4.2.4, "Outpatient Observation Room Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

The HHSC Medical and Utilization Review Unit recognizes that hospital staff may use guidelines, such as the American Hospital Association's Coding Clinic, to assist them in identifying diagnoses or procedures for statistical and billing purposes. However, the HHSC Medical and Utilization Review Appeals Unit determines the appropriate diagnoses or procedures for reimbursement purposes using the documentation in the medical record (submitted on appeal) and the following guidelines:

- *Principal diagnosis assignment.* The diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The principal diagnosis must be treated or evaluated during the admission to the hospital.
- *Secondary diagnosis assignment.* Conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care or monitoring, or, in the case of a newborn (birth through 28 days of age),

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which the physician deems to have clinically significant implications for future health care needs. Normal newborn conditions or routine procedures should not be considered as complications or comorbidities for DRG assignment.

If the principal diagnosis, secondary diagnoses, or procedures are not substantiated in the medical record, not sequenced correctly, or have been omitted, the codes may be changed, added, or deleted by the HHSC Medical and UR Appeals physician or designee. When it is determined the diagnoses or procedures are substantiated and sequenced correctly, a final DRG assignment is made.

If the hospital is displeased with the appeals decision, the attending physician or medical director of the hospital may request an educational conference with the HHSC Medical and UR Appeals physician or designee. The educational conference is held by telephone between the physician or designee and the hospital medical director or attending physician. This is an opportunity for the physicians to discuss the deciding factors in the case and any hospital billing processes that may have affected the adjudication of the case. The educational conference will not alter the previous appeal decision.

7.3.3.2 Final Technical Denials

Hospitals may submit a request for a written appeal to HHSC Medical and UR Appeals only if the hospital has evidence that the HHSC OIG UR Unit issued a final technical denial in error, or did not provide proper notification of the preliminary technical denial. The request must include a letter explaining the reasons why the HHSC OIG UR decision is incorrect and a copy of the HHSC OIG UR decision letter.

The written appeal request must be received by HHSC Medical and UR Appeals within 120 days of the date of the original HHSC OIG UR decision letter. If the request is not received within the 120 days, the appeal is not conducted and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request.

If the appeal time frame is met, the HHSC Medical and UR Appeals Unit reviews all the documentation and renders a final decision on the case. If it is determined the technical denial was issued correctly by the HHSC OIG UR Unit, HHSC's decision is upheld. The hospital is notified in writing of the decision. This decision is the final decision.

If it is determined that the final technical denial decision should be overturned, the HHSC Medical and UR Appeals Unit will request a copy of the complete medical record and an original, properly completed, notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document. The HHSC Medical and UR Appeals physician or designee performs a complete review for the medical necessity of the admission, DRG validation, quality of care or continued stay, and ancillary charges (for TEFRA Hospitals) using only the medical record documentation. After completion of the review, the physician or designee renders a final decision on the case. The hospital is notified in writing of the final decision.

If the requested documentation is not received within the required 21-day time frame, the case is closed without further opportunity for review and the original HHSC OIG UR decision is considered final.

7.3.4 Provider Complaints

TMHP provides for due process for resolving all provider complaints. A *complaint* is defined as any dissatisfaction expressed by telephone or in writing by the provider, or on behalf of that provider, concerning Texas Medicaid. The definition of *complaint* does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction. The definition also does not include a provider's oral or written dissatisfaction with an adverse determination or appeals regarding claim payments and denials.

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Procedures governing the provider complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Most complaints are resolved within 30 calendar days. Complaints to TMHP may be submitted using the following methods:

- By using the Email Us button on the TMHP Contact web page
- By telephone at 800-925-9126
- In writing to:

TMHP
Complaints Resolution Department
PO Box 204270
Austin, TX 78720-4270

Questions regarding the complaint process or the status of a complaint should be directed to the TMHP Contact Center at 800-925-9126.

7.3.4.1 Provider Complaint Policy

TMHP takes seriously and acts on each provider complaint. Depending on the level and nature of the complaint, TMHP works with the provider to resolve the issue or directs the complaint to the appropriate department.

The Medical Affairs Division handles complaints that relate to utilization of services (including ER use), denial of continued stay, and all clinical and access issues. This includes provider's appeal of an adverse authorization decision.

If the complaint relates to a medical issue, the Medical Affairs Division staff may assist in resolving the complaint. The provider complaints process applies only to the resolution of disputes within the control of Texas Medicaid, such as administrative or medical issues. The provider complaint process does not apply to allegations of negligence against third parties, including other Texas Medicaid providers. These complaints are referred to HHSC for review and evaluation and are resolved by HHSC.

7.3.4.2 Provider Complaint Process

The TMHP Complaints Resolution Department handles all provider complaints. The processing of a provider's complaint is described as follows:

- Providers must submit their complaint by telephone or in writing (mail or fax).
- Providers will receive a written acknowledgement letter from TMHP within five business days of receipt of the complaint.
- Referrals to other departments, such as Provider Relations or Medical Affairs, are made when appropriate.
- If the complaint cannot be resolved within 30 calendar days, the provider is notified in writing of the status of the complaint.
- If the Email Us option on the TMHP contact page is used, providers can select to receive communication by text, email, or both.

Providers who believe they did not receive due process regarding their complaint from TMHP may file a complaint with HHSC. Providers are encouraged to utilize the appeals and grievance process with TMHP before filing a complaint with HHSC.

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7.3.4.3 Complaints to HHSC—Texas Medicaid Fee-for-Service

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

Refer to: Subsection 7.3, "Appeals to HHSC Texas Medicaid Fee-for-Service" in this section for information about submission of an appeal to HHSC.

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning Texas Medicaid. The term *complaint* does not include the following:

- A misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction.
- A provider's oral or written dissatisfaction with an adverse determination.

Under the complaint process, the HHSC Claims Administrator Operations Management works with TMHP and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program and contract issues, as applicable.

Complaints must be in writing and received by the HHSC Claims Administrator Operations Management within 60 calendar days from TMHP's written notification of the final appeal decision.

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

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

Complaint requests may be mailed to the following address:

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

7.4 Cost Report Settlement Appeal Process

A provider who is dissatisfied with the determination contained in the Notice of Program Reimbursement (NPR) from TMHP Medicaid Audit may request an appeal as follows:

- The request for appeal must be in writing.
- The request for appeal must be filed within 180 calendar days from the date of receipt of the NPR.

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- If the amount in controversy is at least $1,000, the request for the appeal must be filed with TMHP Medicaid Audit.
- If the NPR shows that the provider is indebted to Texas Medicaid, TMHP must take the necessary action to recover the overpayment, including a suspension of interim payments. This process will take place even if an appeal has been requested.

7.4.1 Appeals to TMHP Medicaid Audit

A provider's request to appeal his or her NPR must include the following:

- Identify specific individual items in TMHP Medicaid Audit's determination with which the provider disagrees.
- Give the reasons the provider believes these are incorrect.
- Identify the amount in controversy for each item and provide a calculation of that amount.

The appeal may include any materials the provider believes will support its position.

TMHP Medicaid Audit completes a desk review of the appeal within six months of the date of receipt of complete documentation supporting the appeal. TMHP does the following:

- Reviews the materials submitted by the provider.
- Informs the provider if it appears that the request for an appeal was not timely or the amount of controversy is not at least $1,000.
- Reviews the record that formed the basis for the determination of the total payment due to the provider.
- Attempts to resolve as many points in controversy as possible with the provider and inform him or her in writing the issues that have been resolved and those that the provider may appeal to HHSC.
- Ensures all available documentation in support of the provider or TMHP Medicaid Audit is part of the record.

To appeal to TMHP Medicaid Audit, send the written notice within 120 days of receipt of the NPR letter to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit Operations Director
PO Box 200345
Austin, TX 78720-0345

7.5 Forms

The following linked forms can be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Business Records Affidavit Form
Texas Medicaid Refund Information Form

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Section 8: Third Party Liability (TPL)

Texas Medicaid Provider Procedures Manual: Vol. 1

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TEXAS
Health and Human Services

SECTION 8: THIRD PARTY LIABILITY (TPL)

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8.1 Third Party Liability (TPL)

Texas Medicaid Third Party Liability program recovers payments from third parties that are responsible for paying towards a medical claim for services rendered to a Texas Medicaid client. A third party resource (TPR) is the entity, individual, or other source (other than Medicaid, Medicaid managed care organizations (MCOs), Medicaid managed care dental plans, the client, non-TPR sources, or Medicare) that is legally responsible for paying the medical claims of Texas Medicaid clients. The Third Party Liability program helps reduce Medicaid costs by shifting claims expenses to third party payers.

As a condition of eligibility, Medicaid clients assign their rights (and the rights of any other eligible individuals on whose behalf he or she has legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's TPR or other insurance. To the extent allowed by federal law, a health-care service provider must seek reimbursement from available third party insurance that the provider knows about or should know about before billing Texas Medicaid. Medicaid pays only after the third party has met its legal obligation to pay (i.e., Medicaid is the payer of last resort). All claims submitted for Texas Medicaid payment for clients with other insurance coverage must reference the information, regardless of whether a copy of the explanation of benefits (EOB) from the insurance company is submitted with the claim.

Refer to: Subsection 7.2, "Refunds to TMHP" in "Section 7: Appeals" (*Vol. 1, General Information*) for information regarding refunds to TMHP resulting from other insurance payments and conditions surrounding provider billing of third party insurers.

Eligible clients enrolled in private health maintenance organizations (HMOs) must not be charged the co-payment amount because the provider has accepted Medicaid assignment.

8.2 Verifying a Client's TPR

Providers can verify a client's TPR and other insurance information by:

- Using TexMedConnect.
- Accessing the Medicaid Client Portal for Providers.

To ensure receipt of TPR disposition of payment or denial, providers must obtain an assignment of insurance benefits from the client at the time of service. Providers are asked not to provide claim copies or statements to the client.

Providers that are aware that a client has other health insurance that is not indicated on TexMedConnect or the Medicaid Client Portal for Providers must notify TMHP of the details concerning the type of policy and scope of benefits.

Providers can notify TMHP by calling TPR at 1-800-846-7307, sending a fax to 1-512-514-4225, or mailing the Other Insurance Form to the following address:

Texas Medicaid & Healthcare Partnership
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-2948

Any indemnity insurance policy that pays cash to the insured for wages lost or for days of hospitalization rather than for specific medical services is considered a TPR if the policy is assignable to someone else. The Health and Human Services Commission (HHSC) has assignment to any Medicaid applicant's or client's right of recovery from a third party health insurer, to the extent of the cost of medical care services paid by Medicaid. Texas Medicaid requires a provider take all reasonable measures to use a client's TPR before billing Medicaid.

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Medicaid-eligible clients may not be held responsible for billed charges that are in excess of the TPR payment for services covered by Texas Medicaid. If the TPR pays less than the Medicaid-allowable amount for covered services, the provider should submit a claim to TMHP for any additional allowable amount.

8.3 TPR Sources

A provider who furnishes services and participates in Texas Medicaid may not refuse to furnish services to an eligible client because of a third party's potential liability for payment of the services.

TPR includes payments from any of the following sources:

- Other health insurance including assignable indemnity contract
- Health maintenance organization (HMO)
- Public health programs available to clients with Medicaid such as Medicare and Tricare
- Profit and nonprofit health plan
- Employment-related health insurance
- Self-insured plans
- Casualty coverage resulting from an accidental injury such as automobile or property insurance (including no-fault insurance); No-fault automobile insurance such as personal injury protection (PIP) and automobile medical insurance
- Liability insurance
- Life insurance policies, trust funds, cancer policies, or other supplemental policies
- Workers' Compensation
- Medical support from absent parents
- Court judgments or settlements from a liability insurer
- First party probate-estate recoveries
- Other federal programs unless excluded by statute
- Other liable third parties

Claims for family planning services (including Title XIX and the Department of State Health Services [DSHS] Family Planning Program) must be submitted to TMHP before billing a client's TPR. Federal regulations protect the client's confidential choice of birth control and family planning services. Confidentiality is jeopardized when seeking information from TPRs.

School Health and Related Services (SHARS) providers are not required to file claims with private insurance before billing Medicaid.

Early Childhood Intervention (ECI) providers are not required to file claims with private insurance before billing Medicaid for Targeted Case Management services and Specialized Skills Training (SST).

Case Management for Children and Pregnant Women providers are not required to file claims with other health insurance before filing with Medicaid.

THSteps medical and dental providers are not required to bill other insurance before billing Medicaid. If the provider is aware of other insurance, however, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client's other insurance before submitting the claim to Medicaid.

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- If the provider chooses to bill Medicaid and not the client's other insurance, the provider is indicating acceptance of the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.
- If the provider learns of other insurance coverage after Medicaid has paid, and the provider chooses to bill the other insurance, the provider must refund Medicaid before billing the other insurance.

8.3.1 Exceptions

Certain funding sources are an exception to TPR. Adoption agencies or foster parents are not considered a TPR. Medicaid is primary in the STAR Health program (except when court-ordered to provide health insurance). This is an exception to the rule that Medicaid is payer of last resort. Providers must not bill other health insurance unless there is a court order that places this responsibility elsewhere. For Texas Health Steps (THSteps), providers must refer to the MCO, or dental plan that administers the client's managed care benefits for additional information.

Refer to: Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

Non-TPR sources are secondary to Texas Medicaid and may only pay benefits after Texas Medicaid. The following are the most common non-TPR sources:

- Texas Workforce Solutions–Vocational Rehabilitation Services
- Texas Kidney Health Care Program
- Crime Victims' Compensation Program
- Muscular Dystrophy Association
- Children with Special Health Care Needs (CSHCN) Services Program
- Texas Band of Kickapoo Equity Health Program
- Maternal and Child Health
- DSHS Family Planning Program
- State Legalization Impact Assistance Grant (SLIAG)
- Adoption Agencies
- Home and Community-based Waivers Programs through HHSC
- Blind and Visually Impaired Services
- Healthy Texas Women

If providers have questions about others not listed, they may contact a provider relations representative.

Note: *Claims for clients who are seeking disability determination must be submitted to HHSC for consideration of reimbursement. Refer to the HHS website at www.hhs.texas.gov/ for additional information about disability determinations and claims filing.*

Denied claims or services that are not a benefit of Medicaid may be submitted to non-TPR sources.

If a claim is submitted inadvertently to a non-TPR source listed above before submission to TMHP, the claim may be submitted to TMHP within the filing deadlines.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

If a non-TPR source erroneously makes a payment for a dual-eligible client for services also covered by Medicaid, the payment is refunded to the non-TPR source.

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8.3.1.1 Adoption Cases

Texas Medicaid, not the adoption agency, should be billed for all medical services that are a benefit of Texas Medicaid. If a claim is inadvertently sent to the adoption agency before it is sent to TMHP, TMHP must receive the claim within 95 days of the date of disposition from the adoption agency denial, payment, requests for refund or recoupment, to be considered for payment.

If the adoption agency inadvertently makes a payment for services that are covered by Medicaid, the provider must refund the payment to the agency.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

A copy of the non-TPR disposition must be submitted with the claim and received at TMHP within 95 days of the date of the disposition (denial, payment, request for refund, or recoupment of payment by the non-TPR source).

8.4 Non-TPR Sources

A non-TPR is secondary to Texas Medicaid and may only pay benefits after Texas Medicaid. Non-TPR sources include, but are not limited to, accident-only policies, managed care plans, Indigent Health Care, and Medicaid/Children's Health Insurance Program (CHIP).

The provider bills TMHP directly within 95 days from the date of service. However, if a non-TPR is billed first, TMHP must receive the claim within 95 days of the claim disposition by the other entity.

Note: *The provider must submit a copy of the disposition with the claim.*

8.5 TPL for Hospitals

Inpatient and outpatient hospitals and providers enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers must fax the Other Insurance Form for Health Insurance or the Tort Response Form for accidents to 1-512-514-4225 or mail it to the following address:

Texas Medicaid & Healthcare Partnership
TPL Correspondence
Third Party Liability Unit
PO Box 202948
Austin, TX 78720-2948

8.6 TPL for Managed Care

Medicaid MCO and dental plan claims payments for services rendered to Texas Medicaid managed care clients are subject to the federal and state requirement for other insurance payments. As directed by HHSC, Texas Medicaid will recover payments based on claims data processed by the Medicaid MCO or dental plan.

TPR includes payments from any of the following sources:

- Other health insurance, including assignable indemnity contracts
- Commercial MCOs (other insurance available through a source other than Texas Medicaid or Medicare)

A provider who furnishes services and participates in Texas Medicaid may not refuse to furnish services to an eligible client because of a third party's potential liability for the payment of the services.

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8.7 Tort

HHSC contracts with TMHP to administer third party liability cases. To ensure that Texas Medicaid is the payer of last resort, TMHP performs postpayment investigations of potential casualty and liability cases. TMHP also identifies and recovers Medicaid expenditures in casualty cases involving Medicaid clients.

The Human Resources Code, chapter 32, section 32.033 establishes automatic assignment of a Medicaid client's right of recovery from personal insurance as a condition of Medicaid eligibility.

Investigations are a result of referrals from many sources, including attorneys, insurance companies, health-care providers, Medicaid clients, and state agencies. Referrals should be faxed to 1-512-514-4225 or mailed to:

TMHP TPL/Tort Department
PO Box 202948
Austin, TX, 78720-2948

Referrals must be submitted on the English or Spanish version of the Use and Release of Health Information Authorization on the TMHP website at www.tmhp.com.

TMHP releases Medicaid claims information when an HHSC Use and Release of Health Information Authorization form is submitted. The form must be signed by the Medicaid client. Referrals are processed within ten business days.

Refer to: Use and Release of Health Information Authorization form on the TMHP website at www.tmhp.com.

An attorney or other person who represents a Medicaid client in a third party claim or action for damages for personal injuries must send written notice of representation. The written notice must be submitted within 45 days of the date on which the attorney or representative undertakes representation of the Medicaid client, or from the date on which a potential third party is identified. The following information must be included:

- The Medicaid client's name, address, and identifying information.
- The name and address of any third party or third party health insurer against whom a third party claim is or may be asserted for injuries to the Medicaid client.
- The name and address of any health-care provider that has asserted a claim for payment for medical services provided to the Medicaid client for which a third party may be liable for payment, whether or not the claim was submitted to or paid by TMHP.

If any of the information described above is unknown at the time the initial notice is filed, it should be indicated on the notice and revised if and when the information becomes known.

An authorization to release information about the Medicaid client directly to the attorney or representative may be included as a part of the notice and must be signed by the Medicaid client. The HHSC Use and Release of Health Information Authorization form must be used.

HHSC must approve all trusts before any proceeds from a third party are placed into a trust.

Providers may direct third party liability questions to the TMHP TPL/Tort Contact Center at 1-800-846-7307 with the option for accident, injury, and informational claims.

8.7.1 Accident-Related Claims

TMHP monitors all accident claims to determine whether another resource may be liable for the medical expenses of clients with Medicaid coverage. Providers are requested to ask clients whether medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers enter the appropriate code and date in Block 10 of the CMS-1500 paper claim form, and Blocks 31-34 on the UB-04 CMS-1450 paper claim form.

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If payment is immediately available from a known third party such as Workers' Compensation or Personal Injury Protection (PIP) automobile insurance, that responsible party must be billed before Medicaid, and the insurance disposition information must be filed with the Medicaid claim. If the third party payment is substantially delayed because of contested liability or unresolved legal action, a claim may be submitted to TMHP for consideration of payment.

TMHP processes the liability-related claim and pursues reimbursement directly from the potentially liable party on a postpayment basis. Include the following information on these claims:

- Name and address of the liable third party
- Policy and claim number
- Description of the accident including location, date, time, and alleged cause
- Reason for delayed payment by the liable third party

8.7.1.1 Accident Resources, Refunds

Acting on behalf of HHSC, TMHP has specific rights of recovery from any settlement, court judgment, or other resources awarded to a client with Medicaid coverage (Texas Human Resources Code, Chapter 32.033). In most cases, TMHP works directly with the attorneys, courts, and insurance companies to seek reimbursement for Medicaid payments. If a provider receives a portion of a settlement for services also paid by Medicaid, the provider must make a refund to TMHP. Any provider filing a lien for the entire billed amount must contact the TPL/Tort Department at TMHP for Medicaid postpayment activities to be coordinated. A provider may not file a lien for the difference between the billed charges and the Medicaid payment. A lien may be filed for services not covered by Medicaid. A lien is the liability of the client with Medicaid coverage.

Providers should contact the TPL/Tort Department at TMHP after submitting an itemized statement and/or claim copies for any accident-related services billed to Medicaid if they received a request from an attorney, a casualty insurance company, or a client.

The provider must submit the following information to TMHP:

- Client's name
- Medicaid ID number
- Dates of service involved
- Name and address of the attorney or casualty insurance company (including the policy and claim number)

This information enables TMHP to pursue reimbursement from any settlement. Providers must use the Tort Response Form to report accident information to TMHP. When the form is completed, providers must remit it to the TMHP TPL/Tort Department (the address and fax number are on the form).

Providers may contact the TMHP TPL/Tort Department by calling 1-800-846-7307, Option 3, sending a fax to 1-512-514-4225, or mailing to the following address:

Texas Medicaid & Healthcare Partnership
TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

8.7.1.2 Workers' Compensation

Payment of covered services under Workers' Compensation is considered reimbursement in full. The client must not be billed. Services not covered by Workers' Compensation must be billed to TMHP.

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8.7.2 Providers Filing Liens for Third Party Reimbursement

Any provider filing a lien for the entire billed amount must contact the TMHP TPL/Tort Department for Medicaid postpayment activities to be coordinated.

A provider may file a lien for the entire billed amount only after meeting the criteria in Title 1 Texas Administrative Code (TAC) §354.2322. Providers who identify a third party, within 12 months of the date of service, and wish to submit a bill or other written demand for payment or collection of debt to a third party after a claim for payment has been submitted and paid by Medicaid must refund any amounts paid before submitting a bill or other written demand for payment or collection of debt to the third party for payment, and they must comply with the provisions set forth in 1 TAC §354.2322, which states:

Providers may retain a payment from a third party in excess of the amount Medicaid would otherwise have paid only if the following requirements are met:

- The provider submits an informational claim to TMHP within the claims filing deadline. (Refer to subsection 8.7.3, "Informational Claims" in this section.)
- The provider gives notice to the client or the attorney or representative of the client that the provider may not or will not submit a claim for payment to Medicaid and the provider may or will pursue a third party, if one is identified, for payment of the claim. The notice must contain a prominent disclosure that the provider is prohibited from billing the client or a representative of the client for any Medicaid-covered services, regardless of whether there is an eventual recovery or lack of recovery from the third party or Medicaid.
- The provider establishes the right to payment separate of any amounts claimed and established by the client.
- The provider obtains a settlement or award in its own name separate from a settlement obtained by or on behalf of the client or award obtained by or on behalf of the client, or there is an agreement between the client or attorney or representative of the client and the provider, that specifies the amount that will be paid to the provider after a settlement or award is obtained by the client.

8.7.3 Informational Claims

If providers determine that a third party may be liable for a Medicaid client's accident-related claim, they can submit an informational claim to the TMHP Tort Department to indicate that a third party is being pursued for payment. This allows providers to secure the 95-day claims filing deadline in the event that the payment is not received from the third party.

TMHP processes informational claims for all claims administered by TMHP, including fee-for-service claims and carve-out services. TMHP does not process informational claims for managed care claims that are administered by the client's MCO or dental plan.

8.7.4 Submission of Informational Claims

Providers must submit informational claims to TMHP:

- On a CMS-1450 UB-04 or CMS-1500 paper claim form. Informational claims cannot be submitted to TMHP electronically or by fax.
- On an Informational Claims Submission Form. Providers should complete only one form per client, regardless of how many separate informational claims are being submitted with the form.
- By certified mail.
- Within the 95-day claims filing deadline. Informational claims will not be accepted after the 95-day claims filing deadline.

Refer to: Informational Claims Submission Form on the TMHP website at www.tmhp.com.

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Providers must complete either the Insurance Information field (liable third party) or the Attorney Information field on the Informational Claims Submission Form.

Providers must send the informational claims and the Informational Claims Submission Form by certified mail to TMHP at:

TMHP TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

TMHP will send providers a letter to confirm that the informational claim was received. The letter will provide the date on which TMHP must receive a request from the provider to convert the informational claim to a claim for payment. If TMHP receives an informational claim that cannot be processed, TMHP will notify the provider of the reason.

Providers can inquire about the status of an informational claim by calling the TMHP TPL/Tort Department at 1-800-846-7307. If a provider has not received confirmation that TMHP has received the informational claim within 30 days, the provider should contact the TMHP TPL/Tort Department at 1-800-846-7307 to validate the status of the request.

8.7.5 Informational Claim Converting to Claims for Payment

If providers have submitted an informational claim to TMHP but have not received payment from the liable third party, they must make one of the following determinations and notify TMHP within 18 months of the date of service:

- Providers can continue to pursue a claim for payment against the third party and forego the right to convert an informational claim to a claim for payment by Texas Medicaid.
- Providers can submit a request to convert to the informational claim to a claim for payment consideration from Texas Medicaid.

Providers that decide to convert an informational claim to a claim for payment consideration must submit a request to TMHP. The request must be submitted:

- On provider letterhead.
- With the client's name and Medicaid ID, the date of service, and total billed amount that was originally submitted on the UB-04 CMS-1450 or CMS-1500 paper claim form.
- By fax 1-512-514-4225 or by mail to:

TMHP/Tort Department
P0 Box 202948
Austin, TX 78720-2948

TMHP will not accept any conversion request that is submitted more than 18 months after the date of service, regardless of whether an informational claim was submitted timely to TMHP. All payment deadlines are enforced regardless of whether the provider decides to pursue a third party claim. The conversion of informational claims to actual claims is not a guarantee of payment by TMHP.

8.8 Other Insurance Claims Filing

The following information must be provided in the "Other Insurance" field on the paper claim and in the appropriate field of electronic claims. On the CMS-1500 paper claim form, Blocks 9 or 11, and 29 must contain the appropriate information:

- Name of the other insurance resource
- Address of the other insurance resource
- Policy number and group number

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- Policyholder
- Effective date if available
- Date of disposition by other insurance resource (used to calculate filing deadline)
- Payment or specific denial information

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and Texas Medicaid when appropriate as payment in full. The client cannot be held liable for any balance or copays related to Medicaid-covered services.*

8.8.1 Unbundled Services That Are Prior Authorized and Manually Priced Procedure Codes

Providers that submit prior authorization requests and claims to TMHP must:

- Unbundle any bundled procedure codes that have been submitted to the client's other insurance company.
- Itemize the rates.

If prior authorization has been obtained for services that use manually priced procedure codes, providers must submit claims for the services using the manufacturer's suggested retail price (MSRP) that was submitted with the authorization request and the following information that is listed on the authorization letter:

- The authorization number
- The NPI
- The procedure codes
- The dates of service
- The types of service
- The required modifiers

If the authorization letter shows itemized details, the claim must include all rendered services as they are itemized on the authorization letter and the MSRP rate for each of those services. The procedure codes and MSRP rates that are detailed on the claim must match the procedure codes that are detailed in the authorization letter and the MSRP rates that were submitted with the authorization request. Claims processing and payment may be delayed if there is not an exact match between the detailed information on the authorization letter, the approved authorization, and the information that was submitted on the claim.

Important: *For appropriate processing and payment, the Pay Price that is indicated on the authorization letter should not be submitted on the claim.*

Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

8.8.2 Other Insurance Credits

Providing other insurance payment information, even when no additional payment is expected from TMHP, provides benefit to all parties involved in Texas Medicaid. When a TPR issues a payment or partial payment to a provider, the other insurance credit must be indicated on the claim form submitted to TMHP.

This procedure benefits both providers and TMHP even if the TPR payment exceeds the Medicaid allowed amount. Although additional payment may not be issued by TMHP, informing TMHP of the other insurance credit allows TMHP to track the appropriate use of TPRs. Informing TMHP of a TPR

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credit provides hospitals with a more accurate standard dollar amount (SDA) rate setting and assists the program in tracking recoveries and reducing Medicaid medical expenditures by informing TMHP of liable third parties.

Providers must report TPR payments correctly in the appropriate electronic field or the paper claim form block as follows:

Claim Form	Reference
CMS-1500	Block 29, CMS-1500 Blank Claim Form
UB-04 CMS-1450	Block 54, UB-04 CMS-1450 Blank Claim Form
THSteps Dental	Block 31, ADA Dental Claim Form

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for claim filing instructions.

8.8.2.1 Deductibles

TMHP will consider deductibles for reimbursement when the original third party payor applied the payment amount directly to the client's deductible. The explanation of benefit reflecting the application of the payment by the other insurance (third party payor) and a completed signed claim copy must be submitted to TMHP for consideration.

8.8.2.2 HMO Copayments

TMHP processes and pays HMO copayments for private and Medicare HMOs as well as private and Medicare preferred provider organization (PPO) copayments for clients who are eligible for reimbursement under Medicaid guidelines.

TMHP pays the copayment in addition to the service the HMO or PPO has denied, if the client is eligible for Texas Medicaid and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.

An office or emergency room (ER) visit (the ER physician is paid only when the ER is not staffed by the hospital) is reimbursed a maximum copayment of $10 per visit. The hospital ER visit is reimbursed at a maximum of $50 to the facility. TMHP pays up to four copayments per day, per client. ER visits are limited to one per day, per client, and are considered one of the four copayments allowed per day.

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and Texas Medicaid when appropriate as payment in full. The client cannot be held liable for any balance related to Medicaid-covered services.*

The following Medicaid codes have been created for copayments, which are considered an atypical service:

POS 1 - Office	Description
CP001	Private HMO copayment-professional
CP002	Private PPO copayment-professional

POS 5 - Outpatient	Description
CP005	Private HMO copayment-outpatient
CP006	Private PPO copayment-outpatient

Important: *Providers must submit a new claim when filing for procedure codes CP001 and CP002. No explanation of benefits (EOB) or any other accompanying documentation is required to be attached to the claim form when filing for these services.*

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8.8.2.3 PPO Discounts

PPO discounts are not considered a part of other insurance payments. Electronic submitters must supply the PPO discount amount when submitting other insurance information; however, this information is not included in the total other insurance payment during claims processing. Paper submitters are not required to add the PPO discount to the other insurance payment.

8.8.2.4 Verbal Denial

Providers may call the other insurance resource and receive a verbal denial. The other insurance record can either be updated when the provider files the claim or calls the TPL/Tort Customer Service line at 1-800-846-7307. When calling the TPL/Tort Customer Service line and when filing claims to TMHP, the provider must have the following information before any updates are made.

Verbal denial requirements:

- Date of the telephone call to the other insurance resource
- Insurance company's name and telephone number
- Name of the individual contacted at the insurance company
- Policyholder and group information for the client
- Specific reason for the denial, including the client's type of coverage to enhance the accuracy of future claims processing (for example, a policy that covers inpatient services or physician services only)

Providers that update a client's insurance records through the TMHP TPL/Tort Customer Service line must follow the current appeal process once the other insurance information has been updated on the client's file.

8.8.2.5 110-Day Rule

When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. If a TPR has not responded or delays payment or denial of a provider's claim for more than 110 days after the date the claim was billed, Medicaid considers the claim for reimbursement. However, the 365-day federal filing deadline requirement must still be met. The following information is required:

- Name and address of the TPR
- Date the TPR was billed
- Statement signed and dated by the provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

When TMHP denies a claim because of the client's other coverage, information that identifies the other insurance appears on the provider's Remittance and Status (R&S) Report. The claim is not to be refiled with TMHP until disposition from the TPR has been received or until 110 days have lapsed since the billing of the claim with no disposition from the TPR. A statement from the client or family member which indicates that they no longer have this resource is not sufficient documentation to reprocess the claim.

When a provider is advised by a TPR that benefits have been paid to the client, the information must be included on the claim with the date and amount of payment made to the client if available. If a denial was sent to the client, refer to the verbal denial guidelines above for required information. This enables TMHP to consider the claim for reimbursement.

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8.8.2.6 Filing Deadlines

In accordance with federal regulations, all claims must initially be filed with TMHP within 365 days of the date of service (DOS). Claims that involve filing to a TPR have the following deadlines:

- Claims with a valid disposition (payment or denial) must be received by TMHP within 95 days of the date of disposition by the TPR and within 365 days of the DOS. Appealed claims that were originally denied with EOB 00260, which indicates that the provider files with a TPR, must be received within 95 days of the date of disposition by the TPR or within 120 days of the date on which TMHP denied the claim.
- The provider must appeal the claim to TMHP with complete other insurance information, which includes all EOBs and disposition dates. The disposition date is the date on which the other insurance company processed the payment or denial.
- If a provider submits other insurance EOBs without disposition dates, the appeal will be denied. If the other insurance disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being submitted to TMHP is on a subsequent page or pages, the provider must submit the first page that shows the disposition date and all of the pages that show the claim that is being submitted to TMHP.
- If more than 110 days have passed from the date a claim was filed to the TPR without a response, the claim is submitted to TMHP for consideration of payment.

Refer to: Subsection 6.12.2.3, "Crossover Paper Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about filing deadlines for clients with other insurance.

8.9 Other Insurance Appeals

To appeal a claim denial due to other insurance coverage, the provider must submit complete other insurance information including the disposition date. The disposition date indicates when the other insurance company processed the payment or denial. An appeal submitted without this information will be denied.

If submitting a paper appeal the provider must submit EOBs containing disposition dates. If the disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being appealed is on a subsequent page, the provider must also include the first page of the EOB that shows the disposition date.

Note: *Claims denied for TPL/other insurance cannot be appealed through the TMHP Automated Inquiry System (AIS).*

8.10 Refunds Resulting from Other Insurance Payments

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments when overlapping payments by Medicaid and a TPR occur.

Providers can use the Texas Medicaid Refund Information Form to:

- Refund the overpayment by issuing a check to TMHP. Providers must submit the refund check to TMHP along with the Texas Medicaid Refund Information Form and all required information requested on the form.
- Request that the claim be reprocessed and the money recouped. The overpayment will be reduced from next weekly payment made after claims are processed.

Refer to: The Texas Medicaid Refund Information Form, which is available in the Forms section of the TMHP website at www.tmhp.com.

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If the amount paid by the other insurance carrier is less than Medicaid's allowed amount, providers may bill TMHP for the difference. All claims must meet all timely filing deadlines.

Providers are prohibited from receiving payment from Medicaid and billing a TPR without refunding the Medicaid payment.

If within 12 months of the date of service a provider identifies that the client has other insurance and wants to submit a claim for payment to the other insurance company, the provider must refund any amounts previously paid by TMHP before submitting the claim to the other insurance.

If other insurance paid for the services submitted on the claim, the provider must submit the following to TMHP:

- The exact amount paid.
- The insurance company's name and address.
- The client's policy number and group number.

Providers are limited to the Medicaid allowed amount for the services. Providers are required to accept the TMHP paid amount as payment in full. If the provider fails to refund a payment to TMHP before submitting a claim to the other insurance, TMHP will recoup the entire other insurance payment.

In accordance with 1 TAC §§354.2321 [g] and 354.2322 [i], providers that do not follow TPR rules "may be referred for investigation and prosecution for violations of state or federal Medicaid or false claims laws." Providers should refer to the full text of these rules for a full description of payment requirements.

8.11 Contact Information

TPL/Tort Telephone and Fax Communication

Contact	General Inquiry Telephone number	Fax Number
Third Party Resources (TPR)	1-800-846-7307	1-512-514-4225
Tort	1-800-846-7307	1-512-514-4225

Written Communication with TMHP

Contact	Address
TPL/Tort	Texas Medicaid & Healthcare Partnership Third Party Liability/Tort PO Box 202948 Austin, TX 78720-2948
HHSC - Third Party Liability (TPL)	Health and Human Services Commission Attn: Third Party Liability 4900 N. Lamar Blvd. Mail Code: 1354 Austin, TX 78751

8.12 Forms

Forms
Your Texas Benefits Medicaid card (English and Spanish)
Informational Claims Submission Form
Other Insurance Form
Use and Release of Health Information Authorization form

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Forms
Use and Release of Health Information Authorization form (Spanish)
Tort Response Form
Texas Medicaid Refund Information Form

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Appendix A: State, Federal, and TMHP Contact Information

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TEXAS
Health and Human Services

APPENDIX A: STATE, FEDERAL, AND TMHP CONTACT INFORMATION

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A.1 Texas Health and Human Services Commission (HHSC) and Texas Department of State Health Services (DSHS) Office Addresses

Use the following address for general inquiries or for any group that is not listed in the following table:

Texas Health and Human Services Commission
PO Box 13247
Austin, TX 78711-3247

Note: *Remember to use the four-digit addition to the ZIP Code.*

Use the following address for the HHSC Inspector General:

Texas Health and Human Services Commission
Office of Inspector General
PO Box 85200
Austin, TX 78708-5200

Note: *Remember to use the four-digit addition to the ZIP Code.*

For the following groups, use the corresponding address and include the group name on the second line of the address.

Address	Group Name
HHSC Medicaid CHIP–H-200 PO Box 85200 Austin, TX 78708	
HHSC Quality Review/Limited Program—1323 PO Box 85200 Austin, TX 78708	
HHSC Third Party Liability (TPL) PO Box 85200 Mail Code 1354 Austin, TX 78708-5200	
HHSC Medical & UR Appeals Mail Code H-230 4601 W Guadalupe ST Austin, TX 78751	
HHSC Vendor Drug Program (MC-2250) 701 W. 51st St. Austin, TX 78751	
HHSC Family Planning PO Box 149347 Mail Code 0224 Austin, TX 78714-9347	
DSHS PO Box 149347 Austin, TX 78714-9347	Children with Special Health Care Needs (CSHCN) Services Program (Mail Code 1938) Genetic Services (1918) Indigent Health Care (Mail Code 2831) Texas Health Steps (THSteps) (Mail Code 1938) Case Management for Children and Pregnant Women (Mail Code 1938)

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A.2 HHSC Access and Eligibility Services (AES)

Region	Regional Director			Administrative Assistant
01 Lubbock	Beth Miller	Office:	1-806-783-6637	
	6302 Iola Avenue	FAX:	1-806-783-6630	1-806-783-6632
	Lubbock, TX 79424	Mail Code: 217-1		
	Amarillo: 1-806-356-3151	Toll Free:	211 1-877-541-7905	
02/09 Abilene	Sandra McKinney	Office:	1-325-795-5526	
	4601 South First Street	FAX:	1-325-795-5523	1-325-795-5522
	Abilene, TX 79604	Mail Code: 001-1		
	PO Box 521 Abilene, TX 79604	Toll Free:	211 1-877-541-7905	
03 Grand Prairie	Tracy Hays	Office:	1-972-337-6171	
	801 South State Hwy 161	FAX:	1-972-337-6298	1-972-337-6166
	Grand Prairie, TX 75051	Mail Code: 012-5		
	PO Box 532089 Grand Prairie, TX 75053-2089	Toll Free:	211 1-877-541-7905	
04 Tyler	Fay Booker	Office:	1-903-509-5142	
	302 East Rieck Road	FAX:	1-903-509-5133	1-903-509-5125
	Tyler, TX 75703	Mail Code: 313-5		
		Toll Free:	211 1-877-541-7905	
05 Beaumont	Stephanie Semien	Office:	1-409-951-3425	
	350 Pine Street, 9th Floor	FAX:	1-409-951-3449	1-409-730-4027
	Beaumont, TX 77701	Mail Code: 028-1		
		Toll Free:	211 1-877-541-7905	
06 Houston	Gracie Perez	Office:	1-713-767-2417	
	5425 Polk Street, Suite 230	FAX:	1-713-767-2323	1-713-767-3177
	Houston, TX 77023	Mail Code: 178-7		
	PO Box 16017 Houston, TX 77222-6017	Toll Free:	211 1-877-541-7905	
07 Austin	Sandra Dillett	Office:	1-512-832-7617	
	4616-1 West Howard Lane, Suite 120	FAX:	1-512-832-7665	1-512-832-7692
	Austin, TX 78728	Mail Code: 016-1		
		Toll Free:	211 1-877-541-7905	
08 San Antonio	Teriann Lyons	Office:	1-210-619-8226	
	11307 Roszell	FAX:	1-210-619-8293	1-210-619-8019
	San Antonio, TX 78217	Mail Code: 279-4		
	PO Box 23990 San Antonio, TX 78223	Toll Free:	211 1-877-541-7905	

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Region	Regional Director			Administrative Assistant
10 El Paso	Kate Hill	Office:	1-915-834-7580	
	401 East Franklin	FAX:	1-915-834-7582	1-915-834-7581
	El Paso, TX 79901	Mail Code: 111-1		
	PO Box 981017 El Paso, TX 79998-1017	Toll Free:	211 1-877-541-7905	
11 Edinburg	Cynthia Pena	Office:	1-956-316-8272	
	2520 South Veterans Road	FAX:	1-956-316-8175	1-956-316-8277
	Edinburg, TX 78539	Mail Code: 108-1		
	PO Box 960 Edinburg, TX 78540-0960	Toll Free:	211 1-877-541-7905	1-956-316-8361
ART & Customer Care Center	Debra Gault	Office:	1-713-696-2380	
	1457 E 40th St	FAX:	1-956-316-8175	1-979-282-6519
	Houston, TX 77022	Mail Code: 945-1		
MEPD	Rachel Patton	Office:	1-512-908-9431	
	1601 Rutherford Lane	FAX:		1-903-927-0280
	Austin, TX 78754	Mail Code: 227-1		

For additional office information, visit the HHSC website at hhs.texas.gov.

Refer to: Subsection A.5, "DSHS Health Service Regions Map" in this section to identify the regional boundaries.

A.2.1 Telephone Communication with HHSC and DSHS

Contact	Telephone Number
Assessment Utilization Services (limited program) (Option 4)	1-800-436-6184
HHSC Hearing Services for Children (HSC) (hearing aid, evaluations)	1-800-925-9126
DSHS Emergency Medical Services Division	1-512-834-6700
DSHS ImmTrac2 Help Desk	1-800-348-9158
DSHS Immunization Branch	1-800-252-9152
Medical Transportation Program (MTP) Hotline	1-877-633-8747
THSteps/EPSDT Hotline	1-877-847-8377
Vendor Drug Program Pharmacy and Technical Call Center (fee-for-service)	1-800-435-4165

A.3 Client Telephone Communication with HHSC

Clients can call the client toll-free number at 1-800-252-8263.

A.4 Federal and State Telephone Numbers

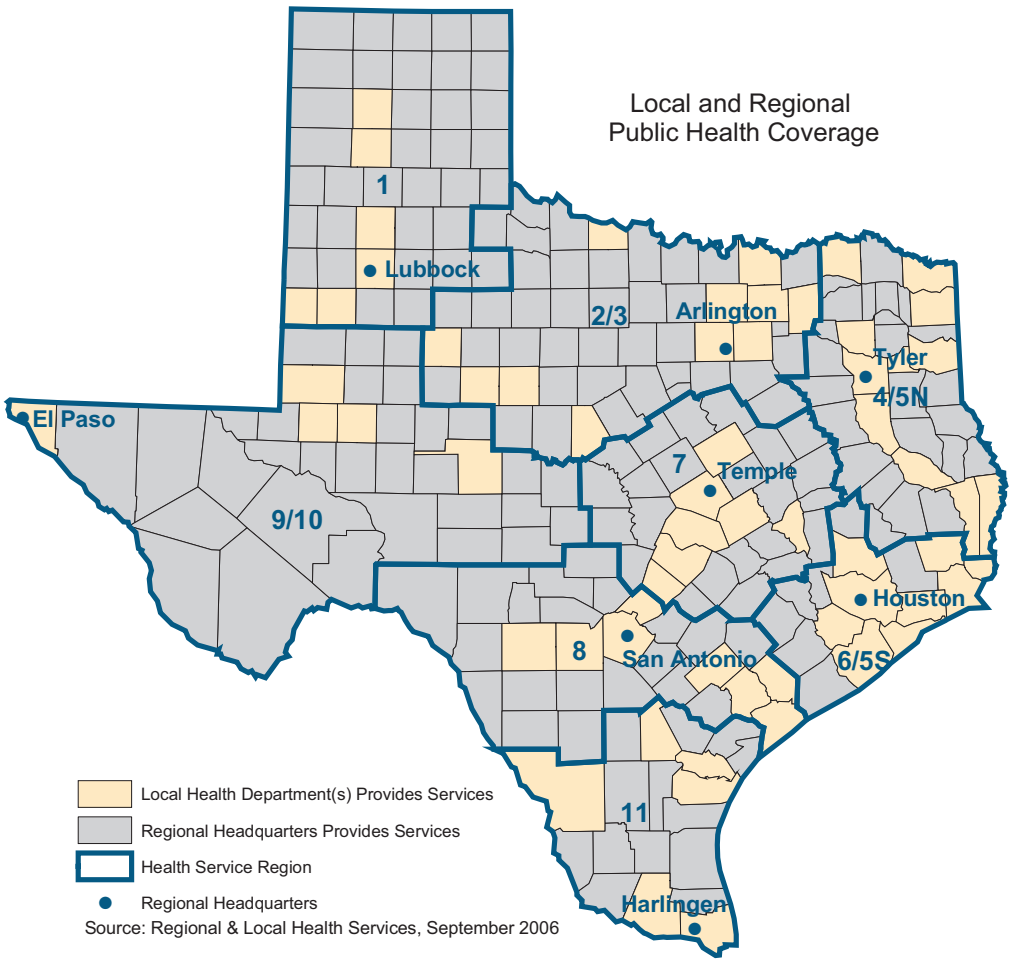
Telephone Number	Department/Program
1-800-CDC- INFO 1-800-232-4636)	AIDS Hotline (Nationwide, distributed by Centers for Disease Control and Prevention [CDC], Atlanta, Georgia)
1-800-299-2437	HIV/STD InfoLine
1-800-255-1090	Texas HIV Medication Program
1-800-252-5400	Child/Elder Abuse Intake (Department of Family and Protective Services [DFPS])
1-512-776-7420	Vision and Hearing Screening Program (DSHS)
1-512-834-6650, Ext. 2601	*Clinical Laboratory Improvement Amendments* (CLIA) Certification Line

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Telephone Number	Department/Program
1-800-458-9858	Client Abuse Hotline for Long Term Care Services and Support—Nursing Facilities (HHSC)
1-800-252-8263	Client Inquiry Hotline (HHSC) (Medicaid questions from clients with Medicaid only)
1-512-776-7745	THSteps Program (DSHS)
1-888-963-7111 ext. 7318 or 1-512-776-7318 Fax: 1-512-776-7294	THSteps Laboratory Services (DSHS)
1-888-963-7111 ext. 7661 or 1-512-776-7661 Fax: 1-512-776-7672	Laboratory Supply Orders (DSHS)
1-888-963-7111 ext. 7578 or 1-512-776-7578	Report of Laboratory Test Results (DSHS)
1-512-776-7796	HHSC Family Planning
1-800-436-6184	Fraud or Abuse of Provider Services (HHSC Office of Inspector General)
1-800-436-6184	Fraud or Abuse/Long Term Care Services and Support—Nursing Facilities/HHSC
1-800-436-6184	Fraud or Abuse/Client/HHSC Office of the Inspector General
1-800-792-1109	Goal-Directed Therapy
1-512-438-3169 or 1-800-252-8010	Hospice Program (HHSC Policy Development division)
1-800-252-9152	Immunization Branch (DSHS)
1-800-925-9126	Medically Needy Spend Down Unit
1-800-MEDICARE or 1-800-633-4227	Medicare/Social Security Administration
1-800- 925-9126	Newborn Screening (DSHS)
1-800-925-9126	HHSC Hearing Services for Children (HSC)
1-877-787-8999	HHS Office of the Ombudsman (for information about ECI or to refer a child.)
1-800-436-6184	Recipient Utilization Control Unit (HHSC) (for limited status review and for referrals from providers for potential client overutilization, etc.)
1-512-776-7796	Breast and Cervical Cancer Services (DSHS)
1-713-526-2559	Snellen Letter (Tumbling E Wall Chart)
1-800-435-4165	Vendor Drug Program (HHSC) (fee-for-service) (specifically for pharmacy use)
1-877-728-3927	Vendor Drug Program Prior Authorization Center (fee-for-service)
1-866-993-9972	Healthy Texas Women (HTW) program Eligibility
1-512-776-7796	Cervical Cancer Screening

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A.5 DSHS Health Service Regions Map



A.6 DSHS Health Service Region Contacts

Health Service Region 1 Regional Office (Lubbock)	Health Service Regions 2 & 3 Regional Office (Arlington)
DSHS/PHR 1 6302 Iola Ave. Lubbock, TX 79424 1-806-744-3577 Fax: 1-806-783-6435	DSHS/PHR 2 & 3 1301 S. Bowen, Suite 200 Arlington, TX 76013 1-817-264-4500 Fax: 1-817-264-4506
Regional Medical Director Peter W. Pendergrass, MD, MPH	Regional Medical Director James A. Zoretic, MD
Deputy Regional Director Barry Wilson	Deputy Regional Director (acting) Earlene Quinn
Manager of Social Work Services and Case Management Judy Lara, LBSW	Manager of Social Work Services and Case Management Lindsay Matousek, LMSW, CCM
Communicable Disease Manager Vacant	Director of Clinic Operations Dorothy Kuhlmann, RN
Immunization Program Manager Keila Johnson	Immunization Program Manager Sonna Sanders

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Health Service Region 1 Regional Office (Lubbock)	**Health Service Regions 2 & 3 Regional Office (Arlington)**
Tuberculosis Team Leader Melanie Lee	Communicable Disease Program Manager Gary Willett
THSteps Operations Lead Elizabeth Stanford 6302 Iola Ave Lubbock, TX 79424 Mail Code: 1899 1-806-783-6445 Fax: 1-806-783-6455	Tuberculosis Team Leader Jeff Ralston Emergency Preparedness Bryan Flow, DVM
	THSteps Operations Lead Grady Asher 1301 S. Bowen Road #200, Mail Code 1905 Arlington, TX 76013 1-817-264-4918 Fax: 1-817-264-4910
	HIV/STD Program Manager Vacant

Health Service Regions 4 & 5 (North) Regional Office (Tyler)	**Health Service Regions 6 & 5 (South) Regional Office (Houston)**
DSHS/PHR 4 & 5 North 2521 West Front Street Tyler, TX 75702 1-903-595-3585 Fax: 1-903-593-4187	DSHS 6 & 5 South 5425 Polk Avenue, Suite J Houston, TX 77023 1-713-767-3000 Fax: 1-713-767-3049
Regional Medical Director Dr. Paul K. McGaha, DO, MPH	Regional Medical Director (Acting) John G. Jordan, M.D., MPH
Deputy Regional Director Vacant	Deputy Regional Director Greta Etnyre, MS, RD
Manager of Social Work Services and Case Management Caleb Rackley, LMSW	Manager of Social Work Services and Case Management Vacant
Director of Nursing Barbara Lay, RN, MSN	Director of Nursing Melinda Denson, RN, MPH
Immunization Program Manager Toni Wright	Immunization Program Manager Angel H. Angco, MBA, RN
HIV/STD Program Manager Charles O'Brien	HIV/STD Program Manager Linda Hollins
Tuberculosis Program Manager Teresa Santiago, RN	Tuberculosis Program Manager Lewis Gonzalez, MD
THSteps Operations Lead Sherrylynn Adams, LBSW 2521 W. Front, Mail Code 1358 Tyler, TX 75702 1-903-533-5357 Fax: 1-903-595-4706	THSteps Operations Lead Shannon Jones 5425 Polk Avenue, Suite J, Mail Code 1906 Houston, TX 77023-1497 1-713-767-3105 Fax: 1-713-767-3125

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* Health Service Region 7 Regional Office (Temple)	Health Service Region 8 Regional Office (San Antonio)
DSHS/PHR 7 2408 S 37th Street Temple, TX 76504-7168 1-254-778-6744 Fax: 1-254-778-4066	DSHS/PHR 8 7430 Louis Pasteur Drive San Antonio, TX 78229 1-210-949-2000 Fax: 1-210-949-2015
Regional Medical Director Lisa Cornelius, MD, MPH	Regional Medical Director Sandra Guerra-Cantu, MD, MPH
Deputy Regional Director Jon Huss	Deputy Regional Director Gail Morrow, MPH
Manager of Social Work Services and Case Management Leesa Ferrero, LMSW	Manager of Social Work Services and Case Management Leticia Guerra, LBSW
Director of Nursing Pauline Culbert, MSN, RN	Director of Nursing Sandra Jones, MSN, CNS
Immunization Program Manager Diane Romnes	Immunization Program Manager Laurie Henefey
HIV/STD Program Manager Al Gonzales	Communicable Disease Program Manager Cherise Rohr-Allegrini, PhD
Tuberculosis Program Manager/Nurse Consultant Dana Schoepf, RN	HIV/STD Program Manager Joanna Nichols, MPH
THSteps Operations Co-Leads Kimberly Langley 1-254-760-1176 2408 S. 37th Street, Mail Code 1902 Temple, TX 76504 Fax: 1-254-778-5490	THSteps Operations Lead Velma Stille 7430 Louis Pasteur Drive, Mail Code 5716 San Antonio, TX 78229 1-210-949-2159 Fax: 1-210-949-2041
THSteps Operations Co-Leads Suzan Hutchison 1-254-231-9195 2408 S. 37th Street, Mail Code 1902 Temple, TX 76504 Fax: 1-254-778-5490	

Health Service Regions 9 & 10 Regional Office (El Paso)	Health Service Region 11 Regional Office (Harlingen)
DSHS/PHR 9 & 10 401 E. Franklin, Suite 210 El Paso, TX 79901 1-915-834-7682 Fax: 1-915-834-7808	DSHS/PHR 11 601 W. Sesame Drive Harlingen, TX 78550 1-956-423-0130 Fax: 1-956-444-3293
Regional Medical Director James A. Zoretic, M.D., M.P.H., Interim Regional Medical Director	Regional Medical Director Brian Smith, MD, MPH
Deputy Regional Director Blanca Serrano, MPH, RS	Deputy Regional Director Sylvia Garces-Hobbs
Manager of Social Work Services and Case Management Patrice Loge, LMSW	Manager of Social Work Services and Case Management Angelica Martinez, MS, LBSW
Director of Nursing Sharon Lindsey, RN	Director of Nursing Darlene Farias, RN
Immunization Program Manager Jose Padilla	Immunization Program Manager Ivette Nunez

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Health Service Regions 9 & 10 Regional Office (El Paso)	Health Service Region 11 Regional Office (Harlingen)
HIV/STD Program Manager Oscar Hernandez	HIV/STD Program Manager Richard Anguiano
Communicable Disease Manager Gale Morrow, MPH, CHES	Tuberculosis Program Manager Maria San Pedro, MSPHN, RN
THSteps Operations Lead Patrice Loge, LMSW 401 E. Franklin, Suite 200, Mail Code 1903 El Paso, TX 79901 1-915-834-7733 Fax: 1-915-834-7802	THSteps Operations Lead Ray Garza 601 W. Sesame Drive, Mail Code 1907 Harlingen, TX 78550 1-956-421-5563 Fax: 1-956-444-3293

A.7 State Participating Local Health Departments and Public Health Districts

Information for local health departments and public health districts can be found on the Texas Department of State Health Services website at: https://www.dshs.texas.gov/regional-local-health-operations/public-health-regions/texas-local-public-health

A.8 Texas Health and Human Services Commission Blind Children's Vocational Discovery and Development Program (BCVDDP)

HHSC, BCVDDP	
Abilene 4601 S. 1st Street, Suite M Abilene, TX 79605-1463 PO BOX 521 MC: 6846 Abilene, TX 79604-0521 1-325-795-5845	Irving 440 S. Nursery Rd. MC: 1469 Irving, TX 75060 1-972-721-6580
Amarillo 28 Western Plaza Dr. MC: 0052 Amarillo, TX 79109 1-806-351-3881	Laredo 1500 N. Arkansas MC: 2031 Laredo, TX 78043 1-956-764-6284
Austin 7701 Metropolis Dr., BLDG 12, Ste. 100 MC: 0172 Austin, TX 78744 1-512-416-5263	Lubbock 6302 Iola St. MC: 2171 Lubbock, TX 79424 1-806-783-6630
Beaumont 3105 Executive Blvd. MC: 0291 Beaumont, TX 77708 1-409-730-1098	McAllen 4501 West Business 83 MC: 2222 McAllen, TX 78501 1-956-971-1281
Bryan College Station 3000 East Villa Maria Rd MC: 7331 Bryan, TX 77803 1-979-776-7492	Odessa 3016 Kermit Hwy. MC: 2503 Odessa, TX 79764 1-432-334-5624

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HHSC, BCVDDP	
Corpus Christi 4410 Dillon Ln. MC: 0734 Corpus Christi, TX 78415 1-361-878-7707	San Angelo 622 South Oakes, Suite D MC: 6979 San Angelo, TX 76903 1-325-659-7653
Dallas 1545 W. Mockingbird Ln. MC: 0889 Dallas, TX 75235 1-214-638-7575	San Antonio 11307 Roszell MC: 2794 San Antonio, TX 78217 1-210-619-8147
El Paso 401 E. Franklin, Suite #240 MC: 6900 El Paso, TX 79901 1-915-834-7072	Tyler 3303 Mineola Highway MC: 3137 Tyler, TX 75702 1-903-595-4841
Fort Worth 4733 E. Lancaster Ave. MC: 1469 Fort Worth, TX 76103 1-817-535-3893	Victoria 2306 Leary Ln. MC: 3192 Victoria, TX 77901 1-361-574-7342
Harlingen 3625 W. Business 83 MC: 1606 Harlingen, TX 78552 1-956-365-0129	Waco 801 Austin Street, Suite 710 MC: 6820 Waco, TX 76701 1-254-750-9623
Houston 1459 E. 45th St. MC: 1737 Houston, TX 77022 1-713-696-3669	Wichita Falls 1328 Oakhurst Dr. MC: 3323 Wichita Falls, TX 76302 1-940-720-8446
Houston-Southeast 10060 Fuqua MC: 6949 Houston, TX 77089 1-713-948-7957	

A.9 HHSC Open Records Requests

Providers who would like to make open records requests should visit the Open Records page of the HHSC website. For general inquiries, such as claim status inquiries, eligibility verification, and prior authorization requests, refer to subsection A.10, "TMHP Telephone and Fax Communication" in this section for contact information.

A.10 TMHP Telephone and Fax Communication

Contact	PA Request Telephone Number	General Inquiry Telephone Number	Fax Number
General Information			
TMHP Contact Center	N/A	1-800-925-9126 or 1-512-335-5986	
Automated Inquiry System (AIS)	N/A	1-800-925-9126 or 1-512-335-5986	
Provider Enrollment	N/A	TMHP Contact Center	1-512-514-4214
Telephone appeals	N/A	1-800-745-4452	

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Contact	PA Request Telephone Number	General Inquiry Telephone Number	Fax Number
TMHP Electronic Data Interchange (EDI) Help Desk	N/A	1-888-863-3638	1-512-514-4228 1-512-514-4230
Program and Prior Authorization Information			
Ambulance (Medicaid and CSHCN Services Program)	1-800-540-0694	TMHP Contact Center	1-512-514-4205 Prior Authorization Only
Children with Special Health Care Needs (CSHCN) Services Program	N/A	1-800-568-2413	1-512-514-4222 Prior Authorization Only
Comprehensive Care Program (CCP) (for CCP prior authorization status and general CCP and Home Health Services information)	N/A	1-800-846-7470	1-512-514-4212 Prior Authorization Only
CCP personal care services (PCS)	N/A	1-888-648-1517	N/A
Inpatient Psychiatric Services Option 1 – CCP Option 2 – Substance use	N/A	1-800-213-8877	1-512-514-4211 Prior Authorization Only
Home Health Services	Requests for new prior authorization or extensions cannot be made over the telephone.	TMHP Contact Center	1-512-514-4209 Prior Authorization Only
Obstetric ultrasound	1-800-302-6167	TMHP Contact Center	1-512-302-5039 Prior Authorization Only
Special Medical Prior Authorization (SMPA)	N/A	TMHP Contact Center	1-512-514-4213) Prior Authorization Only
Texas Health Steps (THSteps) dental inquiries	N/A	1-800-568-2460	N/A
THSteps medical inquiries	N/A	1-800-757-5691	N/A
Family Planning (tubal ligation and vasectomy consent forms)	N/A	TMHP Contact Center	1-512-514-4229
Hysterectomy acknowledgment statements	N/A	TMHP Contact Center	1-512-514-4218
Vendor Drug Program - Texas Pharmacy Prior Authorization Call Center (fee-for-service)	877-728-3927	877-728-3927	866-469-8590
Other Program and Reimbursement Information			
Health Insurance Premium Payment (HIPP)	N/A	1-800-440-0493	
Long Term Care (LTC) operations	N/A	1-800-626-4117	
LTC—Nursing Facilities	N/A	1-800-727-5436	
Medicaid Audit/Cost Reports	N/A	1-512-506-7630	N/A
Third Party Liability (TPL) (Option 2)	N/A	1-800-846-7307	1-512-514-4225
Tort (Option 3)	N/A	1-800-846-7307	1-512-514-4225

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A.11 Written Communication With TMHP

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

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

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

Correspondence	Address
Appeals/adjustments of claims (except zero paid/zero allowed on Remittance & Status [R&S] Reports) Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report	Texas Medicaid & Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645
All first-time claims	Texas Medicaid & Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555
Ambulance Authorization (includes out-of-state transfers)	Texas Medicaid & Healthcare Partnership Ambulance Prior Authorizations P O Box 200735 Austin, TX 78720-0735
CCP requests (prior authorization and appeals)	Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735
CSHCN Services Program claims	Texas Medicaid & Healthcare Partnership CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0855
Home Health Services prior authorizations	Texas Medicaid & Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977
Medicaid audit correspondence	Texas Medicaid & Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345
Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence	Texas Medicaid & Healthcare Partnership Medically Needy Clearinghouse PO Box 202947 Austin, TX 78720-2947
Provider Enrollment correspondence	Texas Medicaid & Healthcare Partnership Provider Enrollment PO Box 200795 Austin, TX 78720-0795
Other provider correspondence	Texas Medicaid & Healthcare Partnership Provider Relations PO Box 202978 Austin, TX 78720-0978

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Correspondence	Address
Send all other written communication to TMHP	Texas Medicaid & Healthcare Partnership (Department) 12365-A Riata Trace Parkway, Suite 100 Austin, TX 78727
TMHP Fee-for-Service and ICF-IID Dental prior authorization requests	Texas Medicaid & Healthcare Partnership Fee-for-Service and ICF-IID Dental PO Box 204206 Austin, TX 78720-4206
TPL/Tort correspondence	Texas Medicaid & Healthcare Partnership Third Party Liability/Tort PO Box 202948 Austin, TX 78720-2948

A.12 Other TMHP Information

A.12.1 TMHP Website

The TMHP website at www.tmhp.com is a valuable resource that provides:

- Provider education information and training.
- Publications, such as bulletins, banner messages, and provider manuals.
- A TMHP News section with announcements of program changes and other important information.
- Real-time and static fee schedules.
- Online provider enrollment.
- Complete instructions for setting up a Provider Administrator account and the use of online claims status inquiries (CSI), eligibility verification, and Electronic Remittance and Status (ER&S) Reports.
- A chatbot for frequently asked questions and a live chat to speak with an agent.

Additional advanced features are available for those providers who create an account. All enrolled providers are eligible for this free account. Once an account is activated, providers will have access to:

- Texas Medicaid enrollment information.
- CSIs.
- Eligibility verification.
- ER&S Report download option.
- Claims submission.
- Claims appeals.
- Online provider lookup.
- Online fee lookup (OFL) to obtain real-time fee information for an individual or a range of procedure codes. Benefits and limitations for certain services and history up to 2-years is also available.
- Payment amounts search, view, and print capabilities.
- Notification of an invalid address on file for a provider's National Provider Identifier (NPI).
- Notification of pending payments because of inaccurate or incomplete provider information.

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- Manage hospital admission and discharge information on clients residing in an institution for mental diseases (IMD)

Important: *Natural disasters, such as floods or hurricanes, can impact the delivery of health care to Texas Medicaid clients. When disaster strikes, providers should monitor the TMHP website for special instructions.*

New services are always being added to the website. Please visit www.tmhp.com for the latest information on TMHP online services.

A.12.2 TMHP Contact Center

The TMHP Contact Center is available from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

The TMHP Contact Center assists with questions such as:

- Provider enrollment procedures
- Claims filing procedures
- Policy information

The TMHP Contact Center is available to assist providers and clients. Please review the telephone and fax communication guides in this section for a list of contact telephone and fax numbers.

Provider calls, including those that were previously made to the Provider Relations territory representatives, are now handled first by the Contact Center. The Contact Center is well equipped to handle most inquiries about benefits and claims.

If the Contact Center representative determines that an inquiry can best be handled by the TMHP Provider Relations department, the inquiry will be forwarded to Provider Relations. For example, providers who want to talk to their Provider Relations representative about a visit, in-service, or training, can call the Contact Center, and the Contact Center will forward the request to Provider Relations.

Resolution of more complex issues that are referred to Provider Relations for further analysis can take up to 30 days from the date of the referral. For these issues, Provider Relations will contact the provider by telephone or e-mail when the issue has been resolved.

For questions or information about Medicaid eligibility, clients are referred to their caseworker or the local HHSC office.

A.12.3 Automated Inquiry System (AIS)

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

- Claim status
- Patient eligibility
- Benefit limitations

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

A.12.4 TMHP Provider Relations

The TMHP Provider Relations Department comprises a staff of Austin- and field-based provider relations representatives whose goal is to serve the health-care community by furnishing a variety of services and activities designed to inform and educate health-care providers about Texas Medicaid activities and claim submission procedures.

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Provider Relations activities include the following:

- *Provider education through planned events.* Provider Relations representatives conduct a planned program of educational workshops, in-services, webinars, computer-based training (CBT), and other training sessions designed to keep all actively-enrolled providers informed of the latest policies, claim processing procedures, and federal and state regulations affecting Texas Medicaid. Details of all available provider training can be found in the Provider Education section of the TMHP website at www.tmhp.com.
- *Problem identification and resolution.* A staff of research coordinators is available to assist providers with clarification of Medicaid policies and assist with in-depth problem claim submission issues after initial inquiries are made with the TMHP Contact Center. Coordinators work closely with field-based regional representatives to coordinate the educational needs of the community.
- *Relationship with professional health-care organizations.* To ensure that Texas associations that represent health-care professions have up-to-date information about the requirements for participation in Texas Medicaid, the Provider Relations Department maintains a work relationship with these organizations. Also, the Provider Relations Department participates in several events sponsored by Texas health-care associations, such as conventions and conferences.

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

A.12.5 Reporting a Complaint to TMHP

Providers can report complaints by calling the TMHP Contact Center at 1-800-925-9126 or by submitting a written complaint to:

TMHP
Complaints Resolution Department
PO Box 2014270
Austin, TX 778720-4270

A complaint is defined as any dissatisfaction concerning any aspect of Texas Medicaid. The term "complaint" does not include a misunderstanding or a problem with misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction.

Providers should submit the following information when reporting the complaint:

- Point of contact name and phone number or email address
- Provider name
- Provider NPI, if available
- Description of the complaint situation
- Client name
- Client PCN
- Date of service

A.12.6 TMHP Electronic Data Interchange (EDI) Help Desk

The TMHP EDI Help Desk assists Medicaid providers with EDI transactions. The TMHP EDI Help Desk is available at 1-888-863-3638 from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

TMHP EDI Help Desk activities and responsibilities include, but are not limited to, the following:

- Enrolling providers for electronic billing
- Qualifying vendors for TMHP EDI production through testing

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- Diagnosing claim transmission problems through research
- Consulting with provider billing personnel, billing services, and software vendors regarding TMHP EDI

TMHP EDI Help Desk staff assists with questions about TMHP EDI, TexMedConnect, and electronic transmissions at 1-888-863-3638.

Providers who employ hardware or software vendors should contact those vendors for the resolution of technical problems.

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APPENDIX B: HIV/AIDS

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 1

NOVEMBER 2026

TEXAS
Health and Human
Services

APPENDIX B: HIV/AIDS

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B.1 CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings

The revised Centers for Disease Control and Prevention (CDC) recommendations advocate routine voluntary human immunodeficiency virus (HIV) screening as a normal part of medical practice, similar to screening for other treatable conditions. Screening is a basic public health tool used to identify unrecognized health conditions so treatment can be offered before symptoms develop and, for communicable diseases, so interventions can be implemented to reduce the likelihood of continued transmission. HIV screening should be offered as an opt-out test in accordance with CDC testing guidelines, which may be viewed at www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

B.1.1 Routine HIV Testing Procedure Codes

The following table lists the procedure codes for routine HIV testing and the corresponding modifiers that must be submitted for rapid testing. Routine HIV testing is covered as a preventative or screening benefit. Medical necessity is not required.

Procedure Code	Rapid Test Modifier
86689	
86701	92
86702	92
86703	92
87389	92
87390	
87534	
87535	
87536	
99211	
99212	
99213	
99214	
99215	
99385	
99386	
99395	
99396	

B.2 Model Workplace Guidelines for Businesses, State Agencies, and State Contractors

B.2.1 Purpose

The purpose of this policy is to protect the employment rights and privileges of individuals infected with HIV and acquired immunodeficiency syndrome (AIDS) through compliance with federal, state, and local laws. This policy will provide Texas employers, especially state agencies, with a uniform approach to developing policies and education programs that address HIV/AIDS in the workplace. The Department of State Health Services (DSHS) encourages all employers to establish workplace policies

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concerning persons with HIV/AIDS. Employers can adapt this model to fit the particular needs of their organization, work force, and clients; however, the content and intent must remain consistent with this document and the Health and Safety Code (HSC).

B.2.2 Authority

Governance for this policy is found in Vernon's Texas Codes Annotated, HSC §85.010, "Educational Course for Employees and Clients of Health Care Facilities"; §85.111, "Education of State Employees"; §85.112, "Workplace Guidelines"; and §85.113, "Workplace Guidelines for State Contractors."

The model workplace guidelines, developed by the DSHS HIV/Sexually Transmitted Disease (STD) Comprehensive Services Branch, as required by HSC §85.012, "Model Workplace Guidelines," and adopted as HIV/STD Policy No. 090.021, are considered the minimum standards for the development of guidelines for state agencies. This policy also serves as the minimum standard for contractors of certain designated state agencies and organizations funded by those state agencies (HSC §85.113).

Refer to: Subsection B.2.7, "State Agencies Listed Under Health and Safety Code (HSC) §85.113" in this section.

These guidelines are also the standard for health-care facilities licensed by DSHS and the Texas Health and Human Services Commission (HHSC) as stated in HSC §85.010, "Educational Course for Employees and Clients of Health Care Facilities."

B.2.3 Who Must Use Workplace Guidelines

B.2.3.1 State Agencies

State law requires that each state agency adopt and carry out workplace guidelines. The agency's workplace guidelines should incorporate, at a minimum, the DSHS model workplace guidelines in this policy.

B.2.3.2 State Contractors

A program that involves direct client contact and that contracts with or is funded by any of the state agencies listed in subsection B.2.7, "State Agencies Listed Under Health and Safety Code (HSC) §85.113" in this section will adopt and carry out workplace guidelines as stated in HSC §85.113.

B.2.4 Why Have Guidelines

Employers should develop and carry out policies and education programs concerning potentially limiting medical conditions before a crisis arises. Such policies and education programs help reduce employees' fears and misconceptions about HIV/AIDS and help to:

- Provide current and accurate scientific evidence that people with HIV infection do not pose a risk of transmitting the virus to coworkers through ordinary workplace contact.
- Provide workers with current information about HIV risk reduction for employees and their families.
- Avoid conflict between the infected employee and the employer regarding discrimination or other employment issues.
- Prevent work disruption and rejection of the infected employee by coworkers.
- Inform employees that they have rights regarding work continuation, confidentiality of medical and insurance records, and general health and safety.
- Provide specific and ongoing education and equipment to employees in health-care settings who are at risk of exposure to HIV, and to assure that appropriate infection-control procedures are used.
- Reduce the financial impact, legal implications, and other possible effects of HIV/AIDS in the workplace.

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B.2.5 Development of Workplace Policy Content

Individuals infected with HIV have the same rights and opportunities as other individuals. While some employers prefer a policy specific to HIV/AIDS and its unique issues, others prefer a general policy concerning illnesses and disabilities. A general policy should address HIV/AIDS in the same way as other major illnesses. Use of the following statements in agency policy is encouraged:

- Use of a person's HIV status to decide employment status, service delivery, or to deny services to HIV-infected individuals is not acceptable. Employees who believe that they have been discriminated against because of HIV or AIDS should contact the personnel office to discuss the matter, or initiate action through the agency's grievance procedure. Other legal options may also be available.
- This policy is consistent with current information from public health authorities, such as the CDC of the U.S. Public Health Service, and with state and federal laws and regulations.

While the approach and resolution of each employee's situation may vary, similar issues may arise. A workplace policy should address the following issues about HIV/AIDS and other life-threatening illnesses or disabilities:

- *Discrimination.* The Americans with Disabilities Act of 1990 prohibits discrimination against people with disabilities, which includes HIV and AIDS, in employment, public accommodations, public transportation, and other situations.
  A specific policy statement that no one will be denied employment or employment opportunities because of a disability, satisfies the employer and employee's need to address discrimination. Such a statement might be, "This agency complies with the Americans with Disabilities Act protections of all people with disabilities against discrimination in job application procedures, hiring, promotions, discharge, compensation, job training, and other terms or conditions of employment." Managers may want to define ways in which they will deal with discriminatory actions.
- *Desire and Ability to Work.* A workplace policy should address the infected employee's desire and need to work and the infected employee's value to the workplace. Such a statement reassures employees that the employer supports them.
  The health status of someone with HIV may vary from healthy to critically ill. In the work setting, the ultimate concern is whether or not the employee can satisfy job expectations. A policy statement may say, for example, "Procedures may be adapted to provide reasonable accommodation so that people with disabilities may remain employed and productive for as long as possible. All employees, however, are expected to perform the essential functions of their job with or without reasonable accommodation."
- *Performance Standards.* The Americans with Disabilities Act provides protections for disabled persons *qualified* to perform their jobs. And although an employer may be expected to provide reasonable accommodation to a disabled employee or applicant; employers may terminate employees and refuse to hire individuals who cannot perform the essential functions of the job, with or without the reasonable accommodation.
  One suggested statement is, "While the Americans with Disabilities Act does protect disabled employees from employment discrimination, all employees, those with and without disabilities, have the same performance and conduct standards regarding hiring, promotion, transfer, and dismissal."
- *Reasonable Accommodation.* The Americans with Disabilities Act requires employers to provide reasonable accommodations for employees with disabilities. Employers do not have an obligation to provide any accommodation that imposes an undue hardship on the employer. Specific questions about the issue of reasonable accommodation and undue hardship should be directed to staff responsible for coordinating the requirements of the Americans with Disabilities Act.
  Such a policy statement might read, "The following options may be considered for people with HIV/AIDS: possible assignment or reassignment of job duties, working at home, leaves of absence, and flexible work schedules."

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- *Confidentiality and Privacy.* Organizations that receive funds from a state agency for residential or direct client services or programs shall develop and use confidentiality guidelines to protect their clients' HIV/AIDS-related medical information (HSC §85.115, "Confidentiality Guidelines"). Organizations that fail to adopt and use confidentiality guidelines are ineligible to receive state funds.
  Employees are not required to reveal their HIV status to employers. All medical information that an HIV-infected employee provides to medical or management personnel is confidential and private. Employers may not reveal this information without the employee's knowledge and written consent, except as provided by law (HSC §81.103, "Confidentiality; Criminal Penalty").
  A suggested policy statement might be, "This agency will protect the confidentiality of employee medical records and information. Written consent of the employee must be obtained to share any confidential information with other staff. Those with access to confidential information must maintain strict confidentiality and privacy, separating this information from employees' personnel records. Individuals who fail to protect these employee rights commit a serious offense, which may be cause for litigation resulting in both civil and criminal penalties, and may result in dismissal."
- *Coworker Concerns.* Employers need to be aware of the concerns that coworkers may have about an HIV-infected coworker. A policy statement that acknowledges employee concerns and offers HIV/AIDS education helps to increase awareness and decrease fear. Equally important is a policy statement that clarifies the limits of an employer's response to coworker concerns, e.g., "Employees do not have the right to refuse to work with someone who has any disability."
- *Employee Education.* Any health-care facility licensed by DSHS or HHSC must require its employees to complete an educational course about HIV infection (HSC §85.010). A suggested policy statement may be: "All employees will receive education about methods of transmission and prevention of HIV infection and related conditions." In response to HSC, §85.004, "Educational Programs," DSHS developed model education program guidelines. These are available from DSHS, HIV/STD Comprehensive Services Branch, 1100 W. 49th St., Austin, TX. 78756-3199, 1-512-533-3000. Employers may also find the CDC's educational kit, *Business Responds to AIDS*, useful in developing educational courses. HIV/AIDS education should address employee concerns about HIV communicability to themselves, their families, and coworkers. Experience shows that educated coworkers usually respond to persons with HIV/AIDS with support, rather than with fear and ostracism due to misconceptions.
  Education programs must stress that agency employees who provide direct client services may face occupational exposure to a client's blood, semen, vaginal secretions, or other body fluids that are considered to be high-risk for transmission of blood born pathogens, including HIV/AIDS. All individuals receiving direct services are clients and include individuals who are physically or mentally impaired and individuals confined to correctional or residential facilities. All state agencies should have, as part of their employee education program, comprehensive policies and protocols based on universal precautions, body substance isolation, and barrier methods. These precautions prevent the spread of infection in clinical settings. The employer's careful planning will reflect a commitment to the health and well-being of the work force and the community being served.
- *Assistance.* Some employers have designated benefits programs available to employees and family members with HIV infection. Such programs may:
  - Make referrals for testing, counseling, medical, and psychosocial services.
  - Provide HIV/AIDS workplace training for managerial staff.
  - Serve as a liaison between management and the employer's clinical and occupational health programs.
  - Provide counseling for employees who irrationally fear coworkers or clients.

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Employers who have no employee assistance program may consider working with other organizations that provide assistance. Some of these groups include local health departments, AIDS services organizations, American Red Cross chapters, community support groups, clinical treatment and counseling services, and the religious community.

A suggested policy statement might be: "An employee who wants assistance concerning a disability or a life-threatening illness should contact the Personnel Office. This agency offers the following resources to help employees and managers deal with these issues: education and information concerning HIV/AIDS; confidential referral to supportive services for employees and dependents affected by life-threatening illnesses; and benefits consultation to help employees effectively manage health, leave, and other benefits."

B.2.6 Where to Go for Help

Employees may call 2-1-1 for HIV/STD testing locations in Texas. For questions related to issues such as transmission, signs and symptoms, or other concerns about HIV or other sexually transmitted infections, employees may call 1-800-CDC-INFO (English/Español) or 1-888-232-6348 (TTY).

B.2.7 State Agencies Listed Under Health and Safety Code (HSC) §85.113

HSC §85.113, "Workplace Guidelines for State Contractors" states "An entity that contracts with or is funded by… to operate a program involving direct client contact shall adopt and implement workplace guidelines similar to the guidelines adopted by the agency that funds or contracts with the entity." H.B. 2292, 78th Leg., abolished 10 of the 12 existing health and human services agencies and transferred their powers and duties to three new state agencies and to HHSC, which rendered the state agency list found in HSC §85.113 obsolete. The following list reflects the state agency consolidation brought about by H.B. 2292 and identifies the state agencies to which HSC §85.113 applies.

- DSHS
- HHSC
- Texas Department of Criminal Justice
- Texas Juvenile Probation Commission
- Texas Youth Commission

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APPENDIX C: ACRONYM DICTIONARY

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 1

NOVEMBER 2026

TEXAS
Health and Human
Services

1 Acronym Dictionary

Term	Definition
3-D	Three Dimensional
6MWT	6-Minute Walk Test
A/C	Alternating Current
A/EEG	Ambulatory Electroencephalogram
AABR	Automated Auditory Brainstem Response
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
AAPD	American Academy of Pediatric Dentistry
AARC	American Association for Respiratory Care
AASM	American Academy of Sleep Medicine
ABA	Applied Behavior Analysis
ABAI	American Board of Allergy and Immunology
ABG	Arterial Blood Gas
ABI	Auditory Brainstem Implant
ABIM	American Board of Internal Medicine
ABMG	American Board of Medical Genetics
ABMS	American Board of Medical Specialties
ABPS	American Board of Physician Specialties
ABR	Auditory Brainstem Response
ACA	Affordable Care Act of 2010
ACD	Augmentative Communication Device
ACH	Automated Clearinghouse
ACIP	Advisory Committee on Immunization Practices
ACMG	American College of Medical Genetics and Genomics
ACOG	American Congress of Obstetricians and Gynecologists
ADA	American Dental Association
ADL	Activity of Daily Living
AFO	Ankle-Foot Orthosis
AFP	Abdominal Flat Plates
AFT	Autonomic Function Test
aGVHD	Acute Graft Versus Host Disease
AHA	American Heart Association
AHI	Apnea/Hypopnea Index
AI	Auditory Impairment
AIDS	Acquired Immunodeficiency Syndrome
AIR	All Inclusive Rate
AIS	Automated Inquiry System
ALL	Acute Lymphoblastic Leukemia

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Term	Definition
ALP	Alkaline Phosphatase
ALS	Advanced Life Support
ALS	Amyotrophic Lateral Sclerosis
AMA	American Medical Association
AMH	Adult Mental Health
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
APA	American Psychiatric Association
API	Atypical Provider Identifier
APPS	Alternative Prospective Payment System
APRN	Advanced Practice Registered Nurse
ARD	Admission, Review, and Dismissal
ASC	Ambulatory Surgical Center
ASD	Autism Spectrum Disorder
ASL	American Sign Language
ASP	Average Sales Price
ASQ	Ages and Stages Questionnaire
ASQ:SE	Ages and Stages Questionnaire: Social-Emotional
ATP	Automated Test Panel
AWP	Average Wholesale Price
BAHD	Bone-Anchored Hearing Device
BCCS	Breast and Cervical Cancer Services
BCG	Bacillus Calmette-Guérin
BCL-2	B-Cell Lymphoma 2
BCRC	Benefit Coordination and Recovery Center
BCVDDP	Blind Children's Vocational Discovery and Development Program
BGM	Blood Glucose Monitor
BHCM	Behavioral Health Care Manager
BHO	Behavioral Health Organization
BIDS	Border Infectious Disease Surveillance
BiPAP	Bi-level Positive Airway Pressure
BLL	Blood Lead Level
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BON	(Texas) Board of Nursing
BPE	Benign Prostatic Enlargement
BPH	Benign Prostatic Hyperplasia
BRC	Bureau of Radiation Control
BRCA	Breast Cancer Gene (1 and 2)

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Term	Definition
BUN	Blood Urea Nitrogen
BVIC	Blind and Visually Impaired Children
BVM	Bag Valve Mask Resuscitator
BVS	Bureau of Vital Statistics
C21	Compass21
CAD	Clinician-Administered Drug
CAH	Critical Access Hospital
CALD	Cerebral Adrenoleukodystrophy
CAPD	Continuous Ambulatory Peritoneal Dialysis
CBA	Community-Based Alternatives (Program)
CBC	Complete Blood Count
CBO	Community Based Organization
CBT	Computer-based Training
CCP	Comprehensive Care Program
CCPD	Continuous Cycling Peritoneal Dialysis
CDC	Centers for Disease Control and Prevention
CDS	Consumer Directed Services
CDT	Current Dental Terminology
CDTF	Chemical Dependency Treatment Facility
CFC	Community First Choice
CFP	Certified Family Partner
CFR	*Code of Federal Regulations*
CGM	Continuous Glucose Monitoring
CHC	Comprehensive Health Centers
CHIP	Children's Health Insurance Program
CIHCP	County Indigent Health Care Program
CKD	Chronic Kidney Disease
CLASS	Community Living Assistance and Support Services
CLIA	*Clinical Laboratory Improvement Amendments*
CLPPP	Childhood Lead Poisoning Prevention Program
CMBHS	Clinical Management for Behavioral Health Services
CMS	Centers for Medicare & Medicaid Services
CMT	Chiropractic Manipulative Treatment
CNM	Certified Nurse-Midwife
CNS	Clinical Nurse Specialist
CoCM	Collaborative Care Model
CompSA	Complex Sleep Apnea
COPD	Chronic Obstructive Pulmonary Disease
CORF	Comprehensive Outpatient Rehabilitation Facility
CPAP	Continuous Positive Airway Pressure

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Term	Definition
CPM	Chronic Pain Management
CPM	Continuous Passive Motion
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CPW	Children and Pregnant Women
CRCP	Certified Respiratory Care Practitioner
CRF	Chronic Renal Failure
CRNA	Certified Registered Nurse Anesthetist
CSF	Colony Stimulating Factor
CSHCN	Children with Special Health Care Needs (Services Program)
CSI	Claim Status Inquiry
CSSP	Community Services Specialist
CSU	Chronic Spontaneous Urticaria
CT	Computed Tomography
dB	Decibel
DBMD	Deaf/Blind Multiple Disabilities
DBT	Digital Breast Tomosynthesis
DC	Doctor of Chiropractic Medicine
DCIS	Ductal Carcinoma in Situ
DCN	Dorsal Column Neurostimulator
DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Administration
DEFRA	*Deficit Reduction Act* (of 1984)
DFARS	Defense Federal Acquisition Regulation Supplement
DFPP	DSHS Family Planning Program
DFPS	Department of Family and Protective Services
DLBCL	Diffuse Large B-Cell Lymphoma
DMARD	Disease Modifying Antirheumatic Drug
DMD	Doctor of Dental Medicine
DMD	Doctor of Medical Dentistry
DMD	Duchenne Muscular Dystrophy
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prostheses, Orthoses and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DMO	Dental Maintenance Organization
DNA	Deoxyribonucleic Acid
DO	Doctor of Osteopathy
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty
DOS	Date of Service

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Term	Definition
DOT	Directly Observed Therapy
DPC	Diagnostic Procedure Code
DPM	Doctor of Podiatric Medicine
DRG	Diagnosis-Related Group
DRTS	Demand Response Transportation Service
DSHS	(Texas) Department of State Health Services
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
DTaP	Diptheria and Tetanus Toxoids and Acellular Pertussis Vaccine
DX	Diagnosis Code
E/M	Evaluation and Management (Services)
EBLL	Elevated Blood Lead Level
ECF	Extended Care Facility
ECG	Electrocardiogram
ECI	Early Childhood Intervention
ECMO	Extracorporeal Membrane Oxygenation
ECT	Electroconvulsive Therapy
EDC	Estimated Date of Confinement
EDD	Expected Date of Delivery
EDI	Electronic Data Interchange
EDX	Electrodiagnostic
EEG	Electroencephalogram
EFT	Electronic Funds Transfer
EGD	Esophagogastroduodenoscopy
EGPA	Eosinophilic Granulomatosis With Polyangiitis
EHR	Electronic Health Record
EIN	Employer Identification Number
EKG	Electrocardiogram
EMG	Electromyography
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Active Labor Act
ENT	Ear, Nose, and Throat
EOB	Explanation of Benefits
EOG	Electro-Oculogram
EOPS	Explanation of Pending Status
EP	Evoked Potential
EPO	Erythropoietin Alfa
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room

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Term	Definition
ER&S	Electronic Remittance and Status Report
ERA	Estrogen Receptor Assay
ERCP	Endoscopic Retrograde Cholangiopancreatography
eSP	eScreener Plus
ESRD	End Stage Renal Disease
EVP	Eligibility Verification Portal
EVV	Electronic Visit Verification
FAP	Familial Adenomatous Polyposis
FDA	(United States) Food and Drug Administration
FDOS	From Date Of Service
FeNO	Nitric Oxide Expired Gas Determination
FERPA	Family Educational Rights and Privacy Act
FES	Functional Electrical Stimulation
FFCC	Former Foster Care Children
FFP	Federal Financial Participation
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FiO2	Fraction Of Inspired Oxygen Concentration
FIUT	Fetal Intrauterine Transfusion
FMAP	Federal Medical Assistance Percentage
fMRI	Functional MRI
FMS	Financial Management Services
FMSA	Financial Management Services Agency
FNA	Family Needs Assessment
FOBT	Fecal Occult Blood Test
FPL	Federal Poverty Level
FPP	Family Planning Program
FQHC	Federally Qualified Health Center
FQS	Federally Qualified Satellite
FY	Fiscal Year
FYE	Fiscal Year End
G-CSF	Granulocyte Colony Stimulating Factors
GAA	Alpha-Glucosidase
GEP-NET	Gastroenteropancreatic Neuroendocrine Tumor
GERD	Gastroesophageal Reflux Disease
GME	Graduate Medical Education
GNS	Gastric Neurostimulation
GYN	Gynecology/Gynecological/Gynecologist
H.B.	House Bill
HAC	Hospital Acquired Condition

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Term	Definition
HASC	Hospital-based Ambulatory Surgical Center
HAST	High Altitude Simulation Test
hATTR	Hereditary Transthyretin-Mediated
HBAI	Health and Behavior Assessment and Intervention
HBOT	Hyperbaric Oxygen Therapy
HBsAG	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCPCS	Healthcare Common Procedure Coding System
HCS	Home and Community-Based Services
HCV	Hepatitis C Virus
HD	Hemodialysis
HDL	High Density Lipoproteins
Hep A	Hepatitis A
Hep B	Hepatitis B
HFCWCS	High-Frequency Chest Wall Compression System
HFCWO	High-Frequency Chest Wall Oscillation
HHA	Home Health Aide
HHS	(United States Department of) Health and Human Services
HHSC	(Texas) Health and Human Services Commission
HHSN	Home Health Skilled Nursing
HIC	Health Insurance Claim (Number)
HIPAA	*Health Insurance Portability and Accountability Act*
HIPP	Health Insurance Premium Payment
HIV	Human Immunodeficiency Virus
HLD	Handicapping Labio-Lingual Deviations
HLH	Hemophagocytic Lymphohistiocytosis
HMO	Health Maintenance Organization
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HNS	Hypoglossal Nerve Stimulator
HPC	Hematopoietic Progenitor Cell
HPV	Human Papillomavirus
HRC	*Texas Human Resource Code*
HRSA	Health and Human Services Health Resources and Services Administration
HSC	*Texas Health and Safety Code*
HSCT	Hematopoietic Stem Cell Transplant or Transplantation
HSVT	Hemodynamically Significant Ventricular Tachycardia
HTLV	Human T-Lymphotropic Virus
HTW	Healthy Texas Women
IADL	Instrumental Activity of Daily Living
ICD	Implantable Cardiac Defibrillator

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Term	Definition
ICD-10-CM	*International Classification of Diseases*, Tenth Revision, Clinical Modification
ICD-10-PCS	*International Classification of Diseases*, Tenth Revision, Procedure Coding System
ICD-9-CM	*International Classification of Diseases*, Ninth Revision, Clinical Modification
ICF	Intermediate Care Facility (see also SNF and ECF)
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ICHP	Institute for Child Health Policy
ICN	Internal Control Number (in 24-digit Medicaid ICN)
ID	Identification
IDD	Intellectual or Developmental Disability
IDDM	Insulin Dependent Diabetes Mellitus
IDEA	*Individuals with Disabilities Education Act*
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
IIP	Implantable Infusion Pump
ILC	Interstitial Laser Coagulation
IM	Intramuscular
IMD	Institution for Mental Diseases
ImmTrac2	Immunization Tracking system
iMRI	Intraoperative MRI
IOL	Intraocular Lens
IONM	Intraoperative Neurophysiology Monitoring
IPD	Intermittent Peritoneal Dialysis
IPIA	*Improper Payments Information Act* (of 2002)
IPPB	Intermittent Positive-Pressure Breathing
IPV	Inactivated Poliovirus
IPV	Intrapulmonary Percussive Ventilation
IRS	Internal Revenue Service
ISD	Independent School District
ISP	Internet Service Provider
ITP	Individual Transportation Participant
IUD	Intrauterine Device
IV	Intravenous
JCIH	Joint Committee on Infant Hearing
KAFO	Knee-Ankle-Foot Orthoses
KHC	Kidney Health Care
KUB	Kidneys, Ureters, Bladder
LaBA	Licensed Assistant Behavior Analyst
LAR	Legally Authorized Representative

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Term	Definition
LARC	Long-Acting Reversible Contraception
LASIK	Laser-Assisted in Situ Keratomileusis
LBA	Licensed Behavior Analyst
LBHA	Local Behavioral Health Authority
LCHHS	Licensed and Certified Home Health Services
LCSW	Licensed Clinical Social Worker
LDCT	Low Dose Computed Tomography
LDL	Low Density Lipoprotein
LEA	Local Education Agency
LHH	Licensed-only Home Health
LHHS	Licensed Home Health Services
LIDDA	Local Intellectual or Developmental Disability Authorities
LITT	Laser Interstitial Thermal Therapy
LM	Licensed Midwife
LMFT	Licensed Marriage and Family Therapist
LMHA	Local Mental Health Authority
LMS	Learning Management System
LPA	Licensed Psychological Associate
LPC	Licensed Professional Counselor
LPHA	Licensed Practitioner of the Healing Arts
LPN	Licensed Practical Nurse
LSSP	Licensed Specialist In School Psychology
LTC	Long Term Care
LTCH	Long Term Care Hospital
LVEF	Left-Ventricle Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAO	Medical Assistance Only
MAP	Medicare Advantage Plan
MAST	Multiple Antigen Simultaneous Test
MAST	Multiple Radioallergosorbent Test
MAT	Medication Assisted Treatment
MBCC	Medicaid for Breast and Cervical Cancer
MBI	Medicaid Buy-In
MBIC	Medicaid Buy-In for Children
MCO	Managed Care Organization
MCP	Monthly Capitation Payment
MD	Doctor of Medicine
MDCP	Medically Dependent Children Program
MDD	Major Depressive Disorder

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Term	Definition
MDS	Minimum Data Set
MEG	Magnetoencephalography
MFADS	Medicaid Fraud and Abuse Detection System
MFCU	Medicaid Fraud Control Unit
MH	Mental Health
MHR	Mental Health Rehabilitation
MHTCM	Mental Health Targeted Case Management
MIST	Minimally Invasive Therapy
MMPI	Minnesota Multiphasic Personality Inventory
MMWR	Morbidity and Mortality Weekly Report
MNC	Medically Needy Clearinghouse
MNP	Medically Needy Program
MPI	Medicaid Program Integrity
MPS	Mucopolysaccharidosis
MQMB	Medicaid Qualified Medicare Beneficiary
MRA	Magnetic Resonance Angiography
MRADL	Mobility Related Activities of Daily Living
MRAN	Medicare Remittance Advice Notice
MRE	Magnetic Resonance Elastography
MREP	Medicare Remit Easy Print
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MRT	Magnetic Resonance Technology
MSAFP	Maternal Serum Alpha-Fetoprotein
MSC	Maternity Service Clinic
MSLT	Multiple Sleep Latency Test
MSRP	Manufacturer's Suggested Retail Price
mt-sDNA	Multi-targeted Stool DNA
MTFCY	Medicaid For Transitioning Foster Care Youth
MTP	Medical Transportation Program
MUA	Medically Underserved Area
MUE	Medically Unlikely Edit
MUP	Medically Underserved Population
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NBS	Newborn Screen (Neonatal Screen)
NCCI	National Correct Coding Initiative
NCS	Nerve Conduction Studies
NCVIA	*National Childhood Vaccine Injury Act*
NDC	National Drug Code
NDD-CKD	Non-Dialysis-Dependent Chronic Kidney Disease

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Term	Definition
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	Nasogastric
NIC	National Interpreter Certificate
NIPS	Noninvasive Prenatal Screening
NMDP	National Marrow Donor Program
NMES	Neuromuscular Electrical Stimulation
NMIBC	Non-Muscle Invasive Bladder Cancer
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPWT	Negative Pressure Wound Therapy
NSAID	Nonsteroidal Anti-inflammatory Drugs
NSTEMI	Non-ST Elevated Myocardial Infarction
NUCC	National Uniform Claim Committee
OAE	Otoacoustic Emissions
OB	Obstetrics
OB-GYN	Obstetric and Gynecology
OBOT	Office-Based Opioid Treatment
OBRA	*Omnibus Budget Reconciliation Act*
OCR	Office of Civil Rights
OD	Doctor of Optometry
OEFV	Oral Evaluation And Flouride Varnish
OFL	Online Fee Lookup
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMT	Osteopathic Manipulation Treatment
OOS	Out-Of-State
OPL	Online Provider Lookup
OPTN	Organ Procurement and Transportation Network
ORF	Outpatient Rehabilitation Facility
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy, Occupational Therapist
OTC	Over the Counter
OUD	Opioid Use Disorder
PA	Physician Assistant
PaCO2	Partial Pressure of Carbon Dioxide
PACT	Program for Amplification for Children of Texas (Hearing Aids/Services)
PAN	Prior Authorization Number

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Term	Definition
PaO2	Partial Pressure of Oxygen
PAPAW	Push-Rim Activated Power Assist Wheelchair
PASRR	Preadmission Screening and Resident Review
PBM	Pharmacy Benefit Manager
PCAF	Personal Care Assessment Form
PCCM	Primary Care Case Management (Program)
PCN	Patient Control Number
PCOS	Polycystic Ovarian Syndrome
PCS	Personal Care Services
PDA	Personal Digital Assistant
PDF	Portable Document Format
PDL	Preferred Drug List
PDN	Private Duty Nursing
PE	Presumptive Eligibility
PEDS	Parents' Evaluation Of Development Status
PEMS	Provider Enrollment And Management System
PENS	Percutaneous Electrical Nerve Stimulation
PERM	Payment Error Rate Measurement
PET	Positron Emission Tomography
PHC	Primary Home Care
PhD	Doctor of Philosophy
PHI	Protected Health Information
PIF	Provider Information Form
PIP	Personal Injury Protection
PLP	Provisionally Licensed Psychologist
PMD	Powered Mobility Device
POA	Present on Admission
POC	Plan of Care
POS	Place of Service
PPC	Potentially Preventable Complication
PPECC	Prescribed Pediatric Extended Care Center
PPO	Preferred Provider Organization
PPR	Potentially Preventable Readmissions
PPS	Prospective Payment System
PRK	Photorefractive Keratectomy
PRN	Pro Re Nata (As Needed)
PRO	Peer Review Organization
PSC	Pediatric Symptom Checklist
PSON	Practitioner Statement of Need
PT	Physical Therapy, Physical Therapist

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Term	Definition
PT/INR	Prothrombin Time/International Normalized Ratio
PTT	Partial Thromboplastin Time
PVC	Premature Ventricular Contractions
PVP	Photoselective Vaporization of the Prostate
QA	Quality Assurance
QC	Quality Control
QCC	Qualified Credentialed Counselor
QMB	Qualified Medicare Beneficiary
QMHP	Qualified Mental Health Professional
QMHP-CS	Qualified Mental Health Professional-Community Services
QPS	Qualified Peer Supervisor
QRP	Qualified Rehabilitation Professional
R&S	Remittance and Status Report
RAD	Respiratory Assist Devices
RARC	Remittance Advice Remarks Code
RAST	Radioallergosorbent Test
RBC	Red Blood Cell
RBRVS	Resource-Based Relative Value Scale
RBT	Registered Behavior Technician
RDC	Renal Dialysis Center
RDI	Respiratory Disturbance Index
REMS	Risk Evaluation and Mitigation Strategy
RESNA	Rehabilitation Engineering and Assistive Technology Society of North America
RGO	Reciprocating Gait Orthoses
RHC	Rural Health Clinic
RMTS	Random Moment Time Study
RN	Registered Nurse
RNA	Ribonucleic Acid
RR	Reference Range
RSDI	Retirement Survivors Disability Insurance
RSV	Respiratory Syncytial Virus
RV	Residual Volume
RVU	Relative Value Unit
S.B.	Senate Bill
SA	Service Area
SACH	Solid Ankle-Cushion Heel
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SC/SQ	Subcutaneous
SCHIP	State Children's Health Insurance Program

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Term	Definition
SCI	Spinal Cord Injury
SDA	Standard Dollar Amount
SHARS	School Health and Related Services
SID	Surface Identification
SIMV	Synchronized Intermittent Mandatory Ventilation
SLIAG	State Legalization Impact Assistance Grant
SLP	Speech-Language Pathology
SMPA	Special Medical Prior Authorization
SN	Skilled Nursing
SNF	Skilled Nursing Facility (see also ICF and ECF)
SNP	Special Needs Plan
SNS	Sacral Nerve Stimulator
SOC	Start of Care (concerning Home Health Services claims)
SQ	Subcutaneous
SRO	Service Responsibility Option
SRT	Speech Reception Threshold
SSA	Social Security Act or Administration
SSI	Supplemental Security Income (Program)
SSL	Secure Socket Layer
SSLC	State Supported Living Center
SSN	Social Security Number
SST	Specialized Skills Training
ST	Speech Therapy
STAR	State of Texas Access Reform (Program)
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
SVN	Small Volume Nebulizers
SVT	Supraventricular Tachycardia
SWYC	Survey of Well-Being of Young Children
TAC	*Texas Administrative Code*
TAHP	Texas Association of Health Plans
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TCM	Targeted Case Management
TDD	Telecommunications Device for the Deaf
TDLR	Texas Department of Licensing and Regulation
TE	Transient Elastography
TEA	Texas Education Agency
TEFRA	*Tax Equity and Fiscal Responsibility Act* (of 1982)
TEHDI	Texas Early Hearing Detection and Intervention

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Term	Definition
TENS	Transcutaneous Electrical Nerve Stimulation
TFC	Texas Family Code
THKAO	Thoracic-Hip-Knee-Ankle Orthoses
THSteps	Texas Health Steps
TICP	Transportation For Indigent Cancer Patients
TID	Tooth Identification Number
TIN	Tax Identification Number
TMHP	Texas Medicaid & Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TMRM	Texas Medicaid Reimbursement Methodology
TMRP	Texas Medical Review Program
TNC	Transportation Network Companies
TNF	Tumor Necrosis Factor
TOB	Type of Bill
TOS	Type of Service
TP	Type Program
TP/INR	Time/Internationalized Normalized Ration
TPL	Third Party Liability
TPN	Total Parenteral Nutrition
TPR	Third Party Resource
TRR	Texas Resilience and Recovery
TSB	Total Serum Bilirubin
TSBDE	Texas State Board of Dental Examiners
TSBEP	Texas State Board of Examiners of Psychologists
TSBP	Texas State Board of Pharmacy
TST	Tuberculin Skin Test
TTY	Teletypewriter
TUIP	Transurethral Incision of the Prostate
TUMT	Transurethral Microwave Thermotherapy
TUNA	Transurethral Needle Ablation
TURP	Transurethral Resection of the Prostate
TVFC	Texas Vaccines for Children (Program)
TWC	Texas Workforce Commission
TX CLPPP	Texas Childhood Lead Poisoning Prevention Program
TxHmL	Texas Home Living
UCB	University of California at Berkeley
UHMS	Undersea and Hyperbaric Medical Society
UM	Utilization Management
UNOS	United Network for Organ Sharing
UR	Utilization Review

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Term	Definition
USC	*United States Code*
USDA	United States Department of Agriculture
USN	Ultrasonic Nebulizers
USPSTF	U.S. Preventative Services Task Force
VA	Veterans Administration
VAERS	Vaccine Adverse Events Reporting System
VDP	Vendor Drug Program
VDRL	Venereal Disease Research Laboratory
VEMP	Vestibular Evoked Myogenic Potentials
VF	Ventricular Fibrillation
VIS	Vaccine Information Statement
VNS	Vagal Nerve Stimulator
VPN	Virtual Private Network
VRE	Vancomycin-Resistant Enterococci
VSU	Vital Statistics Unit
VV	Veno-Venous
WAIS-R	Wechsler Adult Intelligence Scale–Revised
WCD	Wearable Cardiac Defibrillator
WIC	Women, Infants, and Children (Program)
YES	Youth Empowerment Services

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Ambulance Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

November 2026

TEXAS
Health and Human Services

AMBULANCE SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for Texas Medicaid ambulance providers. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to emergency and nonemergency ambulance transports.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 5.1.8, "Prior Authorization for Nonemergency Ambulance Transport" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about nonemergency ambulance transport.

2 Ambulance Services

2.1 Enrollment

To enroll in Texas Medicaid, ambulance providers must operate according to the laws, regulations, and guidelines governing ambulance services under Medicare Part B; equip and operate under the appropriate rules, licensing, and regulations of the state in which they operate; acquire a license from the Texas Department of State Health Services (DSHS) approving equipment and training levels of the crew; and enroll in Medicare.

A hospital-operated ambulance provider must be enrolled as an ambulance provider and submit claims using the ambulance NPI and taxonomy code, not the hospital NPI and taxonomy code.

Refer to: Subsection 2.4.3, "Medicare and Medicaid Coverage" in this handbook.

Note: *Air ambulance providers are not required to enroll in Medicare.*

Reminder: *When ambulance providers enroll in Texas Medicaid, they accept Medicaid payment as payment in full. They cannot bill clients for Texas Medicaid-covered benefits.*

2.1.1 Subscription Plans

The Texas Insurance Code does not apply to ambulance providers who finance, in part or in whole, an ambulance service by subscription plan. DSHS's license requirements do not permit providers of membership or subscription programs to enroll Medicaid clients. Emergency Medical Services (EMS) Subscription Programs are regulated by the DSHS-EMS Compliance Group. An EMS provider must have specific approval to operate a subscription program.

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For more information, providers should contact the DSHS Office of EMS/Trauma Systems Coordination at 1-512-834-6700. A list of EMS office and contact information is available at http://dshs.texas.gov/emstraumasystems/contact.shtm.

2.2 Services, Benefits, Limitations, and Prior Authorization

Emergency and nonemergency ambulance transport services are a benefit of Texas Medicaid when the client meets the definition of emergency medical condition or meets the requirements for nonemergency transport.

Cardiopulmonary resuscitation (CPR) is included in ambulance transport when needed and is not a separately billable service. Claims for CPR during transport will be denied. If CPR is performed during a nonemergency transport, the advanced life support (ALS) procedure code must be billed.

Reimbursement for disposable supplies is separate from the established global fee for ambulance transports and is limited to one billable code per trip.

Providers must calculate the number of miles traveled by using the ambulance vehicle odometer reading or an Internet mapping tool. Mileage reported on the claim must be the actual number of miles traveled.

Procedure codes for ground ambulance transports (A0426, A0428, A0433, A0434, and A0999) must be submitted with mileage procedure code A0425. Emergency ground ambulance transports (procedure codes A0427 and A0429) may be billed without mileage code A0425 for Emergency Triage, Treat, and Transport (ET3) and Treatment in Place (TIP) services. Ambulance providers must include TIP destination modifier W in the destination position of the origin/destination modifier combination.

Medical necessity and coverage of ambulance services are not based solely on the presence of a specific diagnosis. Medicaid payment for ambulance transportation may be made only for those clients whose condition at the time of transport is such that ambulance transportation is medically necessary. For example, it is insufficient that a client merely has a diagnosis such as pneumonia, stroke, or fracture to justify ambulance transportation. In each of those instances, the condition of the client must be such that transportation by any other means is medically contraindicated. In the case of ambulance transportation, the condition necessitating transportation is often an accident or injury that has occurred giving rise to a clinical suspicion that a specific condition exists (for instance, fractures may be strongly suspected based on clinical examination and history of a specific injury).

It is the requesting provider's responsibility to supply the contractor with information describing the condition of the client that necessitated ambulance transportation. Medicaid recognizes the limitations of ambulance personnel in establishing a diagnosis, and recognizes therefore, that diagnosis coding of a client's condition using *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM) codes when reporting ambulance services may be less specific than those reported by other professional providers. Providers who submit diagnosis codes must choose the code that best describes the client's condition at the time of transport. As a reminder to providers of ambulance services, "rule out" or "suspected" diagnoses must not be reported using specific ICD-10-CM codes. In such instances where a diagnosis is not confirmed, it is correct to use a symptom, finding, or injury code.

The ambulance provider may be sanctioned, including nonparticipation in the Medicaid Title XIX programs, for completing or signing a claim form that includes false or misleading representations of the client's condition or the medical necessity of the transport.

The inpatient hospital stay benefit includes medically necessary emergency and nonemergency ambulance transportation of the client during an inpatient hospital stay.

Ambulance transport during a client's inpatient stay will not be reimbursed to the ambulance provider. One-time ambulance transports that occur immediately after the client's discharge may be considered for reimbursement.

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2.2.1 Emergency Ambulance Transport Services

Emergency ambulance transport is covered in emergent situations in which specially equipped ambulance transportation is required to safely manage the client's medical condition. Emergency transportation may be initiated by an emergency response system 9-1-1 call, fire, police, or other locally established system for medical emergency calls. At the time of the call, emergency teams are required to respond; however, upon arrival on the scene, the services required at that time (based on field evaluation by the emergency team) may be determined to be:

- Emergent, or
- Non-emergent but medically necessary.

An emergency ambulance transport service is a benefit when the client has an emergency medical condition. An emergency medical condition is defined, according to 1 TAC §354.1111, as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance use) such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

- Placing the client's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

An emergency behavioral health condition is defined as any condition that, in the opinion of a prudent layperson with an average knowledge of health and medicine, requires immediate intervention or medical attention regardless of the nature, without which the client would present an immediate danger to himself, or herself or others, or that renders the client incapable of controlling, knowing, or understanding the consequences of his or her actions.

Emergency transports are to be to the nearest medical facility that is equipped to provide medical care for the illness or injury of the client. An appropriate facility includes the equipment, personnel, and capability to provide the services necessary to support the required medical care.

Facility-to-facility transports may be considered an emergency if emergency treatment is not available at the first facility and the client still requires emergency care. When an emergency transport is made to a facility other than the nearest appropriate facility and the type of transport is medically necessary, reimbursement for mileage is limited to the amount that would be reimbursed to transport to an appropriate facility.

All other facility-to-facility transport is considered nonemergent and will require prior authorization.

Transports to out-of-locality providers (one-way transfers of 50 or more miles from the point of pickup to the point of destination) are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility.

When there are two responders to an emergency, the company that transports the client will be reimbursed for their services.

2.2.1.1 Prior Authorization for Emergency Out-of-State Transport

All emergency out-of-state (air, ground, and water) transports require authorization before the transport is considered for payment.

Prior authorization for emergency transport is required for out-of-state providers with the exception of those providers located within 200 miles of the Texas border.

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Refer to: Subsection 2.6, "Out-of-State Medicaid Providers" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for additional information on providers who are not considered out-of-state providers.

To initiate the prior authorization process, providers must call 1-800-540-0694.

Texas Medicaid & Healthcare Partnership (TMHP) is responsible for processing prior authorization requests for all Medicaid clients.

2.2.2 Emergency Triage, Treat, and Transport (ET3)

Emergency Triage, Treat, and Transport (ET3) services are designed to allow greater flexibility for Medicaid-enrolled ambulance providers to address clients' health-care needs following a 9-1-1 call, fire, police, or other locally established system for emergency calls. ET3 permits emergency transportation (ground ambulance) providers to:

- Transport a client to an alternative destination, other than an emergency department; or
- Initiate and facilitate appropriate treatment in place (TIP) at the scene; or
- Initiate and facilitate appropriate TIP through telemedicine or telehealth.

2.2.2.1 Transport to an Alternative Destination

An ambulance provider may transport a client to an alternative destination (such as an urgent care clinic, mental health center, FQHC, etc.) when upon evaluation the following requirements apply:

- The client's condition is determined to be non-emergent but requires medical attention.
- An alternative destination will meet the client's level of care more appropriately than an emergency department.
- There is no other appropriate transportation available.

The alternative destination must be within or near the responding emergency transportation provider's service area.

Prior to initiating ET3 transport to an alternative destination, the provider must have pre-established arrangements with alternative destination partners within their region, and have knowledge of the alternative destination's:

- Hours of operation.
- Clinical staff available.
- Services provided.

HHSC expects ambulance providers to use best practices and exercise their normal standard of care to determine the nearest, most appropriate alternative destination for a client.

2.2.2.2 Treatment in Place (TIP)

Upon the emergency response team's arrival to the scene and their evaluation of the client, if the services required at that time are determined to be medically necessary but not emergent, ambulance staff may provide treatment to the client under the supervision of a physician, such as the medical director of the ambulance company, or under the supervision of a qualified health care professional, such as a physician assistant or advanced practice registered nurse contracted by the ambulance company. Ambulance staff must provide TIP in accordance with their emergency transport service's medical direction and established protocols.

Treatment on scene may also be performed, when medically necessary, through a telemedicine or telehealth visit performed in accordance with telemedicine and telehealth services requirements outlined in the *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)*.

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Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for telehealth and telemedicine services requirements.

2.2.3 Nonemergency Ambulance Transport Services

According to 1 TAC §354.1111, nonemergency transport is defined as a transport provided by an ambulance provider for a Medicaid recipient to or from a scheduled medical appointment, to or from another licensed facility for treatment, or to the recipient's home after discharge from a hospital. Nonemergency transport is appropriate when the Medicaid recipient's medical condition is such that the use of an ambulance is medically required, e.g., bed confinement, and alternate means of transport are medically contraindicated.

Note: *In this circumstance, contraindicated means that the client cannot be transported by any other means from the origin to the destination without endangering the individual's health.*

According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

Providers requesting prior authorization must document whether the client is currently an inpatient in a hospital when requesting prior authorization. Prior authorization will not be approved if the provider indicates the client is currently an inpatient in a hospital, except for one-time transports immediately after the client's discharge from the hospital.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Medical necessity must be established through prior authorization for all nonemergency ambulance transports. Retrospective reviews may be performed to ensure that documentation supports the medical necessity of the transport.

Clients who do not meet medical necessity requirements for nonemergency ambulance transport may be able to receive transport through the Medical Transportation Program (MTP).

Transports must be limited to those situations where the transportation of the client is less costly than bringing the service to the client.

For nonemergency ambulance transportation services rendered to a client, ambulance providers may coordinate the nonemergency ambulance prior authorization request between the requesting provider, which may include a physician, nursing facility, healthcare provider, or other responsible party. Ambulance providers may assist in providing necessary information such as their National Provider Identifier (NPI) number, fax number, and business address to the requesting provider. However, the Non-emergency Ambulance Prior Authorization Request form must be signed, dated, and submitted by the Medicaid-enrolled requesting provider, not the ambulance provider.

Refer to: Subsection 5.1.8, "Prior Authorization for Nonemergency Ambulance Transport" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about nonemergency ambulance transport prior authorization requests and appeals.

The *Medical Transportation Program Handbook* (*Vol. 2, Provider Handbooks*) for more information about the Medical Transportation Program.

2.2.4 Levels of Service

Levels of services as defined by Texas Medicaid:

- Basic Life Support (BLS) is emergency care that uses noninvasive medical acts and, if allowed by licensing jurisdiction, may include the establishment of a peripheral intravenous (IV) line.

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- Advanced Life Support (ALS) is emergency care that uses invasive medical acts. For Medicaid purposes only, ALS services are divided into two categories, Level 1 and Level 2.
  - Level 1 ALS includes an ALS assessment or at least an ALS intervention.
  - Level 2 ALS includes either of the following:
    - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids); or
    - At least one of the ALS 2 procedures: manual defibrillation/cardioversion; endotracheal intubation; central venous line; cardiac pacing; chest decompression; surgical airway; or intra-osseous line.

2.2.5 Oxygen

Reimbursement for oxygen (procedure code A0422) is limited to one billable code per transport.

2.2.6 Types of Transport

2.2.6.1 Multiple Client Transports

Multiple client transports occur when more than one client with Medicaid coverage is transported simultaneously in the same vehicle. A claim for each client must be billed with the transport procedure code and the mileage procedure code with the GM modifier that indicates multiple client transport. Claims must include the names and Medicaid numbers of other Texas Medicaid clients who shared the transfer, or indicate "Not a Medicaid client" in Block 19 of the CMS 1500 paper form. Providers must enter charges on a separate claim for each client. TMHP adjusts the payment to 80 percent of the allowable base rate for each claim and divides mileage equally among the clients who share the ambulance.

Refer to: Subsection 6.4, "Claims Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

2.2.6.2 Air or Water Specialized Emergency Medical Services Vehicle Transports

Air ambulance transport services, by means of either fixed or rotary wing aircraft, and other specialized emergency medical services vehicles may be covered only if one of the following conditions exists:

- The client's medical condition requires immediate and rapid ambulance transportation that could not have been provided by standard automotive ground ambulance.
- The point of client pick up is inaccessible by standard automotive ground vehicle.
- Great distances or other obstacles are involved in transporting the client to the nearest appropriate facility.

Claims for air ambulance transports procedure codes A0430 and A0431 must be submitted with the corresponding air mileage procedure code A0435 or A0436. Specialized emergency medical services vehicles (i.e., boat or airboat) must be billed using unlisted ambulance service (procedure code A0999).

2.2.6.3 Specialty Care Transport (SCT)

SCT (procedure code A0434) is the interfacility transport of a critically injured or ill client by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the emergency medical technician (EMT) or paramedic. SCT is necessary when a client's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical-care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

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2.2.6.4 Transports for Pregnancies

Transporting a pregnant woman may be covered as an emergency transfer if the client's condition is documented as an emergency situation at the time of transfer.

Claims documenting an emergency home delivery or delivery en route are considered emergency transfers. Premature labor and early onset of delivery (less than 37 weeks gestation) may also be considered an emergency. Active labor without more documentation of an emergency situation is not payable as an emergency transport.

If the pregnant client is transported in an ambulance for a nonemergency situation, all criteria for nonemergency prior authorization must be met.

2.2.6.5 Transports to or from Prescribed Pediatric Extended Care Centers (PPECC)

Nonemergency ambulance transports between a client's home and a PPECC are not covered.

2.2.6.6 Transports to or from State Institutions

Ambulance transports to or from a state-funded hospital for admission or following discharge are covered when nonemergency transfer criteria are met. Ambulance transfers of clients while they are inpatients of the institution are not covered. The institution is responsible for routine nonemergency transportation.

2.2.6.7 Not Medically Necessary Transports

Providers must use the GY modifier to submit claims for instances when the provider is aware no medical necessity existed. When billing for this type of transportation, ambulance providers must maintain a signed Client Acknowledgment Statement indicating that the client was aware, prior to service rendered, that the transport was not medically necessary. The Client Acknowledgment Statement is subject to retrospective review.

Claims submitted with a GY modifier indicating no medical necessity existed for transport will automatically deny and will not be suspended for additional documentation. The ambulance provider must maintain a waiver, signed by the client, indicating that the client was instructed prior to the transport that there was no medical necessity for the transport and that the client agreed to provide reimbursement for the services if reimbursement for the transport is denied by Texas Medicaid. A signed waiver from the client is subject to retrospective review.

Refer to: Subsection 1.7.12.1, "Client Acknowledgment Statement" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2.6.8 Transports for Nursing Facility Residents

Nursing facilities are responsible for providing or arranging transportation for their residents. Arranging transportation for Medicaid clients includes obtaining prior authorizations for nonemergency ambulance transports. The Non-emergency Ambulance Prior Authorization Request form must be filled out and submitted to TMHP by the facility or the physician's staff that is most familiar with the client's condition. The ambulance provider must not assist in completing or submitting any portion of this form.

Transports from a nursing facility to a hospital are covered if the client's condition meets emergency criteria.

A return trip to a nursing facility following an emergency transport is not considered routine; therefore, transport back to the facility must be requested by the discharging hospital. Nonemergency transport for the purpose of required diagnostic or treatment procedures that are not available in the nursing facility (such as dialysis treatments at a freestanding facility) is allowable only for clients whose medical condition is such that the use of an ambulance is the only appropriate means of transport (e.g., alternate means of transport are medically contraindicated).

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The cost of routine nonemergency transportation is included in the nursing facility vendor rate. This nonemergency transport requires the nursing facility to request and obtain a Prior Authorization Number (PAN) from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Transports of nursing facility residents to outpatient departments or to physicians' offices for recertification or examinations for rehabilitative treatment (i.e., physical therapy) are not reimbursable ambulance services. The cost of such transportation is included in the nursing facility vendor rate.

Claims for services to nursing facility residents must indicate the medical diagnosis or problem requiring treatment, the medical necessity for use of an ambulance for the transport, and the type of treatment rendered at the destination (e.g., admission or X-ray).

If a client is returned by ambulance to a nursing facility following inpatient hospitalization, the acute condition requiring hospitalization must be noted on the ambulance claim form. This transport is considered for payment only if the client's medical condition is appropriate for transport by ambulance. This nonemergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Ambulance providers may bill a nursing facility or client for a nonemergency ambulance transport only under the following circumstances:

- *Providers may bill the nursing facility* when the nursing facility requests the nonemergency ambulance transport without a PAN.
- *Providers may bill the client* only when the client requests transport that is not an emergency and the client does not have a medical condition such that the use of an ambulance is the only appropriate means of transport (i.e., alternate means of transport are medically contraindicated). The provider must advise the client of acceptance as a private pay patient at the time the service is provided, and the client is responsible for payment of all services. Providers are encouraged to have the client sign the Private Pay Agreement.

Providers may refer questions about a nursing facility's responsibility for payment of a transport to the TMHP Contact Center at 1-800-925-9126 or TMHP provider relations representatives.

2.2.6.9 Emergency Transports Involving a Hospital

Hospital-to-hospital transports that meet the definition of an emergency transport do not require prior authorization.

Providers must use modifier ET and one of the facility-to-facility transfer modifiers (HH, HI, or IH) on each procedure code listed on the claim.

Modifier	Transport Type
HH	From hospital to hospital
HI	From hospital to site of transfer
IH	From site of transfer to hospital

2.2.6.10 No Transport

Texas Medicaid reimburses ambulance providers for ground emergency transports (procedure codes A0427 and A0429) that do not result in a transport to a facility only as part of ET3 services when the destination modifier is W, indicating TIP is included on the claim. For all other transports, if a client contacts an ambulance provider, but the call does not result in a transport, the provider should have the client sign an acknowledgment statement and may bill the client for services rendered.

Texas Medicaid will not reimburse for the return trip of an empty ambulance. Texas Medicaid will not reimburse air or ground mileage when the client is not on board the ambulance.

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2.3 Documentation Requirements

The requesting provider, which may include a physician, nursing facility, health-care provider, or other responsible party, is required to maintain the supporting documentation, physician's orders, the Non-emergency Ambulance Prior Authorization Request form and if applicable, the Non-emergency Ambulance Exception form.

The requesting provider (i.e., physician, nursing facility, healthcare provider, or other responsible party) must contact the transporting ambulance provider with the PAN and the dates of service that were approved. The transporting ambulance provider will submit claims for the nonemergency ambulance transportation services, using the approved PAN provided by the requesting provider.

An ambulance provider is required to maintain documentation that represents the client's medical condition and other clinical information to substantiate medical necessity, the level of service, and the mode of transportation requested. This supporting documentation is limited to documents developed or maintained by the ambulance provider.

When physical restraints are needed, documentation must include, but is not limited to, the following:

- Type of restraint
- Time frame of the use of the restraint
- Client's condition

Note: *The standard straps used in an ambulance transport are not considered a restraint.*

Physicians, nursing facilities, health-care providers, or other responsible parties are required to maintain physician orders related to requests for prior authorization of nonemergency and out-of-state ambulance services. These providers must also maintain documentation of medical necessity for the ambulance transport.

In hospital-to-hospital transports or hospital-to-outpatient medical facility transports, the TMHP Ambulance Unit considers information by telephone from the transferring hospital. Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the transferring hospital fax the supporting documentation. Hospitals are allowed to release a client's protected health information (PHI) to a transporting emergency medical services provider for treatment, payment, and health-care operations.

Providers must document whether the client is currently an inpatient in a hospital when requesting prior authorization. Prior authorization will not be approved if the provider indicates the client is currently an inpatient in a hospital, except for one-time transports immediately after the client's discharge from the hospital.

The hospital must maintain documentation of medical necessity, including a copy of the authorization from TMHP in the client's medical record for any item or service that requires prior authorization. The services provided must be clearly documented in the medical record with all pertinent information regarding the client's condition to substantiate the need and medical necessity for the services.

2.3.1 Medicaid Surety Bond Requirements

Ambulance providers attempting to renew their Emergency Medical Services (EMS) license must submit a surety bond to TMHP for each license they are attempting to renew. A copy of the surety bond must also be attached to an application for renewal of an EMS license when submitted to DSHS.

Refer to: Subsection 1.1.6, "Surety Bond Enrollment Requirement" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information.

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2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Emergency and nonemergency claims may be billed electronically. For electronic billers, the hospital's NPI must be entered in the Facility ID field. Providers should consult their software vendor for the location of this field on the electronic claim form.

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 the Texas Medicaid medical policy are no longer valid.

The CMS NCCI and MUE guidelines can be found in the NCCI web page, which are available on the CMS website. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

2.4.2 Reimbursement

Ground and air ambulance providers are reimbursed based on the lesser of a provider's billed charges or the maximum fee established by the Texas Health and Human Services Commission (HHSC) in accordance with 1 TAC §355.8600. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement methodologies.

Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for information on Medicaid exclusions.

2.4.2.1 Ambulance Disposable Supplies

Ambulance disposable supplies are included in the global fee for specialty care transport and must not be billed separately.

Reimbursement for BLS or ALS disposable supplies (procedure codes A0382 and A0398 respectively) is separate from the established fee for ALS and BLS ambulance transports and is limited to one billable procedure code per transport.

Claims submitted for BLS supplies (procedure code A0382) will be denied unless a corresponding BLS transport is billed on the same claim.

Claims for ALS supplies (procedure code A0398) will be denied unless a corresponding ALS transport is billed on the same claim.

Equipment and nondisposable supplies are included in the base rate. These items are not separately reimbursable and are considered part of another procedure. Therefore, equipment and supplies cannot be billed to the client.

2.4.2.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

The three-day and one-day payment window reimbursement guidelines do not apply for ambulance services.

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Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2.4.3 Medicare and Medicaid Coverage

All ambulance claims are exempt from Medicare equalization, which pays the lesser of the coinsurance and deductible or the remainder of the amount that Medicaid would have paid for the same service minus what Medicare has already paid on Medicare crossover claims.

Ambulance providers can include copayment amounts as coinsurance for non-contracted Medicare Part C clients on dual eligible claims submitted to TMHP. Providers do not have to bill Medicare copay procedure codes to TMHP for ambulance services.

All claims for ambulance services provided to dual-eligible clients are reimbursed the full amount of the Medicare coinsurance and deductible for Part B claims and Part C claims from non-contracted Medicare Advantage Plans.

Medicaid prior authorization is not required for ambulance services for Qualified Medicare Beneficiary (QMB) clients because QMB clients are not eligible for Medicaid benefits. Providers can contact Medicare for the Medicare prior authorization guidelines.

Medicaid Qualified Medicare Beneficiary (MQMB) clients are eligible for all Medicaid benefits; therefore, the provider should simultaneously request prior authorization for the nonemergency transport from TMHP for the MQMB client in the event the service requested is denied by Medicare as a non-covered service.

Refer to: Subsection 4.9, "Medicare and Medicaid Dual Eligibility" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for additional information about Medicare coinsurance and deductible payments and exceptions.

2.4.3.1 Medicare Services Paid

Assigned claims filed with and paid by Medicare should automatically transfer to TMHP for payment of the deductible and coinsurance liability. According to current guidelines, providers must submit Medicare-paid claims that do not cross over to TMHP for the coinsurance and deductible. Providers must send the Medicare Remittance Advice Notice (MRAN) with the client information circled in black ink.

2.4.3.2 Medicare Services Denied

A Medicare ambulance claim that has been denied must go through the appropriate Medicare claim appeals process with a decision by the administrative law judge before TMHP will process the ambulance claim. MQMB ambulance claims that have exhausted the Medicare third level of appeal by the administrative law judge (ALJ) must be submitted to TMHP with the disposition letter from the ALJ along with all other required documents for an appeal.

An assigned claim that was denied by Medicare because the client has no Part B benefits or because the transport destination is not allowed can be submitted to TMHP for consideration. Providers must send claims to TMHP on a CMS-1500 paper claim form with the ambulance NPI and taxonomy code, unless they are a hospital-based provider. Hospital-based ambulance providers must send Medicare denied claims to TMHP on a CMS-1500 paper claim form with the ambulance NPI and taxonomy code and a copy of the MRAN.

Note: *All claims for STAR+PLUS clients with Medicare and Medicaid must follow the same requirements used for obtaining prior authorization for Medicaid-only services from TMHP. The STAR+PLUS HMO is not responsible for reimbursement of these services.*

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2.4.4 Ambulance Claims Coding

Providers must submit claims for emergency and ET3 transports with the ET modifier on each procedure code submitted. Any procedure code submitted on the claim for emergency and ET3 transports without the ET modifier will be subject to prior authorization requirements.

2.4.4.1 Place of Service Codes

The place of service (POS) for all ambulance transports is considered the destination.

POS codes 41 and 42 (other) are national POS codes that are accepted by Texas Medicaid only for electronic claims. POS code 9 is accepted by Texas Medicaid for ambulance claims submitted on paper.

2.4.4.2 Origin and Destination Codes

All claims submitted on paper or electronically must include the two-character origin and destination codes for every claim line. The origin is the first character, and the destination is the second character.

The following are the origin and destination codes accepted by Texas Medicaid:

Origin and Destination Code	Description
D	Diagnostic or therapeutic site/freestanding facility (e.g., radiation therapy center) other than P or H
E	Residential/domiciliary/custodial facility (e.g., nonskilled facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital (e.g., inpatient or outpatient)
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled Nursing Facility (SNF) (swingbed is considered an SNF)
P	Physician's office
R	Residence (client's home or any residence)
S	Scene of accident or acute event
X	Intermediate stop at physician's office in route to the hospital (destination code only)

The following are the ET3 Alternative Destinations and Treatment in Place Codes codes accepted by Texas Medicaid:

Destination	Description
C	Community Mental Health Center (including Substance Use Disorder Center)
F	Federally Qualified Health Center
O	Physician's office
U	Urgent care facility
W	Treatment in Place (in person or via telehealth)

Nonemergency claims filed electronically must include the PAN in the appropriate field. For nonemergency hospital-to-hospital transfers, indicate the services required from the second facility and unavailable at the first facility in Block 19 of the CMS-1500 paper claim form. If the destination is a hospital, enter the name and address and the NPI of the facility in Block 32.

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For nonemergency transports, ambulance providers must enter the ICD-10-CM diagnosis code to the highest level of specificity available for each diagnosis observed in Block 21 of the claim form.

Reminder: *Providers must submit multiple transports for the same client on the same date of service through one claim submission. Additional claims information can be found within individual topics in this section.*

Providers should consult their software vendor for the location of the field on the electronic claim form. Providers must submit ambulance services to TMHP on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from a vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.5 Air or Specialized Vehicle Transports

Procedure codes A0430 and A0435, or A0431 and A0436 are used to bill air transport. Procedure code A0999 is used to bill for specialized vehicle transports (i.e., boat and airboat). Transport claims may be submitted electronically with a short description of the client's physical condition in the comment field. If the client's condition cannot be documented, providers must file a paper claim with supporting documentation.

Refer to: Subsection 2.2.6.2, "Air or Water Specialized Emergency Medical Services Vehicle Transports" in this handbook for more information about how to meet the specific criteria for reimbursement consideration for air or specialized transport claims.

2.4.6 Emergency Transport Billing

Emergency transport is a benefit when billed with the ET modifier and the most appropriate emergency medical condition codes. The ET modifier is required for every detail on an emergency transport claim, but is not required to be listed in the first position on the claim line.

The following procedure codes are for emergency transport:

Procedure Codes									
A0382	A0398	A0422	A0424	A0425*	A0427	A0429	A0430	A0431	A0433
A0434	A0435	A0436	A0999	G2022	Q3014				
***A0425 is denied if it is billed without procedure code A0427, A0429, A0433, or A0434.**									

One of the following emergency medical condition code is required on all emergency ambulance claims and must be listed in Box 21 of the CMS-1500 claim form:

Emergency Medical Condition Codes							
B9689	B999	D75A	D8130	D8131	D8132	D8139	E869
F068	F10929	F19939	F29	G4489	G8929	H579	H814
I2693	I2694	I4811	I4819	I4820	I4821	I469	I499

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Emergency Medical Condition Codes							
I80241	I80242	I80243	I80249	I80251	I80252	I80253	I80259
I82451	I82452	I82453	I82459	I82461	I82462	I82463	I82469
J9600	J984	M549	O2690	Q7960	Q7961	Q7962	Q7963
Q7969	R002	R0602	R0603	R0689	R079	R092	R0989
R100	R109	R238	R4182	R4189	R4589	R509	R52
R55	R569	R58	R6889	R7309	S02121A	S02121B	S02121S
S02122A	S02122B	S02122S	S02129A	S02129B	S02129S	S02831A	S02831B
S02831S	S02832A	S02832B	S02832S	S02839A	S02839B	S02839S	S02841A
S02841B	S02841S	S02842A	S02842B	S02842S	S02849A	S02849B	S02849S
S0285XA	S0285XB	S0285XS	S0590XA	T07XXXA	T148XXA	T1490XA	T1491XA
T17300A	T25739S	T300	T50904A	T50911A	T50911S	T50912A	T50912S
T50913A	T50913S	T50914A	T50914S	T50915A	T50915S	T50916A	T50916S
T59891A	T5994XA	T6701XA	T6701XS	T6702XA	T6702XS	T6709XA	T6709XS
T672XXA	T675XXA	T68XXXA	T699XXA	T7500XA	T751XXA	T754XXA	T782XXA
T7840XA	T8189XA	T82519A	T887XXA	Y35009A	Y35009S	Y35019A	Y35019S
Y35029A	Y35029S	Y35039A	Y35039S	Y35049A	Y35049S	Y35099A	Y35099S
Y35109A	Y35109S	Y35119A	Y35119S	Y35129A	Y35129S	Y35199A	Y35199S
Y35209A	Y35209S	Y35219A	Y35219S	Y35299A	Y35299S	Y35309A	Y35309S
Y35319A	Y35319S	Y35399A	Y35399S	Y35409A	Y35409S	Y35419A	Y35419S
Y35499A	Y35499S	Y35819A	Y35819S	Y35831A	Y35831S	Y35832A	Y35832S
Y35833A	Y35833S	Y35839A	Y35839S	Y3599XA	Y3599XS	Y710	Y828
Z209	Z7401	Z779	Z9181	Z9981	Z9989		

While ICD-10-CM codes are not precluded from use on ambulance claims, they are currently not required (per the Health Insurance Portability and Accountability Act [HIPAA] of 1996) on most ambulance claims and the use of these codes generally does not trigger a payment or a denial of a claim.

Claims for emergency transports that are denied for not meeting the emergency criteria will be considered on appeal with additional documentation to support the emergency nature of the transport. Claims that have denied for not meeting emergency transport criteria cannot be appealed for reimbursement as a nonemergency claim.

Refer to: Subsection 2.2.1, "Emergency Ambulance Transport Services" in this handbook.

2.4.7 Emergency Triage Services Billing

To bill for ET3 services, a provider must:

- Be enrolled in Texas-Medicaid as an ambulance provider.
- Be responding to a call initiated by an emergency response system (9-1-1 call, fire, police, or other locally established system for medical emergency calls).
- Upon arrival at the scene, the emergency team's field evaluation determines the client's needs are non-emergent but require medical attention.
- Follow all requirements as outlined in section 2.2, Services, Benefits, Limitations, and Prior Authorization.

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2.4.7.1 Transport to an Alternative Destination Billing

For transport to an alternative destination reimbursement, providers must bill using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, and the appropriate destination modifier. Providers may also include the mileage code (A0425) in the claim as appropriate.

Note: *If an emergency transportation provider transports a client to an alternative destination and determines at the time that the site is either closed, or unable to provide the needed level of care, then the emergency transportation provider shall transport the client to the nearest emergency department. In these cases, the provider may not bill for two transports.*

2.4.7.2 Treatment in Place Billing

Treatment in place (TIP) is classified as an emergency transportation service and must be billed using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, and the W destination modifier to indicate TIP.

Claims must include TIP destination modifier W in the destination position of the origin/destination modifier combination. TIP claims without modifier W in the emergency indicator field will be denied.

The medical services provided under the supervision of a physician, such as the medical director of the ambulance company or a health care professional, must be billed separately with the appropriate codes by the physician or health care professional who provides supervision of care on the scene. Ambulance providers may only bill for initiating or facilitating TIP using the corresponding emergency ground transport code (A0427 or A0429).

Supplies (procedure codes A0382 and A0398) and oxygen (procedure code A0422) are payable, but mileage (procedure code A0425) and other ambulance transportation services are not payable for TIP services. Claims billed with non-payable ambulance TIP services will be denied.

The following are valid Treatment in Place Ambulance Claim Origin/Destination Modifiers:

Codes	Origination Site	Destination
DW	Diagnostic or therapeutic site, or freestanding facility (e.g., radiation therapy center) other than H or P	TIP
EW	Residential, domiciliary, or custodial facility (unskilled facility)	TIP
JW	Nonhospital-based dialysis facility	TIP
PW	Physician's office	TIP
RW	Residence (client's home or any residence)	TIP
SW	Scene of accident or acute event	TIP

If a client being treated in place has a real-time deterioration in the clinical condition necessitating immediate transport to an emergency department, the ambulance provider must not bill for both treatment in place ambulance service and the transport to the emergency room. In this case, the ambulance provider must bill only for the emergency department transport.

For informational purposes, ambulance providers may include procedure code G2022 on ambulance transportation claims to an emergency department that met ET3 requirements, but the client refused TIP or transportation to an alternative destination.

When billing for TIP via telemedicine or telehealth, providers must bill using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, the W destination modifier to indicate TIP, and procedure code Q3014. Procedure code Q3014 will be informational only and used by Medicaid to identify TIP through telemedicine or telehealth services.

Multiple TIP and transport claims rendered on the same date of service for the same client will suspend for review.

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2.4.8 Nonemergency Transport Billing

The following procedure codes are used when billing for nonemergency ambulance services:

Procedure Codes									
A0382	A0398	A0420	A0422	A0424	A0425*	A0426	A0428	A0430	A0431
A0433	A0434	A0435	A0436						
***A0425 is denied if it is billed without procedure code A0426, A0428, A0433, or A0434.**									

2.4.9 Extra Attendant

The use of additional attendants (procedure code A0424) must be related to extraordinary circumstances when the basic crew is unable to transport the client safely.

An extra attendant must be certified by DSHS to provide emergency medical services.

Situations when an extra attendant may be required beyond the basic crew include, but are not limited to:

- Necessity of additional special medical equipment or treatment en route to destination (describe what special treatment and equipment is required and why it requires an attendant).
- Client behavior that may be a danger to self or ambulance crew or that requires, or may require, restraints.
- Extreme obesity of client (provide weight and client's functional limitations).
- The use of an extra attendant for air transport is not a benefit of Texas Medicaid. Claims submitted with procedure code A0424 will be denied if billed with air transports (procedure code A0430 or A0431).

2.4.9.1 Emergency Transports

Emergency transports that use an extra attendant do not require prior authorization. Modifier ET must be billed with the extra attendant procedure code A0424.

The billing provider's medical documentation must clearly indicate the services the attendant performed along with rationale for the services to indicate the medical necessity of having the attendant. The billing provider must keep the information that supports medical necessity in the client's medical record, which will be subject to retrospective review.

When more than one client is transported at the same time in the same vehicle, the use of an extra attendant may be required when each client who is being transported requires medical attention or close monitoring.

2.4.9.2 Nonemergency Transports

Prior authorization is required when an extra attendant is needed for any nonemergency transport. When a client's condition changes, such as a need for oxygen or an extra attendant for transport, the prior authorization request must be updated.

To receive prior authorization, the requesting provider must prove medical necessity and identify attendant services that could not be provided by the basic crew. The information supporting medical necessity must be kept in the requesting provider's medical record and is subject to retrospective review.

Texas Medicaid does not reimburse for an extra attendant based only on an ambulance provider's internal policy. Reimbursement for an extra attendant will be based on prior authorization requirements.

2.4.10 Night Call

Texas Medicaid does not reimburse an extra charge for a night call.

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2.4.11 Waiting Time

Procedure code A0420 may be billed when it is the general billing practice of local ambulance companies to charge for unusual waiting time (longer than 30 minutes). Providers must use the following procedures:

- Separate charges must be billed for all clients, Medicaid and non-Medicaid, for unusual waiting time.
- The circumstances requiring waiting time and the exact time involved must be documented in Block 24 of the CMS-1500 paper claim form.
- The amount charged for waiting time must not exceed the charge for a one-way transfer.

Important: *Waiting time is reimbursed up to one hour.*

2.4.12 Appeals

Only a denial of prior authorization may be appealed. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406. The Non-emergency Ambulance Prior Authorization Request form is not considered to be documentation after the service has been rendered.

Claims denied due to an inappropriate emergency medical condition code may be resubmitted with the appropriate emergency medical condition code.

On appeal, supporting documentation is critical for determining the client's condition at the time of transport. Ambulance providers who file paper claims must include all information that supports the reason for the transport and attach a copy of the run sheet to the claim. The EMT who transported the client must sign the documentation.

Refer to: Subsection 2.3, "Documentation Requirements" in this handbook.

Medicaid clients have the right to request a Fair Hearing within 90 days of the date of the denial action.

2.4.13 Relation of Service to Time of Death

Medicaid benefits cease at the time of the client's death. However, if the client dies in the ambulance while in route to the destination, Texas Medicaid covers the transport. If a physician pronounces a client dead after the ambulance is called, Texas Medicaid covers the ambulance service (base rate plus mileage) to the point of pick up. Providers must indicate the date and time the client died in Block 19 of the CMS-1500 paper claim form. If a physician or coroner pronounces the client dead before the ambulance is called, the service is not covered.

2.5 Claims Resources

Providers may refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

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Resource	Location
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

2.6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

3 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Non-emergency Ambulance Prior Authorization Request

4 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Ambulance Non-emergency Transport
Ambulance Emergency Transport from Residence to Hospital
Ambulance Emergency Transport from Scene of Accident to Hospital

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Behavioral Health and Case Management Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

November 2026

TEXAS
Health and Human Services

BEHAVIORAL HEALTH AND CASE MANAGEMENT SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for the Case Management for the Blind Children's Vocational Discovery and Development Program (BCVDDP), Case Management for Children and Pregnant Women, and services provided by a licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), psychologist, physician, advanced practice registered nurse (APRN), physician assistant (PA), or providers of intellectual and developmental disability (IDD) case management, mental health targeted case management, and mental health rehabilitative services.

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.7.1.2, "Reporting Child Abuse or Neglect" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) and subsection 1.7.1.5, "Training" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure to deliver, at all times, health-care items and services to Medicaid eligible persons in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Section 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

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2 Blind Children's Vocational Discovery and Development Program (BCVDDP)

2.1 Overview

BCVDDP services are provided to help children who are blind and visually impaired to develop their individual potential. This program offers a wide range of services that are tailored to each child and their family's needs and circumstances. By working directly with the entire family, this program can help children develop the concepts and skills needed to realize their full potential.

BCVDDP services include the following:

- Assisting the child in developing the confidence and competence needed to be an active part of their community
- Providing support and training to children in understanding their rights and responsibilities throughout the educational process
- Assisting family and children in the vocational discovery and development process
- Providing training in areas like food preparation, money management, recreational activities, and grooming
- Supplying information to families about additional resources

2.2 Enrollment

Texas Health and Human Services Commission (HHSC) Blind Children's Vocational Discovery and Development Program (BCVDDP) is the Medicaid provider of case management for persons who are 22 years of age and younger and blind or visually impaired. Providers must meet educational and work experience requirements that are commensurate with their job responsibilities and must be trained in BCVDDP case management activities.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about procedures for enrolling as a Medicaid provider.

2.3 Services, Benefits, Limitations, and Prior Authorization

Services eligible for reimbursement are limited to one contact per month, per person, regardless of the number of contacts that are made during the month. HHSC BCVDDP providers should bill procedure code G9012.

A contact is defined as "an activity performed by a case manager with the person or organization on behalf of the person to locate, coordinate, and monitor necessary services."

Refer to: Subsection A.8, "Texas Health and Human Services Commission Blind Children's Vocational Discovery and Development Program (BCVDDP)" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

2.3.1 Prior Authorization

Prior authorization is not required for BCVDDP case management services.

2.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including BCVDDP services.

BCVDDP services are subject to retrospective review and recoupment if documentation does not support the service billed.

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2.5 Claims Filing and Reimbursement

BCVDDP case management services must be submitted to the Texas Medicaid & Healthcare Partnership (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.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills or itemized statements are not accepted as claim supplements. Providers must not submit a claim when or after the person turns 21 years of age.

Claims may be submitted up to 365 days from the date of service in accordance with 1 TAC §354.1003.

Any child who has a suspected or diagnosed visual impairment may be referred to BCVDDP. HHSC BCVDDP assesses the impact the visual impairment has on the child's development and provides blindness-specific services to increase the child's skill level in the areas of independent living, communication, mobility, social, recreational, and vocational discovery and development. For more information, visit the HHS website at www.hhs.texas.gov/.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 2.9, "Federal Medical Assistance Percentage (FMAP)" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for federal matching percentage.

3 Case Management for Children and Pregnant Women

3.1 Overview

Case management services are provided to help Medicaid eligible persons gain access to necessary medical, social, educational, and other services. Case managers assess a person's need for these services and then develop a service plan to address those needs. Case Management for Children and Pregnant Women (CPW) services are outlined in the Texas Administrative Code (TAC).

3.1.1 Eligibility

CPW services are a benefit for children birth through 20 years of age who:

- Are Medicaid eligible in Texas.

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- Have, or are at risk for, a health condition illness, injury, or disability that results in limitation of function, activities, or social roles in comparison with healthy peers of the same age in the general areas of physical, cognitive, emotional, or social growth and development.
- Are in need of Case Management for Children and Pregnant Women services.
- Choose such services.

CPW services are a benefit for pregnant women of any age who:

- Are Medicaid eligible in Texas.
- Are pregnant and have a medical and/or psychosocial condition(s) that places them and their fetus(es) at a greater than average risk for complications, either during pregnancy, delivery, or following birth.
- Are in need of Case Management for Children and Pregnant Women services.
- Choose such services.

Clients that are Medicaid-eligible, but not yet enrolled may have Medicaid coverage assigned retroactively.

Verbal or written consent must be obtained from the client, parent, or legal guardian prior to the initiation of any CPW services. If the client receiving CPW services is a minor, all CPW services and visits must be completed with a parent or legal guardian present.

3.1.2 Referral Process

To refer a Medicaid eligible person for Case Management for Children and Pregnant Women services, providers may do one of the following:

- Visit www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women to obtain a referral form.
- Call THSteps toll free at 877-847-8377 from 8 a.m. to 6 p.m., Central Time, Monday through Friday.
- Contact a Case Management for Children and Pregnant Women provider directly at www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women. A case management provider will contact the client to offer a choice of providers and obtain information necessary to determine eligibility for case management services.

A referral for Case Management for Children and Pregnant Women services can be received from any source.

3.2 Enrollment

Providers must be at least 18 years of age, enrolled in Medicaid, and approved by the Health and Human Services Commission (HHSC) to provide CPW services.

A provider shall not be approved as a provider of CPW services unless they meet one of the following qualifications:

- APRN who holds a license under Texas Occupations Code Chapter 301; or
- Registered nurse (RN) who holds a license under Texas Occupations Code Chapter 301 and has a baccalaureate degree in nursing, or
- RN who holds a license under Texas Occupations Code Chapter 301 and has an associate degree in nursing with:
    - At least 2 years cumulative paid full-time work experience; or two years of supervised, full-time educational internship/practicum experience in the past ten years with children, up to age 21, and/or pregnant women; or

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- Social worker who holds a license, other than a provisional or temporary license, under Texas Occupations Code Chapter 505, appropriate for the individual's practice, including the practice of independent social work in the State of Texas; or
- Community health worker as defined by Section 48.001, Health and Safety Code, who is certified by the Department of State Health Services; or
- Doula who is certified in alignment with nationally recognized standards, and as determined by HHSC, must have:
  - Five years of experience within the last seven years as a doula; and
  - Attendance in three births in the last seven years; and
  - Three written professional letters of recommendation.
- Doula who is certified in alignment with nationally recognized standards, and as determined by HHSC, who is without five years of experience as a doula must have:
  - Attendance in three births; and
  - Three written professional letters of recommendation; and
  - Training in core competencies is required and must include:
    - Childbirth education
    - Lactation support (or proof of being a certified lactation counselor (CLC) or International Board-Certified Lactation Counselor (IBCLC)
    - Nonmedical comfort measures, prenatal support, and labor support techniques
    - Chronic and acute health conditions during the perinatal period
    - Cultural competency training

A Federally Qualified Health Center (FQHC) that has obtained HHSC approval may be eligible to provide CPW case management services. FQHCs must:

- Use the FQHC provider type, specialty code, and taxonomy code to deliver CPW services.
- Use their own individual National Provider Identifier (NPI) to deliver services.

Enrollment for Case Management for Children and Pregnant Women providers is a four-step process. Providers must complete all of the following:

- A pre-planning process with HHSC.
- The HHSC standardized case management training provided by HHSC.
- The Health Insurance Portability and Accountability Act (HIPAA) training.

  Note: *CPW Authorization to Disclose Protected Health Information forms in English or Spanish located on the HHSC CPW website must be completed as necessary to help the client access services.*

- Providers must receive an approval letter from HHSC to enroll as a state Medicaid provider of CPW services.

Providers may be a group, an individual, or perform services under guidance of a FQHC.

Upon approval by HHSC, potential providers must enroll as a Medicaid provider for Case Management for Children and Pregnant Women and submit a copy of their HHSC approval letter. Facility providers must enroll as a Case Management for Children and Pregnant Women group, and each eligible case manager must enroll as a performing provider for the group. Federally Qualified Health Center (FQHC)

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facilities that provide Case Management for Children and Pregnant Women services will use their FQHC number and should not apply for an additional provider number for Case Management for Children and Pregnant Women.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about the procedures for enrolling as a Medicaid provider.

3.3 Services, Benefits, Limitations, and Prior Authorization

Case Management for Children and Pregnant Women services are limited to one contact per day per person. Additional provider contacts on the same day are denied as part of another service rendered on the same day. Prior authorization is not required for case management services.

Procedure code G9012, with required modifiers, may be reimbursed for Case Management for Children and Pregnant Women (CPW) services. Modifiers are used to identify which service component is provided.

Procedure Code	Procedure Description	Additional Information
G9012	Comprehensive visit (in-person)	Combination Modifier U2 and U5 (both required)
G9012	Comprehensive visit (synchronous audiovisual)	Combination Modifier U2, U5 and 95(all required)
G9012	Follow-up visit (in-person)	Combination Modifier U5 and TS (both required)
G9012	Follow-up visit (synchronous audiovisual)	Combination Modifier U5, TS and 95 (all required)
G9012	Follow-up visit telephone (audio only)	Combination Modifier TS and 93 (both required)

Modifier	Description
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
TS	Follow-up service
U2	Comprehensive visit
U5	Face to face visit

Comprehensive visits are limited to one service per client, per provider in 12 consecutive months from the intake date.

CPW services may be provided using synchronous audiovisual technologies if clinically appropriate and safe, as determined by the provider, and agreed to by the client receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for information on policy restrictions for services delivered by synchronous telephone (audio- only) technologies. Services delivered using audio-only technologies must be billed using the 93 modifier.

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Comprehensive visits completed in-person must be billed with procedure code G9012 and modifiers U2 and U5.

Comprehensive visits completed using synchronous audiovisual technology must be billed with procedure code G9012 and modifiers U2, U5 and 95.

Comprehensive visits may not be completed or billed using synchronous telephone (audio-only) technology.

Follow-up visits completed in-person must be billed with procedure code G9012 and modifiers U5 and TS.

Follow-up visits completed using synchronous audiovisual technology must be billed with procedure code G9012 and modifiers U5, TS and 95.

Follow-up visits completed using synchronous telephone (audio-only) technology must be billed with procedure code G9012 and modifiers TS and 93.

Procedure code G9012 is limited to once per day, any service, any provider.

FQHC's will bill for services using procedure code G9012 with the corresponding modifiers.

Providers must adhere to Case Management for Children and Pregnant Women program rules, policies, and procedures.

Note: *Case Management for Children and Pregnant Women providers are not required to file claims with other health insurance before filing with Medicaid.*

Reminder: *Billable services are defined in program rule 25 TAC §27.11.*

Case Management for Children and Pregnant Women services are not billable when a person is an inpatient at a hospital or other treatment facility.

Reimbursement will be denied for services rendered by providers who have not been approved by HHSC.

Note: *For CPW services delivered through a managed care organization (MCO), providers must refer to the MCO for information about benefits, limitations, prior authorization, reimbursement, and specific claim processing procedures.*

Providers and their case managers must operate in accordance with the laws, rules, regulations, and standards of care relating to the practice of their respective license(s) or certifications.

Providers must provide services according to policies and procedures as published.

Providers must cease providing services and notify HHSC if the professional license or certification of a provider is suspended or revoked.

Providers must assure that case managers attend required trainings provided by HHSC.

Providers must provide services convenient to clients, either in their home, an office setting, or other place of the client's preference.

Providers must have knowledge of, and coordinate services with, providers of health and health-related services, non-covered services, and other active community resources.

Providers must develop and maintain a quality management system for the provision of services.

Providers may be disenrolled by HHSC for failure to comply with provisions of the TMHP Provider Agreement or any applicable law, rule, or policy of the program.

Providers must submit claims for rendered case management services. If no claims are submitted for 24 months, the provider will be disenrolled.

Providers may be disenrolled for not providing services for 12 months or longer.

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During a Declaration of State Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Providers are to disseminate accurate information regarding case management services to health, education, and human service professionals, community organizations, and potential clients to generate referrals. Some examples may include:

- Participate in community outreach events such as health fairs.
- Network with community agencies that serve children and pregnant women.
- Participate in community coalition meetings.
- Distribute brochures to medical/mental health professionals, dental providers, community resources, and schools.
- Conduct presentations.
- Develop community resource documents to include:
  - Local resources supporting nonmedical needs.
  - Providers accepting Medicaid clients.
  - Any other information about resources available specific to the provider's population served.

Providers must ensure that outreach activities do not impede a client's freedom to choose a provider.

Providers must refer and adhere to CPW outreach guidance available on the HHSC CPW website when producing outreach materials.

Providers must comply with the requirements outlined in TAC Title 1, Part 15, Chapter 371, Rule §371.1669, concerning Self-Dealing.

3.3.1 Initial Intake

CPW providers must complete an initial intake with the client, parent, or legal guardian to determine the client's eligibility. The following information must be obtained during the initial intake and must be documented on the CPW Intake and Referral Form located on the HHSC CPW website:

- The health condition(s), health risk, or high-risk condition of the client who would receive case management services
- The health-related non-medical conditions of the eligible client who would receive case management services.
- How the health condition, health risk, or high-risk condition impacts the client's level of functioning
- Detailed information about the client's current need(s) related to the health condition, health risk, high-risk, or non-medical condition
- How the CPW provider will assist the client with their current need(s)

If the client to receive services is a minor, then the initial intake must be completed with the person's parent or legal guardian present.

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The CPW initial intake service is not billable for reimbursement but is a required function of case management services. Providers who are unable to accept a referral, based on approved limitations, must re-direct the referral to the Texas Health Steps Hotline (1-877-THSteps or 1-877-847-8377). The approved limitations are:

- The client resides outside the provider service area.
- The provider is not contracted with the managed care organization (MCO) that is responsible for delivering services to the client.
- The provider has disenrolled as a CPW provider from TMHP.
- The provider cannot serve the individual's needs.

Referrals received for clients in STAR Kids must receive an intake to determine if there are needs for coordinating school services. All other services are to be provided by the client's MCO.

If the CPW initial intake indicates the client is eligible for services and a need for CPW services is identified, then the provider must complete a comprehensive visit within 30 business days of the intake date in which eligibility was determined.

If the CPW initial intake indicates the client is eligible for services and a need for CPW services is identified, but the client is not yet enrolled in Medicaid, then the case manager must complete a comprehensive visit within thirty (30) business days after the client's enrollment period is established.

3.3.2 Comprehensive Visits

The comprehensive visit (procedure code G9012 with the appropriate modifier combination) is a reimbursable service.

The comprehensive visit must include the completion of all the following:

- Family Needs Assessment
- Service Plan
- Service Plan Consent

The comprehensive visit must be completed within 30 business days of the intake date on which eligibility was determined or retroactive eligibility is established. If the client receiving CPW services is a minor, the comprehensive visit must be completed with the person's parent or legal guardian present. The comprehensive visit may be completed in-person or through the use of synchronous audiovisual technology. Comprehensive visits using synchronous audiovisual technology should only be provided if agreed to by the client, parent or legal guardian.

The FNA is completed to determine the need for any medical, educational, social, or other services required to address the client's short- and long-term health and the overall well-being of the client. The FNA must include the following documentation using the FNA form located on the HHSC CPW website:

- Completing a personal and family medical, mental health, and medication history.
- Identifying the client's needs, including any non medical health-related needs.
- Assessing and providing a referral for personal and family issues that impact the client's health condition, health risk, high-risk condition, or non-medical needs and completing related documentation.
- Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the client.

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The Service Plan (SP) is part of the comprehensive visit and must be completed and documented during the comprehensive visit using the Service Plan form on the HHSC CPW website. The Service Plan Consent is completed to authorize the provider to share information as necessary for referrals and for services to be provided. The Service Plan Consent form is located on the HHSC CPW website.

The SP is completed to determine a planned course of action. The service plan must include:

- Activities and goals that are developed in consultation with the client, parent, or legal guardian, involve the participation of the client, and address the medical, social, educational, and other services that are needed by the client receiving CPW services.
- Identify a course of action to respond to the assessed needs of the client, including identifying the individual responsible for contacting the appropriate service providers, and designating the time frame within which the client should access services.

The Service Plan may also include:

- Referral and related activities to help the client obtain needed services, including activities that help link the client with third parties such as medical, social, and educational providers.
- Case management may include collateral contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the client access services and managing the client's care.
- Participating in meetings.
- Providing resource information.
- Problem solving and advocating for the client.

The service plan must be translated or interpreted in the client's preferred language.

The Service Plan and Service Plan Consent forms must have verbal or written consent by the client, parent, or legal guardian and kept in the client's record, to be made available upon request.

3.3.3 Follow-up Visits

Follow-up visits (procedure code G9012 with the appropriate modifier combination) are reimbursable services, and may only be completed after the comprehensive visit has been completed. The follow-up visit and comprehensive visit cannot occur on the same day.

Follow-up visits by a case manager are necessary to ensure the Service Plan is implemented and adequately addresses the client's needs.

Follow-up visits shall be conducted as frequently as necessary. At least one annual follow-up is required for clients who are eligible for case management lasting longer than 12 consecutive months. For reimbursement, follow-up visits must be documented and must include the following:

- The current service plan to include the client's needs and status
- Services are being furnished in accordance with the client's service plan
- How services are addressing the client's needs as outlined in the Service Plan
- Service is maintained and modified when the client's needs or status changes

If the client receiving CPW services is a minor, the follow-up visit must be completed with the client's parent or legal guardian present.

> ***Note:*** *Follow-up visit forms are available on the HHSC CPW website at: www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women.*

Follow-up visits are completed to ensure the service plan is implemented and adequately addresses the person's needs. A follow-up visit must include but is not limited to:

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- Ensuring services are being furnished in accordance with the person's service plan.
- Ensuring services in the service plan are adequate.
- Ensuring the service plan is modified when the person's need(s) changes.

Activities during the follow-up visit must be documented on the Follow-up form found on the HHSC CPW website and must include:

- Reviewing all outstanding needs documented on the Service Plan.
- Problem solving with the client, parent, or legal guardian.
- Problem solving when the client, parent, or legal guardian has not followed through with identified Service Plan action steps.
- Assessing for new needs.
- Determining the next course of action to address outstanding needs.

A follow-up visit may be completed in-person or through the use of synchronous audiovisual technology, or synchronous telephone (audio-only) technology. Follow-up visits completed using synchronous audiovisual technology or synchronous telephone (audio-only) technology should only be provided if agreed to by the client, parent, or legal guardian.

CPW activities that occur between follow-up visits are necessary components of case management for children and pregnant women services, but are not billable. These activities may include:

- Phone calls to the client, parent, or legal guardian between billable follow-up visits.
- Gathering information from other sources, such as family members, medical providers, social workers, and educators on behalf of the client, parent, or legal guardian.

Follow-up visits by the case manager for clients who are pregnant with a high-risk condition or non-medical needs shall occur as needed during the 12-month postpartum period. When all needs related to the health condition, health risk, high-risk pregnancy, or non-medical needs have been addressed, then CPW services must no longer be provided.

The client status is to be documented on the Case Closure Form available on the HHSC CPW website, to identify the outcome of the case when the following apply:

- All eligible needs have been addressed or resolved.
- The client is no longer eligible for case management due to an improvement in their health condition, health risk, or high-risk condition.
- The child reaches 21 years of age and does not meet other eligibility requirements for CPW services.
- The client is no longer eligible for Medicaid and does not anticipate obtaining Medicaid in the near future.
- The client no longer chooses to receive services.
- The client is denied additional visits because documentation does not support continued eligibility.
- The client is lost to follow-up when provider has made three attempts on different dates to contact client, parent, or legal guardian.
- The client relocates or transfers to a new provider.

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- The provider is unable to render services due to the disruptive, unruly, threatening, or uncooperative behavior of the client, parent, or legal guardian.

  Note: *Providers may choose to close a case if the client, parent, or legal guardian is disruptive, unruly, threatening, or uncooperative to the extent the client, parent, or legal guardian seriously impairs the provider's ability to render services or if the client, parent, or legal guardian's behavior jeopardizes the client's own safety, or the providers. The provider should also contact the appropriate authority when necessary.*

3.3.4 Case Transfers

Prior authorization is not required for CPW case management services.

Case transfers must be documented on the Case Transfer form available on the HHSC CPW website. The Case Transfer form is completed if the client continues to meet eligibility criteria, but the case needs to be transferred. Transfers may occur for the following reasons:

- The client requests a transfer.
- The client relocates.
- The provider's service area changes.
- The provider disenrolls as an active CPW provider.
- There is a need to change to another case manager.

The provider must assist a client with a transfer to case management services to another area of Texas.

A client must give approval to a provider to transfer the case management record to the new provider.

Providers must appropriately link clients of a family member that is a migrant worker to resources in the geographic areas in which they live and to which they migrate. This case transfer process is to be documented on the Migrant Information Form available on the HHSC CPW website. Providers are to:

- Determine the family members that migrate.
- Identify the source(s) of payment for medical care if family migrates outside of Texas.
- Determine the location and timeframe for each migrating location.
- Document each new location address, contact persons, medical providers, and school attendance, if needed.

3.4 Technical Assistance

Providers may contact HHSC program staff as needed for assistance with program concerns. Providers should contact TMHP provider relations staff as needed for assistance with claims problems or concerns. Regional DSHS staff make routine contact with providers to ensure providers are delivering services as required.

3.4.1 Assistance with Program Concerns

Providers who have questions, concerns, or problems with program rule, policy, or procedure may contact HHSC program staff at *askcm@hhs.texas.gov*.

3.5 Documentation Requirements

All CPW services require documentation to describe and support the medical necessity of the service rendered.

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Providers must maintain accurate demographic information on their provider record with TMHP. Changing significant provider information must be updated on the Provider Enrollment Management System (PEMS) within seven calendar days of the change including:

- Group Name or Doing Business As (DBA)
- Location Address
- Telephone Number
- Fax Number
- Email Address

Documentation in the client's record must include that verbal or written consent was obtained from the client, parent, or legal guardian prior to the initiation of any CPW services.

CPW forms including the Family Needs Assessment, Service Plan, Follow-Up form, follow-up documentation, and progress notes must be completed and maintained in the client's record. The documentation maintained must meet the requirements as outlined in this handbook. CPW documentation forms are available on the HHSC CPW website at hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women.

Signatures, or documentation confirming verbal consent was received, must be included on all forms and documents that require signatures. All forms and documents completed in relation to CPW services must be maintained in the client's record.

All contacts with or on behalf of the client, parent, or legal guardian must be documented and maintained in the client's record. Documentation of activities, not otherwise documented on CPW required forms, must be recorded on the Progress Notes form available on the HHSC CPW website. Progress notes may include the following information:

- Phone calls to the client, parent, or legal guardian between billable follow-up visits
- Gathering information from other sources, such as family members, medical providers, social workers, and educators on behalf of the client, parent, or legal guardian

Documentation in the client's record must include the reason(s) a CPW service was not provided or completed. This can be documented on the Referral and Intake form during the initial eligibility determination or on the Case Closure form available on the HHSC CPW website.

Records are subject to review by HHSC or its designee.

3.6 Claims Filing and Reimbursement

3.6.1 Claims Information

CPW services are subject to retrospective review and recoupment if documentation does not support the service billed.

The comprehensive visit must not be billed until the FNA and SP are completed, and the SP Consent form is signed or verbal consent is given by the client, parent, or legal guardian. The CPW initial intake service is not billable.

Activities that occur between follow-up visits are necessary components of case management but are not billable. These activities must be documented on a progress note. These activities may include:

- Phone calls to the client, parent, or legal guardian between billable follow-up visits.
- Collateral contacts on behalf of a client, parent, or legal guardian.

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Claims for a client who receives retroactive eligibility must be submitted within 95 days of the date that the client's eligibility was added to the TMHP eligibility file (add date) and within 365 days of the date of service (DOS).

Claims for a client who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the eligibility is added to the TMHP eligibility file.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

3.6.1.1 Exclusions

CPW services are not billable for clients who have already received another case management service on the same day from any billing provider.

CPW services are not billable when a client is in an inpatient at a hospital or other treatment facility.

CPW services are not billable when the exact services are duplicated within the client's managed care organization.

3.6.2 Managed Care Clients

Case Management for Children and Pregnant Women services are carved in to Medicaid managed care and must be billed to the client's managed care organization (MCO).

4 Outpatient Mental Health Services

Outpatient mental health services are used for the treatment of mental illness and emotional disturbances in which the clinician establishes a professional contract with the person and, utilizing therapeutic interventions, attempts to alleviate the symptoms of mental illness or emotional disturbance, and reverse, change, or ameliorate maladaptive patterns of behavior.

Outpatient mental health services include psychiatric diagnostic evaluation, psychotherapy (including individual, family, or group), psychological, neurobehavioral, or neuropsychological testing, pharmacological management, and electroconvulsive therapy (ECT).

Outpatient mental health services are benefits when provided in the office, home, skilled nursing or intermediate care facility (SNF/ICF), outpatient hospital, extended care facility (ECF), or in other locations.

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Outpatient mental health services are benefits of Texas Medicaid when provided to persons who are experiencing a mental health condition that is causing distress, dysfunction, or maladaptive functioning as a result of a confirmed or suspected psychiatric condition as defined in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

Note: *Claims will require the corresponding diagnosis code(s) from the current edition of the International Classification of Diseases (ICD).*

4.1 Provider Enrollment

Mental health service providers include physicians, PAs, APRNs, LCSWs, LMFTs, LPCs, psychologists, licensed psychological associates (LPAs), provisionally licensed psychologists (PLPs), post-doctoral fellows, and pre-doctoral psychology interns.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about procedures for enrolling as a Medicaid provider.

4.1.1 Physicians

To enroll in Texas Medicaid to provide medical services, physicians (doctor of medicine [MD] or doctor of osteopathy [DO]) and doctors (doctor of dental medicine [DMD], doctor of dental surgery [DDS], doctor of optometry [OD], and doctor of podiatric medicine) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only THSteps medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

4.1.2 Physician Assistants (PAs)

To enroll in Texas Medicaid, a PA must be licensed as a PA and be recognized as a PA by the Texas Physician Assistant Board. All PAs are enrolled within the categories of practice as determined by the Texas Medicaid Board. PAs can enroll as an individual, group, or as a performing provider into a clinic/group practice. If enrolling into a Medicare enrolled clinic/group practice, Medicare enrollment is required.

4.1.3 Advanced Practice Registered Nurses (APRNs)

To enroll in Texas Medicaid, whether as an individual or as part of a group, a nurse practitioner (NP) or clinical nurse specialist (CNS) recognized as an APRN must be licensed by the Texas Board of Nursing (BON). NP/CNSs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based NP/CNSs is enrolling as part of a Medicare-enrolled group, then the NP/CNSs must also be enrolled in Medicare.

Providers that hold a temporary license are not eligible to enroll in Medicaid. NP/CNSs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

4.1.4 Licensed Clinical Social Workers (LCSWs)

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LCSW must be licensed by the Texas State Board of Social Worker Examiners. LCSWs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LCSW is enrolling as part of a Medicare-enrolled group, then the LCSW must also be enrolled in Medicare.

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Providers that hold a temporary license are not eligible to enroll in Medicaid. LCSWs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

4.1.5 Licensed Marriage and Family Therapists (LMFTs)

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LMFT must be licensed by the Texas State Board of Examiners of Licensed Marriage and Family Therapists. LMFTs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LMFT is enrolling as part of a Medicare-enrolled group, then the LMFT must also be enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LMFTs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

4.1.6 Licensed Professional Counselors (LPCs)

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LPC must be licensed by the Texas Board of Examiners of Professional Counselors. LPCs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LPC is enrolling as part of a Medicare-enrolled group, then the LPC must also be enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LPCs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

4.1.7 Psychologists

To enroll in Texas Medicaid, whether as an individual or as part of a group, a psychologist must be licensed by the Texas State Board of Examiners of Psychologists (TSBEP). Psychologists must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based psychologist is enrolling as part of a Medicare-enrolled group, then the psychologist must also be enrolled in Medicare. Psychologists cannot be enrolled if they have a license that is due to expire within 30 days. A current license must be submitted. Texas Medicaid accepts temporary licenses for psychologists.

4.1.8 Licensed Psychological Associates (LPAs)

LPAs must be licensed by TSBEP. LPAs are expected to abide by their scope and standards of practice.

Services performed by an LPA are a Medicaid-covered benefit when the following conditions are met:

- The services must be performed under the required supervision of a licensed, Medicaid-enrolled psychologist.
- The supervising psychologist must be in the same office, building, or facility when the service is provided and must be immediately available to furnish assistance and direction.
- The LPA performing the service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist.

Psychological services provided by an LPA must be billed under the supervising psychologist's National Provider Identifier (NPI) or the NPI of the legal entity employing the supervising psychologist.

4.1.9 Provisionally Licensed Psychologists (PLPs)

PLPs must be licensed by TSBEP. A PLP may perform all of the services that are benefits of Texas Medicaid when the services are performed by a psychologist.

PLPs are expected to abide by their scope and standards of practice. Services performed by a PLP are a Medicaid-covered benefit when the following conditions are met:

- The services must be performed under the required supervision of a licensed psychologist in accordance with the TSBEP guidelines.

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- The supervising psychologist must be in the same office, building, or facility when the service is provided and must be immediately available to furnish assistance and direction.
- The PLP who is performing the service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist.

The TSBEP requires a PLP to work under the required supervision of a licensed psychologist and does not allow a PLP to engage in independent practice. Therefore, a PLP will not be independently enrolled in the Medicaid program and must provide services under the delegating psychologist's NPI.

Psychological services provided by a PLP must be billed under the supervising psychologist's NPI or the NPI of the legal entity employing the supervising psychologist.

4.1.10 Post-Doctoral Fellows

Post-doctoral psychology fellows who satisfy the provisional licensure examination requirements but have not yet been awarded the PLP designation are eligible to perform delegated psychological services within their scope of practice and under the required supervision of a licensed psychologist.

Psychology interns are not independently enrolled in the Medicaid program and must provide services under the delegating psychologist's NPI.

Psychological services provided by an intern must be billed under the supervising psychologist's NPI or the NPI of the legal entity employing the supervising psychologist.

4.1.11 Pre-doctoral Psychology Interns

Pre-doctoral psychology interns who are participating in a pre-doctoral psychology internship at a site that is a member of the Association of Psychology Postdoctoral and Internship Centers (APPIC) are eligible to perform delegated psychological services within their scope of practice and under the required supervision of a licensed psychologist.

Psychology interns are not independently enrolled in the Medicaid program and must provide services under the delegating psychologist's NPI.

4.2 * Services, Benefits, Limitations

The following procedure codes may be reimbursed for outpatient mental health services:

Procedure Codes									
90791	90792	90832	90833	90834	90836	90837	90838	90846	90847
90853	90870	90899	96116	96121+	96130	96131+	96132	96133+	96136
96137+									
+ Add-on procedure code must be billed with the appropriate primary code									

The following psychotherapy procedure codes are limited to 30 visits per calendar year. Additional services require prior authorization:

Procedure Codes									
90832	90833+	90834	90836+	90837	90838+	90846	90847	90853	
+ Add-on procedure code must be billed with the appropriate primary code									

Procedure codes 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853 are limited to the following diagnosis codes:

[Revised] Diagnosis Codes							
F0390	F03911	F03918	F0392	F0393	F0394	F03A0	F03A11

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[Revised] Diagnosis Codes							
F03A18	F03A2	F03A3	F03A4	F03B0	F03B11	F03B18	F03B2
F03B3	F03B4	F03C0	F03C11	F03C18	F03C2	F03C3	F03C4
F04	F05	F060	F061	F062	F0630	F0631	F0632
F0633	F0634	F064	F0670	F0671	F068	F070	F0781
F0789	F09	F1010	F1011	F10120	F10121	F10130	F10131
F10132	F10139	F1014	F10150	F10151	F10159	F10180	F10181
F10182	F10188	F1019	F1020	F1021	F10220	F10221	F10230
F10231	F10232	F10239	F1024	F10250	F10251	F10259	F1026
F1027	F10280	F10281	F10282	F10288	F1029	F1090	F1091
F10921	F10930	F10931	F10932	F10939	F1094	F10950	F10951
F10959	F1096	F10980	F10981	F10982	F10988	F1099	F1110
F1111	F11120	F11121	F11122	F11129	F1113	F1114	F11150
F11151	F11159	F11181	F11182	F11188	F1119	F1120	F1121
F11220	F11221	F11222	F11229	F1123	F1124	F11250	F11251
F11259	F11281	F11282	F11288	F1129	F1191	F11920	F11921
F11922	F11929	F1193	F1194	F11950	F11951	F11959	F11981
F11982	F11988	F1199	F1210	F1211	F12120	F12121	F12122
F12129	F1213	F12150	F12151	F12159	F12180	F12188	F1219
F1220	F1221	F12220	F12221	F12222	F12229	F1223	F12250
F12251	F12259	F12280	F12288	F1229	F1291	F12920	F12921
F12922	F12929	F1293	F12950	F12951	F12959	F12980	F12988
F1299	F1310	F1311	F13120	F13121	F13129	F13130	F13131
F13132	F13139	F1314	F13150	F13151	F13159	F13180	F13181
F13182	F13188	F1320	F1321	F13220	F13221	F13229	F13230
F13231	F13232	F13239	F1324	F13250	F13251	F13259	F1326
F1327	F13280	F13281	F13282	F13288	F1391	F13920	F13921
F13929	F13930	F13931	F13932	F13939	F1394	F13950	F13951
F13959	F1396	F1397	F13980	F13981	F13982	F13988	F1399
F1410	F1411	F14120	F14121	F14122	F14129	F1413	F1414
F14150	F14151	F14159	F14180	F14181	F14182	F14188	F1419
F1420	F1421	F14220	F14221	F14222	F14229	F1423	F1424
F14250	F14251	F14259	F14280	F14281	F14282	F14288	F1429
F1491	F14920	F14921	F14922	F14929	F1493	F1494	F14950
F14951	F14959	F14980	F14981	F14982	F14988	F1499	F1510
F1511	F15120	F15121	F15122	F15129	F1513	F1514	F15150
F15151	F15159	F15180	F15181	F15182	F15188	F1519	F1520
F1521	F15220	F15221	F15222	F15229	F1523	F1524	F15250
F15251	F15259	F15280	F15281	F15282	F15288	F1529	F1591
F15920	F15921	F15922	F15929	F1593	F1594	F15950	F15951
F15959	F15980	F15981	F15982	F15988	F1599	F1610	F1611

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[Revised] Diagnosis Codes							
F16120	F16121	F16122	F16129	F1614	F16150	F16151	F16159
F16180	F16183	F16188	F1619	F1620	F1621	F16220	F16221
F16229	F1624	F16250	F16251	F16259	F16280	F16283	F16288
F1629	F1691	F16920	F16921	F16929	F1694	F16950	F16951
F16959	F16980	F16983	F16988	F1699	F1810	F1811	F18120
F18121	F18129	F1814	F18150	F18151	F18159	F1817	F18180
F18188	F1819	F1820	F1821	F18220	F18221	F18229	F1824
F18250	F18251	F18259	F1827	F18280	F18288	F1829	F1890
F1891	F18920	F18921	F18929	F1894	F18950	F18951	F18959
F1897	F18980	F18988	F1899	F1910	F1911	F19120	F19121
F19122	F19129	F19130	F19131	F19132	F19139	F1914	F19150
F19151	F19159	F1916	F1917	F19180	F19181	F19182	F19188
F1919	F1920	F1921	F19220	F19221	F19222	F19229	F19230
F19231	F19232	F19239	F1924	F19250	F19251	F19259	F1926
F1927	F19280	F19281	F19282	F19288	F1929	F1991	F19920
F19921	F19922	F19930	F19931	F19932	F19939	F1994	F19950
F19951	F19959	F1996	F1997	F19980	F19981	F19982	F19988
F1999	F200	F201	F202	F203	F205	F2081	F2089
F209	F21	F22	F23	F24	F250	F251	F258
F259	F28	F29	F3010	F3011	F3012	F3013	F302
F303	F304	F308	F309	F310	F3110	F3111	F3112
F3113	F312	F3130	F3131	F3132	F314	F315	F3160
F3161	F3162	F3163	F3164	F3171	F3172	F3173	F3174
F3175	F3176	F3177	F3178	F3181	F3189	F319	F320
F321	F322	F323	F324	F325	F3281	F3289	F329
F32A	F330	F331	F332	F333	F338	F3341	F3342
F339	F340	F341	F3481	F3489	F349	F39	F4001
F4002	F4010	F4011	F40210	F40218	F40220	F40228	F40230
F40231	F40232	F40233	F40240	F40241	F40242	F40243	F40248
F40290	F40291	F40298	F408	F409	F410	F411	F413
F418	F419	F422	F423	F424	F428	F429	F430
F4310	F4311	F4312	F4320	F4321	F4322	F4323	F4324
F4325	F4329	F4381	F4389	F439	F440	F441	F442
F444	F445	F446	F447	F4481	F4489	F449	F450
F451	F4520	F4521	F4522	F4529	F4541	F4542	F458
F459	F481	F482	F488	F489	F5000	F50010	F50011
F50012	F50013	F50014	F50019	F50020	F50021	F50022	F50023
F50024	F50029	F5020	F5021	F5022	F5023	F5024	F5025
F50810	F50811	F50812	F50813	F50814	F50819	F5082	F5083
F5084	F5089	F509	F5101	F5102	F5103	F5104	F5105

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[Revised] Diagnosis Codes							
F5109	F5111	F5112	F5113	F5119	F513	F514	F515
F518	F519	F520	F521	F5221	F5222	F5231	F5232
F524	F525	F526	F528	F529	F530	F531	F54
F550	F551	F552	F553	F554	F558	F600	F601
F602	F603	F604	F605	F606	F607	F6081	F6089
F609	F630	F631	F632	F633	F6381	F6389	F639
F640	F641	F642	F648	F649	F64A	F650	F651
F652	F653	F654	F6551	F6552	F6581	F6589	F659
F66	F6810	F6811	F6812	F6813	F68A	F69	F70
F800	F801	F802	F804	F8082	F809	F8181	F819
F82	F840	F842	F843	F845	F849	F900	F901
F902	F908	F909	F910	F911	F912	F913	F918
F919	F930	F938	F939	F940	F941	F942	F948
F949	F950	F951	F952	F959	F980	F981	F9821
F9829	F983	F984	F985	F988	F989	G300	G301
G308	G309	G3101	G3109	G3184	G4720	G4721	G4722
G4723	G4724	G4725	G4726	G4727	G4729	I69212	O906
R413	R41840	R41841	R41842	R41843	R41844	R4189	R45850
R45851	R4588	T5892XD	T5892XS	T7401XA	T7401XD	T7401XS	T7402XA
T7412XD	T7412XS	T7421XA	T7421XD	T7421XS	T7422XA	T7422XD	T7422XS
T7431XA	T7431XD	T7431XS	T7432XA	T7432XD	T7432XS	T7451XA	T7451XD
T7451XS	T7452XA	T7452XD	T7452XS	T7461XA	T7461XD	T7461XS	T7462XA
T7462XD	T7462XS	T7601XA	T7601XD	T7601XS	T7602XA	T7602XD	T7602XS
T7611XA	T7611XD	T7611XS	T7612XA	T7612XD	T7612XS	T7621XA	T7621XD
T7621XS	T7622XA	T7622XD	T7622XS	T7631XA	T7631XD	T7631XS	T7632XA
T7632XD	T7632XS	T7651XA	T7651XD	T7651XS	T7652XA	T7652XD	T7652XS
T7661XA	T7661XD	T7661XS	T7662XA	T7662XD	T7662XS	Z0389	Z600
Z608	Z609	Z620	Z621	Z6221	Z6222	Z6223	Z6224
Z62810	Z62811	Z62812	Z62813	Z62820	Z62821	Z62822	Z62823
Z62831	Z62832	Z62833	Z62890	Z62892	Z6331	Z6332	Z634
Z635	Z6372	Z638	Z644	Z654	Z655	Z658	Z69010
Z69011	Z69020	Z69021	Z6912	Z6982	Z72810	Z72811	Z736
Z781	Z818	Z8651	Z9151	Z9152	Z9183		

In addition to the diagnosis codes listed in the table above, procedure code 90791 or 90792 is a benefit when submitted with the following diagnosis codes:

Diagnosis Codes							
F71	F72	F73	F78A1	F78A9	F79		

Procedure codes 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137 are limited to the following diagnosis codes:

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[Revised] Diagnosis Codes							
A8100	A8101	A8109	A8181	A8183	B1001	B1009	B451
D8681	E7500	E7501	E7502	E7509	E7510	E7511	E7519
E7523	E7525	E7526	E7529	E754	F0150	F01511	F01518
F0152	F0153	F0154	F01A0	F01A11	F01A18	F01A2	F01A3
F01A4	F01B0	F01B11	F01B18	F01B2	F01B3	F01B4	F01C0
F01C11	F01C18	F01C2	F01C3	F01C4	F0280	F02811	F02818
F0282	F0283	F0284	F02A0	F02A11	F02A18	F02A2	F02A3
F02A4	F02B0	F02B11	F02B18	F02B2	F02B3	F02B4	F02C0
F02C11	F02C18	F02C2	F02C3	F02C4	F0390	F03911	F03918
F0392	F0393	F0394	F03A0	F03A11	F03A18	F03A2	F03A3
F03A4	F03B0	F03B11	F03B18	F03B2	F03B3	F03B4	F03C0
F03C11	F03C18	F03C2	F03C3	F03C4	F04	F05	F060
F061	F062	F0630	F0631	F0632	F0633	F0634	F064
F0670	F0671	F068	F070	F0781	F0789	F09	F1010
F10120	F10121	F10129	F10130	F10131	F10132	F10139	F1014
F10150	F10151	F10159	F10180	F10181	F10182	F10188	F1019
F1020	F1021	F10220	F10221	F10229	F10230	F10231	F10232
F10239	F1024	F10250	F10251	F10259	F1026	F1027	F10280
F10281	F10282	F10288	F1029	F1090	F1091	F10920	F10921
F10929	F10930	F10931	F10932	F10939	F1094	F10950	F10951
F10959	F1096	F1097	F10980	F10981	F10982	F10988	F1099
F11120	F11121	F11122	F11129	F1113	F1114	F11150	F11151
F11159	F11181	F11182	F11188	F1119	F1120	F1121	F11220
F11221	F11222	F11229	F1123	F1124	F11250	F11251	F11259
F11281	F11282	F11288	F1129	F1191	F11920	F11921	F11922
F11929	F1193	F1194	F11950	F11951	F11959	F11981	F11982
F1199	F1210	F1211	F12120	F12121	F12122	F12129	F1213
F12150	F12151	F12159	F12180	F12188	F1219	F1220	F1221
F12220	F12221	F12222	F12229	F1223	F12250	F12251	F12259
F12280	F12288	F1229	F1290	F1291	F12920	F12921	F12922
F12929	F1293	F12950	F12951	F12959	F12980	F12988	F1299
F1311	F1314	F13120	F13121	F13129	F13130	F13131	F13132
F13139	F13150	F13151	F13159	F13180	F13181	F13182	F13188
F1320	F1321	F13220	F13221	F13229	F13230	F13231	F13232
F13239	F1324	F13250	F13251	F13259	F1326	F1327	F13280
F13281	F13282	F13288	F1391	F13920	F13921	F13929	F13930
F13931	F13932	F13939	F1394	F13950	F13951	F13959	F1396
F13980	F13981	F13982	F13988	F1399	F1410	F1411	F14120
F14121	F14122	F14129	F1413	F1414	F14150	F14151	F14159
F14180	F14181	F14182	F14188	F1419	F1420	F1421	F14220

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[Revised] Diagnosis Codes							
F14221	F14222	F14229	F1423	F1424	F14250	F14251	F14259
F14280	F14281	F14282	F14288	F1429	F1491	F14920	F14921
F14922	F14929	F1493	F1494	F14950	F14951	F14959	F14980
F14982	F14988	F1499	F1510	F1511	F15120	F15121	F15122
F15129	F1513	F1514	F15150	F15151	F15159	F15180	F15181
F15182	F15188	F1519	F1520	F1521	F15220	F15221	F15222
F15229	F1523	F1524	F15250	F15251	F15259	F15280	F15281
F15282	F15288	F1529	F1591	F15920	F15921	F15922	F15929
F1594	F15950	F15951	F15959	F15980	F15981	F15982	F15988
F1599	F1610	F1611	F16120	F16121	F16122	F16129	F1614
F16150	F16151	F16159	F16180	F16183	F16188	F1619	F1620
F1621	F16220	F16221	F16229	F1624	F16250	F16251	F16259
F16280	F16283	F16288	F1629	F1691	F16920	F16921	F16929
F1694	F16950	F16951	F16959	F16980	F16983	F16988	F1699
F1811	F18120	F18121	F18129	F1814	F18150	F18151	F18159
F1817	F18180	F18188	F1819	F1820	F1821	F18220	F18221
F18229	F1824	F18250	F18251	F18259	F1827	F18280	F18288
F1829	F1890	F1891	F18920	F18921	F18929	F18950	F18951
F1897	F18980	F18988	F1894	F1899	F1910	F1911	F19120
F19121	F19122	F19129	F19130	F19131	F19132	F19139	F1914
F19150	F19151	F19159	F1916	F1917	F19180	F19181	F19182
F19188	F1919	F1920	F1921	F19220	F19221	F19222	F19229
F19230	F19231	F19232	F19239	F1924	F19250	F19251	F19259
F1926	F1927	F19280	F19281	F19282	F19288	F1929	F1991
F19920	F19921	F19922	F19929	F19930	F19931	F19932	F19939
F19950	F19951	F19959	F1996	F1997	F19980	F19981	F19982
F19988	F1999	F200	F201	F202	F203	F205	F2081
F2089	F209	F21	F22	F23	F24	F250	F251
F258	F259	F28	F29	F3010	F3011	F3012	F3013
F302	F303	F304	F308	F309	F310	F3110	F3111
F3112	F3113	F312	F3130	F3131	F3132	F314	F315
F3160	F3161	F3162	F3163	F3164	F3170	F3171	F3172
F3173	F3174	F3175	F3176	F3177	F3178	F3181	F3189
F319	F320	F321	F322	F323	F324	F325	F3281
F3289	F329	F32A	F330	F331	F332	F333	F3341
F3342	F338	F339	F340	F341	F3481	F3489	F349
F39	F4001	F4002	F4010	F4011	F40210	F40218	F40220
F40228	F40230	F40231	F40232	F40233	F40240	F40241	F40242
F40243	F40248	F40290	F40291	F40298	F408	F409	F410
F411	F413	F418	F419	F422	F423	F424	F428

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[Revised] Diagnosis Codes							
F429	F430	F4310	F4311	F4312	F4320	F4321	F4322
F4323	F4324	F4325	F4329	F4381	F4389	F439	F440
F441	F442	F444	F445	F446	F447	F4481	F4489
F449	F450	F451	F4520	F4521	F4522	F4529	F4541
F4542	F458	F459	F481	F482	F488	F489	F5000
F50010	F50011	F50012	F50013	F50014	F50019	F50020	F50021
F50022	F50023	F50024	F50029	F5020	F5021	F5022	F5023
F5024	F5025	F50810	F50811	F50812	F50813	F50814	F50819
F5082	F5083	F5084	F5089	F509	F5101	F5102	F5103
F5104	F5105	F5109	F5111	F5112	F5113	F5119	F513
F514	F515	F518	F519	F520	F521	F5221	F5222
F5231	F5232	F524	F525	F526	F528	F529	F530
F531	F54	F550	F551	F552	F553	F554	F558
F600	F601	F602	F603	F604	F605	F606	F607
F6081	F6089	F609	F630	F631	F632	F633	F6381
F6389	F639	F640	F641	F642	F648	F649	F64A
F650	F651	F652	F653	F654	F6551	F6552	F6581
F6589	F659	F66	F6810	F6811	F6812	F6813	F68A
F688	F69	F70	F71	F72	F73	F78A1	F78A9
F79	F800	F801	F802	F804	F8082	F8089	F809
F810	F812	F8181	F819	F82	F840	F842	F843
F845	F848	F849	F88	F89	F900	F901	F902
F908	F909	F910	F911	F912	F913	F918	F919
F930	F938	F939	F940	F941	F942	F948	F949
F950	F951	F952	F958	F959	F980	F981	F9821
F9829	F983	F984	F985	F988	F989	G000	G001
G002	G003	G008	G009	G01	G02	G030	G031
G032	G038	G039	G0400	G0401	G0402	G042	G0430
G0431	G0432	G0439	G0481	G0482	G0489	G0490	G0491
G053	G054	G060	G061	G062	G07	G210	G300
G301	G308	G309	G3101	G3109	G311	G312	G3180
G3181	G3182	G3183	G3184	G3185	G3186	G3187	G3189
G319	G3289	G35A	G35B0	G35B1	G35B2	G35C0	G35C1
G35C2	G35D	G40001	G40009	G40011	G40019	G40B01	G40B09
G40B11	G40B19	G40C01	G40C09	G40C11	G40C19	G40101	G40109
G40111	G40119	G40201	G40209	G40211	G40219	G40301	G40309
G40311	G40319	G40501	G40509	G40801	G40802	G40803	G40804
G40811	G40812	G40813	G40814	G40821	G40822	G40823	G40824
G40841	G40842	G40843	G40844	G4089	G40901	G40909	G40911
G40919	G40A01	G40A09	G40A11	G40A19	G44209	G450	G451

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[Revised] Diagnosis Codes							
G452	G454	G458	G459	G468	G4720	G4721	G4722
G4723	G4724	G4725	G4726	G4727	G4729	G910	G911
G912	G928	G929	G930	G931	G9340	G9341	G9342
G9343	G9344	G9345	G9349	G937	G9381	G9389	G939
G94	H93291	H93292	H93293	H93A1	H93A2	H93A3	H93A9
I6000	I6001	I6002	I6010	I6011	I6012	I602	I6030
I6031	I6032	I604	I6050	I6051	I6052	I606	I607
I608	I609	I610	I611	I612	I613	I614	I615
I616	I618	I619	I6200	I6201	I6202	I6203	I621
I629	I6300	I63011	I63012	I63013	I63019	I6302	I63031
I63032	I63033	I63039	I6309	I6310	I63111	I63112	I63113
I63119	I6312	I63131	I63132	I63133	I63139	I6319	I6320
I63211	I63212	I63213	I63219	I6322	I63231	I63232	I63233
I63239	I6329	I6330	I63311	I63312	I63313	I63319	I63321
I63322	I63323	I63329	I63331	I63332	I63333	I63339	I63341
I63342	I63343	I63349	I6339	I6340	I63411	I63412	I63413
I63419	I63421	I63422	I63423	I63429	I63431	I63432	I63433
I63439	I63441	I63442	I63443	I63449	I6349	I6350	I63511
I63512	I63513	I63519	I63521	I63522	I63523	I63529	I63531
I63532	I63533	I63539	I63541	I63542	I63543	I63549	I6359
I6381	I6389	I6501	I6502	I6503	I6509	I651	I6521
I6522	I6523	I6529	I658	I659	I6601	I6602	I6603
I6609	I6611	I6612	I6613	I6619	I6621	I6622	I6623
I6629	I663	I668	I669	I671	I672	I674	I675
I676	I677	I6781	I6782	I67850	I67858	I6789	I679
I680	I682	I688	I6900	I69010	I69011	I69012	I69013
I69014	I69015	I69018	I69019	I69020	I69021	I69022	I69023
I69028	I69031	I69032	I69033	I69034	I69039	I69041	I69042
I69043	I69044	I69049	I69051	I69052	I69053	I69054	I69059
I69061	I69062	I69063	I69064	I69065	I69069	I69090	I69091
I69092	I69093	I69098	I6910	I69110	I69111	I69112	I69113
I69114	I69115	I69118	I69119	I69120	I69121	I69122	I69123
I69128	I69131	I69132	I69133	I69134	I69139	I69141	I69142
I69143	I69144	I69149	I69151	I69152	I69153	I69154	I69159
I69161	I69162	I69163	I69164	I69165	I69169	I69190	I69191
I69192	I69193	I69198	I6920	I69210	I69211	I69212	I69213
I69214	I69215	I69218	I69219	I69220	I69221	I69222	I69223
I69228	I69231	I69232	I69233	I69234	I69239	I69241	I69242
I69243	I69244	I69249	I69251	I69252	I69253	I69254	I69259
I69261	I69262	I69263	I69264	I69265	I69269	I69290	I69291

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[Revised] Diagnosis Codes							
I69292	I69293	I69298	I6930	I69310	I69311	I69312	I69313
I69314	I69315	I69318	I69319	I69320	I69321	I69322	I69323
I69328	I69331	I69332	I69333	I69334	I69339	I69341	I69342
I69343	I69344	I69349	I69351	I69352	I69353	I69354	I69359
I69361	I69362	I69363	I69364	I69365	I69369	I69390	I69391
I69392	I69393	I69398	I6980	I69810	I69811	I69812	I69813
I69814	I69815	I69818	I69819	I69820	I69821	I69822	I69823
I69828	I69831	I69832	I69833	I69834	I69839	I69841	I69842
I69843	I69844	I69849	I69851	I69852	I69853	I69854	I69859
I69861	I69862	I69863	I69864	I69865	I69869	I69890	I69891
I69892	I69893	I69898	I6990	I69910	I69911	I69912	I69913
I69914	I69915	I69918	I69919	I69920	I69921	I69922	I69923
I69928	I69931	I69932	I69933	I69934	I69939	I69941	I69942
I69943	I69944	I69949	I69951	I69952	I69953	I69954	I69959
I69961	I69962	I69963	I69964	I69965	I69969	I69990	I69991
I69992	I69993	I69998	O906	P102	P103	P520	P521
P5221	P5222	P523	P525	P84	P90	P9160	P9161
P9162	P9163	R0901	R0902	R413	R41840	R41841	R41842
R41843	R41844	R4189	R450	R453	R454	R457	R45850
R45851	R4586	R4587	R4588	R4589	R5600	R5601	R569
S060X0A	S060X0D	S060X0S	S060X1A	S060X1D	S060X1S	S060X9A	S060X9D
S060X9S	S060XAA	S060XAD	S060XAS	S06306A	S06306D	S06306S	S0630AA
S0630AD	S0630AS	S06310A	S06310D	S06310S	S06311A	S06311D	S06311S
S06312A	S06312D	S06312S	S06313A	S06313D	S06313S	S06314A	S06314D
S06314S	S06315A	S06315D	S06315S	S06316A	S06316D	S06316S	S06319A
S06319D	S06319S	S0631AA	S0631AD	S0631AS	S06320A	S06320D	S06320S
S06321A	S06321D	S06321S	S06322A	S06322D	S06322S	S06323A	S06323D
S06323S	S06324A	S06324D	S06324S	S06325A	S06325D	S06325S	S06326A
S06326D	S06326S	S06329A	S06329D	S06329S	S0632AA	S0632AD	S0632AS
S06330A	S06330D	S06330S	S06331A	S06331D	S06331S	S06332A	S06332D
S06332S	S06333A	S06333D	S06333S	S06334A	S06334D	S06334S	S06335A
S06335D	S06335S	S06336A	S06336D	S06336S	S06339A	S06339D	S06339S
S0633AA	S0633AD	S0633AS	S06340A	S06340D	S06340S	S06341A	S06341D
S06341S	S06342A	S06342D	S06342S	S06343A	S06343D	S06343S	S06344A
S06344D	S06344S	S06345A	S06345D	S06345S	S06346A	S06346D	S06346S
S06349A	S06349D	S06349S	S0634AA	S0634AD	S0634AS	S06350A	S06350D
S06350S	S06351A	S06351D	S06351S	S06352A	S06352D	S06352S	S06353A
S06353D	S06353S	S06354A	S06354D	S06354S	S06355A	S06355D	S06355S
S06356A	S06356D	S06356S	S06359A	S06359D	S06359S	S0635AA	S0635AD
S0635AS	S06360A	S06360D	S06360S	S06361A	S06361D	S06361S	S06362A

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[Revised] Diagnosis Codes							
S06362D	S06362S	S06363A	S06363D	S06363S	S06364A	S06364D	S06364S
S06365A	S06365D	S06365S	S06366A	S06366D	S06366S	S06369A	S06369D
S06369S	S0636AA	S0636AD	S0636AS	S06370A	S06370D	S06370S	S06371A
S06371D	S06371S	S06372A	S06372D	S06372S	S06373A	S06373D	S06373S
S06374A	S06374D	S06374S	S06375A	S06375D	S06375S	S06376A	S06376D
S06376S	S06379A	S06379D	S06379S	S0637AA	S0637AD	S0637AS	S06380A
S06380D	S06380S	S06381A	S06381D	S06381S	S06382A	S06382D	S06382S
S06383A	S06383D	S06383S	S06384A	S06384D	S06384S	S06385A	S06385D
S06385S	S06386A	S06386D	S06386S	S06389A	S06389D	S06389S	S0638AA
S0638AD	S0638AS	S064X0A	S064X0D	S064X0S	S064X1A	S064X1D	S064X1S
S064X2A	S064X2D	S064X2S	S064X3A	S064X3D	S064X3S	S064X4A	S064X4D
S064X4S	S064X5A	S064X5D	S064X5S	S064X6A	S064X6D	S064X6S	S064X9A
S064X9D	S064X9S	S064XAA	S064XAD	S064XAS	S065X0A	S065X0D	S065X0S
S065X1A	S065X1D	S065X1S	S065X2A	S065X2D	S065X2S	S065X3A	S065X3D
S065X3S	S065X4A	S065X4D	S065X4S	S065X5A	S065X5D	S065X5S	S065X6A
S065X6D	S065X6S	S065X7A	S065X8A	S065X9A	S065X9D	S065X9S	S065XAA
S065XAD	S065XAS	S066X0A	S066X0D	S066X0S	S066X1A	S066X1D	S066X1S
S066X2A	S066X2D	S066X2S	S066X3A	S066X3D	S066X3S	S066X4A	S066X4D
S066X4S	S066X5A	S066X5D	S066X5S	S066X6A	S066X6D	S066X6S	S066X9A
S066X9D	S066X9S	S066XAA	S066XAD	S066XAS	S06890A	S06890D	S06890S
S06891A	S06891D	S06891S	S06892A	S06892D	S06892S	S06893A	S06893D
S06893S	S06894A	S06894D	S06894S	S06895A	S06895D	S06895S	S06896A
S06896D	S06896S	S06897A	S06899A	S06899D	S06899S	S0689AA	S0689AD
S0689AS	S069X0A	S069X0D	S069X0S	S069X1A	S069X1D	S069X1S	S069X2A
S069X2D	S069X2S	S069X3A	S069X3D	S069X3S	S069X4A	S069X4D	S069X4S
S069X5A	S069X5D	S069X5S	S069X6A	S069X6D	S069X6S	S069X9A	S069X9D
S069X9S	S069XAA	S069XAD	S069XAS	T40411A	T40411D	T40411S	T40412A
T40412D	T40412S	T40413A	T40413D	T40413S	T40414A	T40414D	T40414S
T40415A	T40415D	T40415S	T40416A	T40416D	T40416S	T40421A	T40421D
T40421S	T40422A	T40422D	T40422S	T40423A	T40423D	T40423S	T40424A
T40424D	T40424S	T40425A	T40425D	T40425S	T40426A	T40426D	T40426S
T40491A	T40491D	T40491S	T40492A	T40492D	T40492S	T40493A	T40493D
T40493S	T40494A	T40494D	T40494S	T40495A	T40495D	T40495S	T40496A
T40496D	T40496S	T40711A	T40711D	T40711S	T40712A	T40712D	T40712S
T40713A	T40713D	T40713S	T40714A	T40714D	T40714S	T40715A	T40715D
T40715S	T40716A	T40716D	T40716S	T40721A	T40721D	T40721S	T40722A
T40722D	T40722S	T40723A	T40723D	T40723S	T40724A	T40724D	T40724S
T40725A	T40725D	T40725S	T40726A	T40726D	T40726S	T50912A	T50912D
T50912S	T50914A	T50914D	T50914S	T5801XA	T5801XD	T5801XS	T5802XA
T5802XD	T5802XS	T5803XA	T5803XD	T5803XS	T5804XA	T5804XD	T5804XS

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[Revised] Diagnosis Codes							
T5811XA	T5811XD	T5811XS	T5812XA	T5812XD	T5812XS	T5813XA	T5813XD
T5813XS	T5814XA	T5814XD	T5814XS	T582X1A	T582X1D	T582X1S	T582X2A
T582X2D	T582X2S	T582X3A	T582X3D	T582X3S	T582X4A	T582X4D	T582X4S
T588X1A	T588X1D	T588X1S	T588X2A	T588X2D	T588X2S	T588X3A	T588X3D
T588X3S	T588X4A	T588X4D	T588X4S	T5891XA	T5891XD	T5891XS	T5892XA
T5892XD	T5892XS	T5893XA	T5893XD	T5893XS	T5894XA	T5894XD	T5894XS
T71111A	T71111D	T71111S	T71112A	T71112D	T71112S	T71113A	T71113D
T71113S	T71114A	T71114D	T71114S	T71121A	T71121D	T71121S	T71122A
T71122D	T71122S	T71123A	T71123D	T71123S	T71124A	T71124D	T71124S
T71131A	T71131D	T71131S	T71132A	T71132D	T71132S	T71133A	T71133D
T71133S	T71134A	T71134D	T71134S	T71141A	T71141D	T71141S	T71143A
T71143D	T71143S	T71144A	T71144D	T71144S	T71151A	T71151D	T71151S
T71152A	T71152D	T71152S	T71153A	T71153D	T71153S	T71154A	T71154D
T71154S	T71161A	T71161D	T71161S	T71162A	T71162D	T71162S	T71163A
T71163D	T71163S	T71164A	T71164D	T71164S	T71191A	T71191D	T71191S
T71192A	T71192D	T71192S	T71193A	T71193D	T71193S	T71194A	T71194D
T71194S	T7120XA	T7120XD	T7120XS	T7121XA	T7121XD	T7121XS	T71221A
T71221D	T71221S	T71222A	T71222D	T71222S	T71223A	T71223D	T71223S
T71224A	T71224D	T71224S	T71231A	T71231D	T71231S	T71232A	T71232D
T71232S	T71233A	T71233D	T71233S	T71234A	T71234D	T71234S	T7129XA
T7129XD	T7129XS	T719XXA	T719XXD	T719XXS	T7401XA	T7401XD	T7401XS
T7402XA	T7402XD	T7402XS	T7411XA	T7411XD	T7411XS	T7412XA	T7412XD
T7412XS	T7421XA	T7421XD	T7421XS	T7422XA	T7422XD	T7422XS	T7431XA
T7431XD	T7431XS	T7432XA	T7432XD	T7432XS	T7451XA	T7451XD	T7451XS
T7452XA	T7452XD	T7452XS	T7461XA	T7461XD	T7461XS	T7462XA	T7462XD
T7462XS	T751XXA	T751XXD	T751XXS	T7601XA	T7601XD	T7601XS	T7602XA
T7602XD	T7602XS	T7611XA	T7611XD	T7611XS	T7612XA	T7612XD	T7612XS
T7621XA	T7621XD	T7621XS	T7622XA	T7622XD	T7622XS	T7631XA	T7631XD
T7631XS	T7632XA	T7632XD	T7632XS	T7651XA	T7651XD	T7651XS	T7652XA
T7652XD	T7652XS	T7661XA	T7661XD	T7661XS	T7662XA	T7662XD	T7662XS
Z608	Z634	Z644	Z658	Z72810	Z72811	Z736	Z73810
Z73811	Z73812	Z73819	Z781	Z818	Z8651	Z8659	Z87820
Z878901	Z878902	Z878903	Z878904	Z878909	Z87893	Z9151	Z9152
Z9183							

4.2.1 Telemedicine and Telehealth Services

Providers must defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

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Providers must provide outpatient mental health services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, outpatient mental health services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

4.2.1.1 Synchronous Audiovisual Technology

The following outpatient mental health services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. Outpatient mental health services provided by synchronous audiovisual technology must be billed using modifier 95.

- Psychiatric diagnostic evaluation services with and without medical services (procedure codes 90791 and 90792)
- Psychotherapy (individual, family, or group) services (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853)
- Pharmacological management services (most appropriate E/M code with modifier UD) for psychiatric care only
- Neurobehavioral services (procedure codes 96116 and 96121).
- Neuropsychological and psychological testing services (procedure codes 96130, 96131, 96132, 96133, 96136 and 96137) if the following conditions are met:
  - The psychometric test must be available in an online format, except for tests that are administered and responded to orally;
  - The provider, or test administrator, must observe the person, in real-time, for the duration of the test; and
  - The provider delivers the psychometric test in accordance with their licensing board and professional guidelines.

4.2.1.2 Synchronous Telephone (audio-only) Technology

The following outpatient mental health services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and, if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as, the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of outpatient mental health services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology.

Outpatient mental health services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

- Psychiatric diagnostic evaluation services with and without medical services (procedure codes 90791 and 90792)

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- Psychotherapy (individual, family, or group) services (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853)
- Pharmacological management services (most appropriate E/M code with modifier UD) for psychiatric care only

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological], or ECT) from the same billing provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual outpatient mental health service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

Note: *"Same billing provider" refers to providers that are within the same entity or organization, as identified by the entity's or organization's NPI number or numbers, if the entity or organization has multiple locations (e.g., a clinic/group practice, federally qualified health center or rural health clinic, and can include providers within the same community mental health center).*

Note: *The required in-person or synchronous audiovisual-delivered outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological], or ECT) may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

The billing provider is required to conduct at least one in-person or synchronous audiovisual outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological] or ECT) every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person's medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area
- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person's condition(s)

Modifiers for Telemedicine and Telehealth	Description
95	Delivered by synchronous audiovisual technology
FQ	Delivered by synchronous telephone (audio-only) technology

Note: *The required in-person or synchronous audiovisual-delivered outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological], or ECT) may be delivered by another authorized professional or paraprofessional of*

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the same billing provider (see note above for the definition of same billing provider) as the professional, or paraprofessional, who delivers the service by synchronous telephone (audio-only) technology.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

4.2.2 Psychotherapy Services

Individual psychotherapy is defined as therapy that focuses on a single person.

Group psychotherapy is defined as a type of psychotherapy that involves one or more therapists working with several persons at the same time.

Family psychotherapy is defined as therapy that focuses on the dynamics of the family unit where the goal is to strengthen the family's problem solving and communication skills.

Providers must bill a modifier to identify a separate and distinct service when performing individual psychotherapy (procedure code 90832, 90834, or 90837) and family psychotherapy (procedure code 90846 or 90847) on the same day for the same person. When billing for these services, providers must submit the family psychotherapy procedure code with the modifier on the claim to indicate that the procedure or service was distinct or independent from other services performed on the same day for the same person. Documentation that supports the provision of distinct or independent services must be maintained in the person's medical record and made available to Texas Medicaid upon request.

Note: *The add-on codes may only be billed by physician, APRN, or PA providers.*

Refer to: Subsection 9.2.60.6, "Prolonged Physician Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about prolonged physician services.

Psychotherapy (individual, family, or group) is limited to 4 hours per person, per day.

Psychotherapy is limited to 30 individual, group, or family psychotherapy visits per person, per calendar year. Additional psychotherapy services must be prior authorized. Prior authorization requests in increments of up to 10 additional visits may be considered. The request must be submitted on an Outpatient Mental Health Services Request Form and include the following information:

- Identifying information for the person receiving services
- Provider name and NPI
- Current DSM diagnosis(es)
- Current psychotropic medications
- Current symptoms requiring additional psychotherapy
- Treatment plan, including measurable short-term goals, specific therapeutic interventions utilized, and measurable expected outcomes of therapy
- Number and type of services requested and anticipated dates that the services will be provided
- Indication of court-ordered or Department of Family and Protective Services (DFPS)-directed services

Providers with an established relationship with a person receiving services must request prior authorization when they determine the person is approaching 30 psychotherapy visits for the calendar year. If the person changes providers during the year and the new provider is unable to obtain complete information on the person's previous treatment history, providers are encouraged to obtain prior authorization before rendering services. Requests submitted on the same day as the initial session with a new provider will be considered based on medical necessity criteria.

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Providers must bill the preponderance of each half hour of psychotherapy and indicate the number of units on the claim form.

LMFTs must bill with modifier U8 to differentiate from LPCs.

Supporting documentation for individual, family, or group psychotherapy services must include:

- Start and end time of session
- Modality or modalities utilized
- Frequency of psychotherapy sessions
- Clinical notes for each visit must include diagnosis, symptoms, functional status, focused mental status examination (if indicated), treatment plan (goals and objectives addressed), prognosis, and progress, and the name, signature, and credentials of the individual performing the services.

4.2.2.1 Family Psychotherapy

Family psychotherapy may be provided to Medicaid eligible persons 20 years of age and younger using procedure code 90846 or persons of any age using procedure code 90847.

Family psychotherapy is only reimbursable for one Medicaid eligible person per session regardless of the number of family members present per session.

Family psychotherapy for Medicaid eligible persons 20 years of age and younger may be provided to the child's parent(s), foster parent(s), or legal guardian without the child present, as clinically appropriate, using procedure code 90846. Parent- or guardian-only sessions may be indicated when addressing sensitive topics such as parenting challenges or related stressors that would be inappropriate to discuss with the child present at the session.

Only the following specific relatives may participate in family psychotherapy services:

- Biological parent, foster parent, or legal guardian
- Child
- Grandfather or grandmother
- Sibling (biological, foster, or kinship)
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister

4.2.2.2 Treatment for Alzheimer's Disease and Dementia

Psychotherapy for persons with Alzheimer's disease or dementia is a benefit of Texas Medicaid for persons with very mild or mild cognitive decline.

Documentation to support the treatment for Alzheimer's disease or dementia must be maintained in the person's medical record and may be subject to retrospective review. Psychotherapy services must not be continued if no longer beneficial to the person due to diminished cognitive functioning.

4.2.3 Delegated Services

Services provided by a psychologist, LPA, PLP, psychology intern, or post-doctoral fellow must be billed with a modifier on each detail. Psychological services provided by an LPA, PLP psychology intern, or post-doctoral fellow must be billed under the supervising psychologist's NPI or the NPI of the legal entity employing the supervising psychologist.

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Services performed by a LPA or PLP will be reimbursed at 70 percent of the psychologist rate. Services performed by the psychology intern or post-doctoral fellow will be reimbursed at 50 percent of the psychologist rate.

The following modifiers are to be used with procedure codes for licensed psychologist and delegated services:

Modifier	Description
AH	Identifies service provided by a clinical psychologist
UB	Identifies service provided by a pre-doctoral psychology intern or post-doctoral psychology fellow
UC	Identifies service provided by an LPA
U9	Identifies service provided by a PLP

Claims submitted without a modifier or with two of these modifiers on the same detail will be denied.

Only the LCSW, LMFT, LPC, APRN, or PA performing the mental health service may bill Texas Medicaid. The LCSW, LMFT, LPC, APRN, or PA must not bill for services performed by people under his or her supervision.

4.2.4 Pharmacological Management Services

Pharmacological management is the in-depth management of psychopharmacological agents to treat a person's mental health symptoms.

Pharmacological management is a physician service and cannot be provided by a non-physician or "incident to" a physician service, except for APRNs and PAs whose scope of license in this state permits them to prescribe.

Pharmacological management is limited to one service per day, per person, by any provider in any setting.

The treating provider should use the most appropriate E/M code for the pharmacological management visit depending on the place of service and complexity of the person's condition, along with modifier UD to designate the visit as primarily focused on pharmacological management.

Supporting documentation for pharmacological management services must include:

- Complete diagnosis utilizing diagnostic criteria from the current edition of the DSM
- Current list of medications
- Current psychiatric symptoms and problems, including presenting mental status
- Problems, reactions, and side effects, if any, to medications
- Any medication modifications made during a visit and the reasons for medication adjustments, changes, or discontinuation
- Desired therapeutic drug levels, if applicable, for medications requiring blood level monitoring, e.g. Lithium
- Current laboratory values, if applicable, for medications requiring monitoring for potential side effects, e.g. hyperglycemia caused by anti-psychotic medications
- Treatment goals

4.2.5 Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is the induction of convulsions by the passage of an electric current through the brain used in the treatment of certain psychiatric disorders.

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Psychological, neurobehavioral, or neuropsychological testing billed in addition to ECT on the same day, by any provider will be denied as part of another procedure on the same day.

4.2.6 Psychiatric Diagnostic Evaluation Services

Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations. Psychiatric diagnostic evaluation with medical services also includes a medical assessment, other physical examination elements as indicated, and may also include prescription of medications, and laboratory or other diagnostic studies.

A psychiatric diagnostic evaluation without medical services (procedure code 90791) may be reimbursed to physicians, psychologists, APRNs, PAs, LCSWs, LPCs, LMFTs, PLPs, psychology interns, and post-doctoral fellows.

A psychiatric diagnostic evaluation with medical services (procedure code 90792) may be reimbursed to physicians, APRNs, and PAs.

Psychiatric diagnostic evaluations with and without medical services (procedure codes 90791 and 90792) are limited to once per person, per rolling year, same provider in the office, home, outpatient hospital, or other settings, regardless of the number of professionals involved in the interview. Additional psychiatric diagnostic evaluations may be considered for prior authorization on a case-by-case basis when submitted on an Outpatient Mental Health Services Request Form with supporting documentation, including but not limited to:

- A court order or a DFPS directive
- If a major change of status occurs

Supporting documentation for psychiatric diagnostic evaluation services must include:

- Reason for referral or presenting problem
- Prior diagnoses and any prior treatment
- Other pertinent medical, social, and family history
- Clinical observations and results of mental status examination
- Complete diagnosis utilizing diagnostic criteria from the current edition of the DSM
- Recommendations, including expected long- and short-term goals

4.2.7 Psychological, Neurobehavioral, and Neuropsychological Testing Services

Psychological, neurobehavioral, and neuropsychological testing involves the use of formal tests and other assessment tools to measure and assess a person's emotional, and cognitive functioning in order to arrive at a diagnosis and guide treatment.

Psychological testing (procedure codes 96130, 96131, 96136, and 96137) and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) are limited to eight hours per person, per calendar year. Additional hours require prior authorization when medically necessary. The request must be submitted on an Outpatient Mental Health Services Request Form and include the following information:

- Identifying information for the person receiving services
- Provider name and NPI
- Current DSM diagnoses
- Indication of court-ordered or DFPS-directed services

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- Type of testing requested (psychological, neurobehavioral, or neuropsychological) including specific procedure codes
- Rationale for requested testing, to include the current symptoms of the person receiving services
- Previous history and testing results

Psychological, neurobehavioral, and neuropsychological testing will not be reimbursed to an APRN or a PA. The most appropriate office visit procedure code must be billed. Mental health screening may be performed during an assessment by an APRN or a PA, but will not be reimbursed separately.

Psychological testing (procedure codes 96130, 96131, 96136, and 96137) or neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) may be reimbursed on the same date of service as an initial psychiatric diagnostic evaluation (procedure code 90791 or 90792).

Neurobehavioral testing (procedure code 96116) may not be reimbursed on the same date of service as an initial psychiatric diagnostic evaluation (procedure code 90791 or 90792) to the same provider.

Neurobehavioral testing (procedures codes 96116 and 96121) will not be paid for the same date of service to the same provider as psychological testing (procedure codes 96130, 96131, 96136 and 96137) or neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137). All documentation must be maintained by the provider in the person's medical record.

The reimbursement for procedure codes 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137 includes the face-to-face testing and the scoring and interpretation of the results. The number of units of testing on the claim for procedure codes 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137 must be in accordance with the allowable activities outlined in each code description.

Note: *Add-on procedure codes indicated with asterisk must be billed with the appropriate primary procedure code.*

Assessment, treatment planning, and documentation time, including time to document test results in the person's medical record, is not reimbursed separately. Reimbursement is included in the covered procedure codes.

4.2.7.1 Testing in Facilities

Psychological testing, neurobehavioral testing, or neuropsychological testing may be reimbursed when provided in a skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility (ECF) as clinically indicated. Testing may be indicated, for example, when a person has experienced significant change in mental status requiring specialized testing, or to evaluate a person's competency to return to a community-based setting. Persons with well-established mental or cognitive issues do not require additional testing.

Psychological, neurobehavioral, or neuropsychological testing will not be reimbursed in a SNF, ICF, or ECF when conducted prior to the performance of initial intake assessments such as the Minimum Data Set or Preadmission Screening and Resident Review (PASRR) (a completed Level I Screening and a Level II Evaluation, as applicable).

Supporting documentation for psychological, neurobehavioral, or neuropsychological testing services must include:

- Reason for referral or presenting problem
- The name of the tests (e.g.,WAIS-R, Rorschach, MMPI) performed
- The scoring of the test
- Location where the testing is performed
- The name and credentials of each provider involved in administering, interpreting, and preparing the report

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- Test interpretations, including narrative descriptions of the test findings
- Length of time spent by each provider, as applicable, in administration, interpretation, integrating the test interpretation, and documenting the comprehensive report based on the integrated data
- Recommended treatment, including how test results affect the prescribed treatment
- Recommendations for further testing, including an explanation to substantiate the necessity for retesting, if applicable
- Rationale or extenuating circumstances that impact the ability to complete the testing, such as, but not limited to, the person's condition requires testing over two days and the person does not return, or the person's condition precludes completion of the testing.

Original testing material must be maintained by the provider and must be readily available for retrospective review by HHSC.

When psychological, neurobehavioral, or neuropsychological testing is performed in a SNF, ICF, or ECF, a copy of the test and the resulting report must also be maintained in the person's medical record at the facility.

4.3 Prior Authorization

Prior authorization requests must be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Performing providers may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

All providers must adhere to prior authorization requirements.

4.3.1 Services Requiring Prior Authorization

Prior Authorization is required for the following services:

- Psychiatric diagnostic evaluation (procedure code 90791 or 90792) after the one evaluation per person, per provider, per rolling year limitation has been met
- Individual, family, or group psychotherapy (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853) after the 30 visit per calendar year limitation has been met
- Neurobehavioral testing (procedure codes 96116 and 96121) after the 4 hour per day limitations have been met
- Psychological testing (procedure code 96130, 96131, 96136, or 96137) or neuropsychological testing (procedure code 96132, 96133, 96136, or 96137) after the 8 hour per calendar year limitations have been met
- Unlisted psychiatric service or procedure (procedure code 90899)

Requests for prior authorization for procedure code 90899 must be submitted by the provider to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form with documentation supporting medical necessity including:

- Diagnosis(es)
- Prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the evidence-based service or procedure to be performed, and the intended fee for the service or procedure
- The reason for recommending this particular service or procedure

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- A procedure code that is comparable to the service or procedure being requested
- Documentation that this service or procedure is not investigational or experimental

4.3.2 Prior Authorization Not Required

Prior authorization is not required for the following services:

- One psychiatric diagnostic evaluation (procedure codes 90791 and 90792) per person, per rolling year, per provider (same provider)
- 30 individual, family, or group psychotherapy (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853) visits per person per calendar year
- 4 hours of psychotherapy services per person per day
- 4 hours of neuropsychological testing (procedure codes 96116 and 96121) per person per day
- 8 hours of psychological, neurobehavioral, or neuropsychological testing (procedure codes 96130, 96131, 96132, 96133, 96136, or 96137) per person, per calendar year
- ECT (procedure code 90870)

4.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including mental health services. The documentation must support the medical necessity of the treatment for its entire duration.

Mental health services outlined in this handbook are subject to retrospective review to ensure that the documentation in the person's medical record supports the medical necessity of the services provided. Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

4.5 Twelve Hour System Limitation

The following provider types are limited to a maximum combined total of 12 hours per provider, per day, regardless of the number of persons seen for outpatient mental health services:

- Psychologist
- APRN
- PA
- LCSW
- LMFT
- LPC

The following table lists the procedure codes for mental health services included in the system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

Procedure Code	Time Applied
90791	60 minutes
+ Add-on procedure codes to be billed with the most appropriate E/M procedure code.	

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Procedure Code	Time Applied
90792	60 minutes
90832	30 minutes
90833+	30 minutes
90834	45 minutes
90836+	45 minutes
90837	60 minutes
90838+	60 minutes
90846	50 minutes
90847	50 minutes
96116	60 minutes
96121+	60 minutes
96130	60 minutes
96131+	60 minutes
96132	60 minutes
96133+	60 minutes
96136	30 minutes
96137+	30 minutes
+ Add-on procedure codes to be billed with the most appropriate E/M procedure code.	

Court-ordered and DFPS directed services are not subject to the 12-hour per provider, per day system limitation when billed with modifier H9.

Physicians are not subject to the 12-hour system limitation since they can delegate and may submit claims in excess of 12 hours per day.

Psychologists can delegate to multiple LPAs, PLPs, interns, or post-doctoral fellows and therefore delegated services are not subject to the 12-hour system limitation since they may submit claims for delegated services in excess of 12 hours per day.

4.6 Court-Ordered Services

The court-ordered services listed below for persons who are age 20 years of age and younger or 65 years of age and older are not subject to utilization management reviews, including prior authorization, concurrent reviews, or retrospective reviews that have the effect of denying, reducing, or controverting the court-ordered service. In these situations, the court order is considered the determination of medical necessity.

When billed with modifier H9, court-ordered services are not subject to the 12-hour system limitation per provider, per day.

Federal law prohibits the use of federal Medicaid funding for medical care provided to persons who are considered incarcerated. A person is considered incarcerated when a criminal justice facility has custody of the person. Examples include:

- A person who is currently residing in a criminal justice facility and receiving treatment through a program at the criminal justice facility.
- A person who is committed under Title 1 Texas Code of Criminal Procedure §46(B), which addresses persons ages 18 and older who have been ordered to receive competency restoration.

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- A person who is committed under Title 3 Texas Family Code §§55.01-55.45. These sections refer to persons committed to inpatient psychiatric care because they are deemed unfit to proceed.

The following court-ordered services are required to be provided to Medicaid eligible persons who are not considered incarcerated:

- Emergency detention ordered by a judge or magistrate under Title 7 Texas Health and Safety Code §§573. 011-573.026.
- Mental health services ordered under Title 7 Texas Health and Safety Code §§574.01-574.110. Mental health services may include:
  - A mental health examination.
  - Inpatient or outpatient treatment.
  - Detention under protective custody and temporary mental health services.
- Treatment of persons who are found not guilty based on lack of responsibility under Title 3 Texas Family Code §55.
- Treatment that is a condition of probation.
- Treatment of persons with chemical dependencies ordered under Title 6 Texas Health and Safety Code §462.042.

For authorization of court-ordered services, the provider must submit documentation that includes:

- The court-order.
- Information about the statute under which the court is ordering the services.
- Verification of the person's incarceration status.

For court-ordered inpatient admissions, providers must submit documentation that includes:

- A copy of the doctor's certificate.
- All court-ordered commitment papers signed by the judge.

For persons with fee-for-service benefits, this supporting documentation must be submitted with the Psychiatric Inpatient Extended Stay Request Form.

Requested services beyond those that are court-ordered are subject to medical necessity review.

4.7 Exclusions

The following services are not benefits of Texas Medicaid:

- Psychoanalysis
- Multiple family group psychotherapy
- Marriage or couples counseling
- Narcosynthesis
- Biofeedback training as part of psychophysiological therapy
- Psychiatric day treatment programs
- Services provided by a psychiatric assistant, psychological assistant (excluding master's level LPA), or a licensed chemical dependency counselor

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4.8 Claims Filing and Reimbursement

Providers must bill Medicare before Medicaid when a person is eligible for services under both programs. Medicaid's responsibility for the coinsurance or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the person's Medicare card for Part B coverage before billing Medicaid. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare.

Note: *Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by psychiatrists, psychologists, LCSW, LMFT, and LPC providers.*

Refer to: Subsection 2.7.3, "Part B" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

Subsection 4.9.2, "Medicare Part B Crossovers" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for information about how coinsurance and deductibles may be reimbursed by Texas Medicaid.

LCSW, LMFT, and LPC services 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. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

According to 1 TAC §355.8091, the Texas Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Under 1 TAC §355.8261, an FQHC is reimbursed according to its specific prospective payment system (PPS) rate per visit for LCSW services.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the Reimbursement Rate Changes page of the TMHP website at www.tmhp.com.

Note: *Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by psychiatrists, psychologists, LCSW, LMFT, and LPC providers.*

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 4.5, "Twelve Hour System Limitation" in this handbook for details about the 12-hours-per-day behavioral health services limitation.

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4.9 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. The CMS NCCI and MUE guidelines can be found in the NCCI Policy and Medicaid Claims Processing manuals, which are available on the CMS website. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

Whenever Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

5 Intellectual Disability Service Coordination, Mental Health Targeted Case Management, and Mental Health Rehabilitative Services

5.1 Enrollment

5.1.1 Local Intellectual and Developmental Disability Authority (LIDDA) Providers

A LIDDA provider who is authorized by HHSC to provide service coordination must be enrolled as a Long Term Care provider, and must submit claims through the Long Term Care system.

LIDDAs are the only entities that provide case management (service coordination) services to persons who have an intellectual disability.

Refer to: The TMHP website at www.tmhp.com for additional information about Long Term Care enrollment and billing requirements.

5.1.2 Local Mental Health Authority (LMHA) Providers

LMHA providers are authorized by the HHSC to provide targeted case management services and mental health rehabilitative services. To enroll in Texas Medicaid, LMHA providers must contact HHSC at performance.contracts@hhsc.state.tx.us to be approved.

5.1.3 Non-Local Mental Health Authority (Non-LMHA) Providers

Non-LMHAs are private providers of both mental health (MH) case management and MH rehabilitative services, but they are not LMHAs. They must comply with all applicable federal and local laws and all of the regulations that are related to the services they provide. After receiving approval for enrollment in Texas Medicaid, the Non-LMHA provider must be credentialed by a Texas Medicaid managed care organization (MCO) to provide services to Texas Medicaid eligible persons.

Non-LMHA providers also must register to use the DSHS Clinical Management for Behavioral Health Services (CMBHS) clinical record-keeping system before providing services to Texas Medicaid eligible persons.

5.1.4 Provider Credentials for Facilities Delivering MHTCM and Mental Health Rehabilitative Services

Community Services Specialist (CSSP), Qualified Mental Health Professional - Community Services (QMHP-CS), family partners, and peer providers are eligible to deliver some or all of the mental health rehabilitative services and mental health targeted case management services. The credentialing requirements and services each provider may deliver are listed in the following sections.

Staff administering the assessment instruments must have documentation of current certification in the CANS or ANSA. Certification must be updated annually through an approved entity.

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5.1.4.1 Community Services Specialist (CSSP)

CSSP providers are eligible to deliver Mental Health Targeted Case Management (MHTCM) and Mental Health (MH) Rehabilitative services and must meet the following minimum credentialing requirements:

- High school diploma or high school equivalency;
- Three continuous years of documented full-time experience in the provision of MH rehabilitative services prior to August 30, 2004; and
- Demonstrated competency in the provision and documentation of MHTCM and MH rehabilitative services.

A CSSP performing MHTCM and MH rehabilitative services must:

- Be an employee of the provider where MHTCM services are delivered.
- Be clinically supervised by at least a QMHP-CS.

5.1.4.2 Qualified Mental Health Professional - Community Services (QMHP-CS)

QMHP-CS providers are eligible to deliver MHTCM and MH rehabilitative services and must meet the following minimum credentialing requirements:

- Completed a standardized training curriculum
- Demonstrated competency in the work to be performed
- Obtained one of the following:
    - A bachelor's degree from an accredited college or university with a minimum number of hours that are equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention
    - A license as a registered nurse (RN)

Staff administering the functional assessment instruments must have documentation of current certification in either the Child and Adolescent Needs and Strengths Assessment (CANS) or the Adult Needs and Strengths Assessment (ANSA). Certification in either the CANS or ANSA must be updated annually through an approved entity.

An individual who possesses any of the following licenses is considered a Licensed Practitioner of the Healing Arts (LPHA) and is automatically certified as a QMHP-CS:

- Physician
- Physician Assistant
- Advanced Practice Registered Nurse
- Psychologist
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)

A QMHP-CS must be clinically supervised by another QMHP-CS. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA.

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5.1.4.3 Peer Provider

Peer providers must have a high school diploma or high school equivalency, one cumulative year of receiving mental health services, and be clinically supervised by an LPHA. The supervising LPHA must conduct at least monthly documented meetings with the peer provider and conduct an additional monthly documented observation of the peer providing services.

A peer provider must satisfy all staff credentialing, competency, training, and clinical supervision requirements.

Services provided by a peer provider must be included in the treatment plan.

5.1.4.4 Family Partner

A certified family partner (CFP) must have a high school diploma or high school equivalency and one cumulative year of participating in mental health services as the parent or legally authorized representative (LAR) of a child receiving mental health services.

A CFP must be supervised by at least a QMHP-CS and must satisfy all staff credentialing, competency, training, and clinical supervision requirements.

Services provided by a CFP must be included in the treatment plan.

Family partners must be credentialed as a CFP within one year of their hire date.

The family partner service is provided to parents or LARs for the benefit of the Medicaid eligible child.

5.1.4.5 Certifications for Mental Health Rehabilitative Services

The following provider certifications are required for mental health rehabilitative services:

Service	Provider Types					
	QMHP-CS	CSSP	Peer Provider	Licensed Medical Personnel	Family Partner	RN
Medication Training and Support - Child, Youth, LAR, Primary Caregiver	X	X		X	X	X
Medication Training and Support - adult or LAR	X	X	X	X		X
Psychosocial Rehabilitation (adults only)	X	X	X	X		X
Skills training and development - adult or LAR	X	X	X	X		X
Skills training and development - child/ youth or LAR	X	X		X	X	X
Crisis Intervention	X			X		X
Day Program for Acute Needs - Symptoms management and functioning skills	X	X	X	X		X
Day Program for Acute Needs - Pharmacology issues				X		X

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Service	Provider Types					
	QMHP-CS	CSSP	Peer Provider	Licensed Medical Personnel	Family Partner	RN
Day Program for Acute Needs - Psychiatric Nursing services				X		X

5.2 Services, Benefits, Limitations, and Prior Authorization

5.2.1 Intellectual and Developmental Disabilities Service Coordination

Texas Medicaid provides the following:

- Service coordination for persons who have an intellectual disability or a related condition (adult or child). Persons who have a related condition are eligible if they are being enrolled into the home and community based waiver (HCS); the Texas Home Living Waiver; or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).
- Service coordination for persons who have an intellectual disability or a related condition who are enrolled in HCS or Texas Home Living waiver programs.

Service coordination funded by Medicaid as TCM is reimbursed by encounter.

There are two types of encounters:

- *Comprehensive encounter (Type A):* A face-to-face contact with a person to provide service coordination. The comprehensive encounter is limited to one billable encounter per person per calendar month. HHSC will not authorize payment for a comprehensive encounter that exceeds the cap of one encounter per person per calendar month.
- *Supportive encounter (Type B):* A face-to-face, telephone, or telemedicine contact with a person or with a collateral on the person's behalf to provide service coordination.

A LIDDA is allowed up to three Type B encounters per calendar month for each Type A encounter that has occurred within the calendar month.

The Type B encounters are not limited to three per person. Rather, the allowed Type B encounters may be delivered to any person who needs a Type B encounter. These Type B encounters are allowable as long as the person who received the Type B encounter also received a Type A encounter that same month.

For example, Sam and Mary receive a Type A encounter in June. It is allowable for the LIDDA to bill for one Type B encounter for Sam in June and five Type B encounters for Mary in June.

Payment for a person's Type B encounter is contingent on that the person having a Type A encounter within the same calendar month.

Within the calendar month, the Type A encounter does not have to occur on a date before any of the Type B encounters occur.

Prior authorization is not required for IDD coordination services.

5.2.2 * Mental Health Targeted Case Management (MHTCM)

Mental health targeted case management (MHTCM) services are case management services to persons within targeted groups. The target population that may receive MHTCM as part of the Texas Medicaid Program are persons, regardless of age, with a diagnosis or diagnoses of mental illness or serious emotional disturbance (SED) as defined in the latest edition of the American Psychiatric Association's DSM, and who have been determined via a uniform assessment process to need MHTCM services.

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Persons of any age with a single diagnosis of intellectual and developmental disabilities (IDD) and related conditions, or a single diagnosis of substance use disorder (SUD) are not eligible for MHTCM services.

MHTCM services are furnished to assist persons in gaining access to needed medical, social, behavioral, educational, and other services and supports. MHTCM activities and services include:

- A comprehensive initial assessment and periodic reassessment, as medically necessary, of the person's needs to determine the need for any medical, educational, social, behavioral, or other services.
- The development, and periodic revision, as medically necessary, of a trauma-informed and person-centered plan of care that:
  - Is based on the information collected through the uniform assessment;
  - Specifies the goals and actions to address the medical, social, behavioral, educational, and other services and supports needed by the person;
  - Includes activities, such as ensuring the active participation of the eligible person and working with the person, or the person's authorized health care decision maker, and others to develop these goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible person.
- Making referrals and performing other related activities, such as scheduling an appointment on behalf of the person, to help an eligible person obtain needed services and supports, including activities that help link a person with:
  - Medical, social, behavioral, and educational providers; and
  - Other programs and services that can provide needed services to address identified needs and achieve goals in the plan of care.
- Monitoring and performing the necessary follow-up that is necessary to ensure the plan of care is implemented and adequately addresses the needs of the person.

MHTCM activities may be with the person, family members, LAR, providers, or other entities or individuals and conducted as frequently as necessary, and at least once annually, to determine whether the following conditions are met:

- Services are being furnished in accordance with the person's plan of care;
- Services in the plan of care are adequate in amount, scope, and duration to meet the needs of the person; and
- The plan of care and service arrangements are modified when the needs or status of the person changes.

MHTCM is a benefit for persons transitioning to a community setting for up to 180 consecutive days prior to leaving a nursing facility; however, MHTCM services are coordinated with, and do not duplicate activities provided, as part of nursing facility services and discharge planning activities.

MHTCM consists of intensive case management and routine case management. Intensive case management services are predominantly community-based case management activities provided to the child or youth or to the LAR on behalf of the child or youth (who may or may not be present) to assist a child or youth and caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the child or youth's needs. Routine case management services are primarily office-based case management activities that assist a person, caregiver, or LAR in obtaining and coordinating access to necessary care and services appropriate to the child's or youth's needs.

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Intensive case management and routine case management are benefits for persons who are 20 years of age and younger. Intensive case management and routine case management are not payable on the same day.

Routine case management is a benefit for persons who are 21 years of age and older.

Providers must use procedure code T1017 and the appropriate modifier for MHTCM:

Modifier	Description
95	Delivered by synchronous audiovisual technology
FQ	Delivered by synchronous telephone (audio-only technology)
HA	Child/Adolescent Program
HZ	Funded by criminal justice agency
TF	Routine Case Management
TG	Intensive Case Management

Procedure code T1017 is limited to the following diagnosis codes:

[Revised] Diagnosis Codes							
F060	F061	F062	F0630	F0631	F0632	F0633	F0634
F064	F068	F070	F0789	F09	F200	F201	F202
F203	F205	F2081	F2089	F209	F21	F22	F23
F24	F250	F251	F258	F259	F28	F29	F3010
F3011	F3012	F3013	F302	F303	F304	F309	F310
F3110	F3111	F3112	F3113	F312	F3130	F3131	F3132
F314	F315	F3160	F3161	F3162	F3163	F3164	F3170
F3171	F3172	F3173	F3174	F3175	F3176	F3177	F3178
F3181	F3189	F319	F320	F321	F322	F323	F324
F325	F3281	F3289	F329	F32A	F330	F331	F332
F333	F3340	F3341	F3342	F338	F339	F340	F341
F3481	F348	F349	F39	F4000	F4001	F4002	F4010
F4011	F40210	F40218	F40220	F40228	F40230	F40231	F40232
F40233	F40240	F40241	F40242	F40243	F40248	F40290	F40291
F40298	F408	F409	F410	F411	F413	F418	F419
F422	F423	F424	F428	F429	F430	F4310	F4311
F4312	F4320	F4321	F4322	F4323	F4324	F4325	F4329
F4381	F4389	F439	F440	F441	F442	F444	F445
F446	F447	F4481	F4489	F449	F450	F451	F4520
F4521	F4522	F4529	F4541	F4542	F458	F459	F481
F482	F488	F489	F5000	F50010	F50011	F50012	F50013
F50014	F50019	F50020	F50021	F50022	F50023	F50024	F50029
F5020	F5021	F5022	F5023	F5024	F5025	F50810	F50811
F50812	F50813	F50814	F50819	F5082	F5083	F5084	F5089
F509	F5101	F5102	F5103	F5104	F5105	F5109	F5111
F5112	F5113	F5119	F513	F514	F515	F518	F519

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[Revised] Diagnosis Codes							
F530	F531	F54	F600	F601	F602	F603	F604
F605	F606	F607	F6081	F6089	F609	F630	F631
F632	F633	F6381	F6389	F639	F640	F641	F642
F648	F649	F64A	F6810	F6811	F6812	F6813	F68A
F69	F8082	F900	F901	F902	F908	F909	F910
F911	F912	F913	F918	F919	F930	F938	F939
F940	F941	F942	F948	F949	F980	F981	F9821
F9829	F983	F984	F985	F988	F989	F99	O906
T7402XA	T7402XD	T7402XS	T7412XA	T7412XD	T7412XS	T7422XA	T7422XD
T7422XS	T7452XA	T7452XD	T7452XS	T7462XA	T7462XD	T7462XS	T7602XA
T7602XD	T7602XS	T7612XA	T7612XD	T7612XS	T7622XA	T7622XD	T7622XS
T7652XD	T7652XS	T7662XA	T7662XD	T7662XS			

An MHTCM reimbursable session is the provision of a case management activity by an authorized case manager during a meeting with a person who is authorized to receive that specific type of case management. A billable unit of MHTCM is 15 continuous minutes of contact.

MHTCM is not payable when delivered on the same day as psychosocial rehabilitative services.

The following activities are included in the MHTCM rate and will not be reimbursed separately:

- Documenting the provision of MHTCM services to include developing and revising the plan of care and interventions that are appropriate to a person's needs.
- On-going administration of the uniform assessment to determine amount, duration, and type of MHTCM.
- Travel time required to provide MHTCM services at a location not owned, operated, or under arrangement with the provider.

Texas Medicaid must not be billed for MHTCM services provided before the establishment of a diagnosis of mental illness and the authorization of services.

Note: *MHTCM claims submitted by non-LMHAs for dual-eligible persons will be processed by TMHP in the same manner that dual-eligible LMHA/Local Behavioral Health Authority (LBHA) claims are processed to pay cost-sharing. These claims will be carved-out of managed care and will not be sent to the person's MCO. MHTCM claims submitted by non-LMHAs for persons with Medicaid-only (all persons who are not dual-eligible) will be carved-in for managed care, meaning that FFS will pay the claims until the person chooses an MCO, and then the claims will be forwarded to the person's MCO for processing and reimbursement.*

5.2.2.1 Telemedicine and Telehealth

Providers of MHTCM services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered and primarily driven by the person's choice and not provider convenience.

Providers must provide MHTCM services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, MHTCM services in full accordance with all applicable licensure and certification

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During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

5.2.2.1.1 Synchronous Audiovisual Technology

MHTCM services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR. In addition, approval to deliver the services by synchronous audiovisual technology must be documented in the plan of care of the person receiving services. MHTCM services provided by synchronous audiovisual technology must be billed using modifier 95.

5.2.2.1.2 Synchronous Telephone (Audio-Only Technology)

MHTCM services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and, if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR. In addition, approval to deliver the services by synchronous telephone (audio-only) technology must be documented in the plan of care of the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of MHTCM services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. MHTCM services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual MHTCM, mental health rehabilitation (MHR), or peer specialist service from the same billing provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual MHTCM, MHR, or peer specialist service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

> ***Note:*** *"Same billing provider" refers to providers that are within the same entity, as identified by the entity's NPI number or numbers, if the entity has multiple locations (i.e., the same LMHA/LBHA or same non-LMHA/private provider).*

> ***Note:*** *The required in-person or synchronous audiovisual-delivered MHTCM, MHR, or peer specialist service may be delivered by another authorized professional or paraprofessional of the same LMHA/LBHA or the same non-LMHA as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

The billing provider is required to conduct at least one in-person or synchronous audiovisual MHTCM, MHR, or peer specialist service every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person's medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area.

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- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person's condition(s).

Note: *The required in-person or synchronous audiovisual-delivered MHTCM, MHR, or peer specialist service may be delivered by another authorized professional or paraprofessional of the same LMHA/LBHA or the same non-LMHA as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

5.2.2.2 Collateral Contacts

MHTCM may include contacts with non-eligible individuals who are directly related to identifying the eligible person's needs and care for the purposes of helping the eligible person access services, identifying needs and supports to assist the eligible person in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible person's needs.

MHTCM services involving collateral contacts are only payable when the person or LAR is also present during the case management session.

5.2.2.3 Intensive Case Management for Persons 20 Years of Age and Younger

Intensive case management services incorporate a wraparound approach to care planning and treatment plan implementation. The wraparound process is a strengths-based course of action involving a child or youth and their family, including any additional people identified by the child or youth, LAR, primary caregiver, and family, that results in a unique set of community services and natural supports that are individualized for the child or youth to achieve a positive set of identified outcomes.

Intensive case management services are primarily community-based, meaning that services are provided in whatever setting is clinically appropriate and person-centered, to include telehealth delivery.

A case manager assigned to a child or youth who is authorized to receive intensive case management services must have completed training in the National Wraparound Implementation Center's Wraparound Practice model and must incorporate wraparound process planning or other approved models in developing a plan of care that addresses the unmet needs of the child or youth across life domains.

The case manager must develop an intensive case management plan of care that is trauma-informed and person-centered and is based on the needs of the child or youth, which may include information across life domains from relevant sources.

The case manager must meet with the child or youth and the LAR or primary caregiver:

- Within seven days after the case manager is assigned to the child or youth; or
- Within seven days after discharge from an inpatient psychiatric setting, whichever is later; or
- Document the reasons the meeting did not occur and meet at the soonest available opportunity.

The case manager must identify the child's or youth's strengths, service needs, and assistance that will be required to address the identified needs in the plan of care.

The case manager must take steps that are necessary to assist the child or youth in gaining access to the needed services and service providers, including:

- Making referrals to potential service providers.
- Initiating contact with potential service providers.
- Arranging, and if necessary to facilitate linkage, accompanying the child or youth to initial meetings and non-routine appointments.

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- Arranging transportation to ensure the child or youth attendance.
- Advocating with service providers.
- Providing relevant information to service providers.
- Monitoring the child's or youth's progress toward the goals set forth in the plan.

5.2.2.3.1 Prior Authorization Requirements

Initial Authorization Requirements

Providers of MTHCM services must not bill Texas Medicaid for services prior to the establishment of a diagnosis of mental illness and the authorization or reauthorization of services.

Eligibility and continued eligibility determinations occur at the facility (provider) that is providing MHTCM services using the Clinical Management of Behavioral Health Services (CMBHS) software system. Criteria used to make these service determinations are from the recommended Level of Care (LOC) of the person generated by the CMBHS software system, as derived from the uniform assessment, the needs of the person, and the Texas Resilience and Recovery (TRR) Utilization Management Guidelines. Providers of MTHCM services must ensure the following:

- A Qualified Mental Health Professional-Community Services (QMHP-CS) or Licensed Practitioner of the Healing Arts (LPHA) performs a screening for eligibility using the uniform assessment;
- An LPHA determines the diagnosis, which must include an interview with the person conducted either in-person or by telemedicine or telehealth;
- The clinical needs of the person are evaluated to determine if the amount of MHTCM services associated with the recommended LOC, described in the TRR Utilization Management Guidelines, is sufficient to meet those needs; and
- An LPHA reviews the recommended LOC and verifies whether the services are medically necessary.

If the provider determines the type of MHTCM services associated with the recommended LOC generated by the CMBHS software system is sufficient to meet the needs of the person, the provider must submit a request for prior authorization according to the recommended LOC. If the provider determines that a LOC, other than the recommended LOC, is more appropriate for the person then the provider must submit a prior authorization deviation request that includes the following:

- The word 'Deviation' with a note that the request is for prior authorization of a LOC that is higher or lower than initially recommended; and
- The clinical justification for the request to include the specific reason(s) for why the person requires interventions higher or lower than the recommended LOC (refusal of recommended LOC by the person receiving services may be noted as part of the justification).

For persons enrolled in managed care, LMHAs/LBHAs and non-LMHAs (also referred to as private providers) contracted with MCOs must submit prior authorization requests to the MCO with whom the person is enrolled. MCOs must follow the requirements set forth in the Uniform Managed Care Manual regarding utilization management for MHTCM services. MCOs may choose to waive prior authorization submission requirements.

For persons in fee-for-service (FFS) Medicaid, LMHAs/LBHAs must obtain prior authorization from their internal utilization management department using the CMBHS software system. Non-LMHAs must obtain prior authorization from the TMHP Prior Authorization Department using the Special Medical Prior Authorization (SMPA) request form and the information obtained from the CMBHS software system. When completing the SMPA form for prior authorization, non-LMHAs must complete the following sections of the form as follows:

- Section A – Client information

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    - Complete as indicated in the form.
- Section B – Requested procedure or service information
    - The type of request is 'Other'
    - The expected dates of service are the start and end dates provided by CMBHS
    - The procedure related CPT code is the code for MHTCM and the appropriate modifier(s)
    - The comments text box must indicate if the prior authorization request is an 'initial assessment' or 'reassessment'
- Section C – To be completed by requesting physician or requesting provider
    - The diagnosis(es) is/are the ICD-10 primary diagnosis and related ICD-10 diagnosis code(s)
    - The statement of medical necessity section must indicate the recommended LOC generated by CMBHS software system. If the request is a deviation from the recommended LOC, then the provider must include the following:
        - The word 'Deviation' with a note that the request is for prior authorization of a LOC that is higher or lower than the recommended LOC;
        - The clinical justification for the request to include the specific reason(s) for why the person requires interventions outside the recommended LOC (refusal of recommended LOC by the person receiving services may be noted as part of the justification); and
        - If requested by the TMHP Prior Authorization Department, a copy of the CANS or ANSA functional assessment.
    - Complete provider information as indicated in the form
        - The SMPA form must be signed and dated within 30 calendar days of the expected start date of services.

All plans of care are subject to retrospective review by the state.

Reauthorization Requirements

At a minimum, providers must ensure that a QMHP-CS administers the uniform assessment and obtains a recommended LOC from the CMBHS software system for the person receiving MHTCM services:

- Every 90 calendar days for persons 20 years of age and younger; or
- Every 180 calendar days for persons 21 years of age and older.

Note: *Providers must follow the same process that is used for initial authorization for reauthorization of services at the specified intervals indicated above (i.e., every 90 or 180 calendar days, as applicable).*

5.2.2.4 Eligibility and Service Determinations for Persons Who are 20 Years of Age and Younger

MHTCM is a benefit for persons who are 20 years of age and younger (child or youth) with a diagnosis or diagnoses of mental illness, or SED, as defined in the latest edition of the APA's DSM (excluding a single diagnosis of IDD and related disorders, or a single diagnosis of SUD) and who:

- Have been determined via the uniform assessment process to have a serious functional impairment and to need MTHCM services; or
- Are at risk of disruption of a preferred living or child-care environment due to psychiatric symptoms; or
- Are enrolled in a school system's special education program because of SED.

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The initial assessment is the clinical process of obtaining and evaluating historical, social, behavioral, functional, psychiatric, developmental, or other information from the person seeking services to determine specific treatment and support needs.

Functioning is assessed using one of the following tools:

- The Child and Adolescent Needs and Strengths Assessment (CANS) for persons who are 17 years of age and younger
- The Adult Needs and Strengths Assessment (ANSA) and any necessary supplemental assessments for persons who are 18 to 20 years of age

Services and supports to be provided to the child or youth are determined jointly by the child or youth, family, and the provider.

Children and youth MHTCM services authorized for care by the provider through a clinical override are eligible for the duration of the authorization.

Continued eligibility for children and youth for MHTCM services is based on a reassessment every 90 calendar days and reauthorization of services by the provider of MHTCM services using the CMBHS software system. Assignment of diagnosis in the CMBHS software system is required at any time the APA DSM diagnosis changes and at least annually from the last diagnosis entered in the CMBHS software system.

5.2.2.5 Eligibility and Service Determinations for Persons who are 21 Years of Age and Older

MHTCM is a benefit for persons who are 21 years of age and older (adults) and who have serious mental illness (SMI), such as schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, or other severely disabling mental disorders (excluding a single diagnosis of IDD and related disorders or a single diagnosis of SUD) that require crisis resolution or ongoing and long-term support and treatment.

Adults with a diagnosis of schizophrenia or bipolar disorder are automatically eligible for services. Adults with any other mental health diagnosis require evidence of significant difficulty functioning across one or more domains, such as work or school, to be eligible for services.

The initial assessment is the clinical process of obtaining and evaluating historical, social, behavioral, functional, psychiatric, developmental, or other information from the person seeking services to determine specific treatment and support needs.

Functioning is assessed using the ANSA standardized assessment tool. Continued eligibility for adults for MHTCM services is based on a reassessment every 180 calendar days and reauthorization of services by the provider of MHTCM services using the CMBHS software system. Assignment of diagnosis in the CMBHS software system is required at any time the DSM diagnosis changes and at least annually from the last diagnosis entered into CMBHS software system.

Adults with a diagnosis of schizophrenia or bipolar disorder are automatically eligible for continued services. Adults with a diagnosis of major depressive disorder whose level of functioning qualified them initially are also automatically eligible for continued services, regardless of whether their level of functioning improved.

Adults with any other mental health diagnoses are eligible for continued services if their level of functioning continues to be significantly impaired, as evidenced by the results of the ANSA standardized assessment tool.

5.2.2.6 Documentation Requirements

A comprehensive diagnosis must be included in the person's medical record, including documentation of applicable diagnostic criteria according to the latest edition of the APA's DSM, as well as the specific justification of need for services.

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MHTCM services, including attempts to provide MHTCM services, must be documented in the person's medical record.

For routine case management, the case manager must document the person's strengths, service needs, and assistance required to address the service needs as well as the steps that are necessary to accomplish the goals required to meet the person's service needs.

For intensive case management, the assigned case manager must include the intensive case management plan of care in the child's or youth's medical record and document steps taken to meet the child's or youth's goals and needs in the child's or youth's progress notes.

As a result of the assessments and reassessments conducted, the case manager must document the person's identified strengths, service needs, and assistance given to address the identified need, and specific goals and actions to be accomplished.

The case manager must document the following for all services provided:

- The event or behavior that occurs while providing the MHTCM service or the reason for the specific case management encounter
- The person, persons, or entity, including other case managers, with whom the encounter or contact occurred
- Collateral contacts such as contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the person access services and managing the person's care, including coordination with other case managers
- The recovery plan goal(s) that was the focus of the service, including the progress or lack of progress in achieving recovery plan goal(s)
- The timeline for obtaining the needed services
- The specific intervention that is being provided
- The date the MHTCM service was provided
- The start and end time of the MHTCM service
- The mode of delivery used to provide the MHTCM service
- The name of the provider agency and the signature of the employee providing the MHTCM service, including their credentials
- The timeline for reevaluating the needed service

If the person refuses MHTCM services, the case manager must document the reason for the refusal in the most appropriate area of the person's medical record and request that the person sign a waiver of MHTCM services that is filed in the person's medical record.

The provider must retain documentation in compliance with applicable records retention requirements in federal and state laws, rules, and regulations. Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

5.2.2.7 Exclusions

The following services are not covered by MHTCM:

- Case management activities that are an integral component of another covered Medicaid service

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- The provision of a medical, educational, social, behavioral, or other service to which a person has been referred, including for foster care programs, services such as, but not limited to, the following:
  - Research gathering and completion of documentation required by the foster care program
  - Assessing adoption placements
  - Recruiting or interviewing potential foster care parents
  - Serving legal papers
  - Home investigations
  - Providing transportation, including transporting the person to his/her LAR/primary caregiver
  - Administering foster care subsidies
  - Making placement arrangements
- Performing an activity that does not directly assist a person in gaining or coordinating access to needed services
- Providing medical or nursing services
- Performing preadmission or intake activities
- Monitoring the person's general health status
- Performing outreach activities
- Performing quality oversight of a service provider
- Conducting utilization review or utilization management activities
- Conducting quality assurance activities
- Authorizing services or authorizing the provision of services
- Services to inmates of public institutions

5.2.3 * Mental Health Rehabilitative Services

Mental health rehabilitative services are defined as providing assistance in maintaining or improving functioning and may be considered rehabilitative when necessary to help a person achieve a rehabilitation goal as defined in their plan of care.

Mental health rehabilitative services are provided to a person with a serious mental illness (SMI), as defined in the latest edition of the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual of Mental Disorders (DSM).

Mental health rehabilitative services are age-appropriate, individualized, and designed to ameliorate functional impairments that negatively affect any of the following:

- Community integration
- Community tenure
- Behaviors resulting from SMI or severe emotional disturbance (SED) that interfere with a person's ability to remain in the community as a fully integrated and functioning member of that community

Mental health rehabilitative services may include:

- Medication training and support services
- Psychosocial rehabilitative services
- Skills training and development
- Crisis intervention services

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- Day programs for acute needs

Mental health rehabilitative services may only be provided by a member of the person's therapeutic team. The therapeutic team must include enough staff to adequately address the rehabilitative needs of persons assigned to the team.

Team members must be appropriately credentialed and have completed required trainings to provide the full array of component services, have regularly scheduled team meetings either in person or by teleconference, and every member of the team must be knowledgeable of the needs and the services available to the specific persons assigned to the team.

Mental health rehabilitative services may be a benefit for persons residing in a nursing facility (NF) when medically necessary as determined by a uniform assessment protocol and determined through pread-mission screening and resident review (PASRR) to require specialized services.

The following procedure codes are a benefit for mental health rehabilitation:

Service Category	Procedure Codes	Modifiers
Day Program for Acute Needs	H2012	
Medication Training and Support	H0034	HQ: group services for adults HA/HQ: group services for child/youth
Crisis Intervention	H2011	HA: child/youth
Skills Training and Development	H2014	HQ: group services for adults HA: individual services for child/youth HA/HQ: group services for child/youth
Psychosocial Rehabilitation Services	H2017	TD: individual services provided by RN HQ: group services HQ/TD: group services provided by RN ET: individual crisis services

Mental Health Rehabilitative Services Modifiers	Description
95	Delivered by synchronous audiovisual technology
ET	Emergent treatment
FQ	Delivered by synchronous telephone (audio-only) technology
HA	Child/adolescent program
HQ	Group setting
HZ	Funded by criminal justice agency
TD	Services provided by an RN

Psychosocial rehabilitation is not reimbursable on the same day as MHTCM services or skills training and development.

Reimbursement for procedure codes H0034, H2012, H2014, and H2017 are limited to the following diagnosis codes:

[Revised] Diagnosis Codes							
F060	F061	F062	F0630	F0631	F0632	F0633	F0634
F064	F068	F070	F0789	F09	F200	F201	F202
F203	F205	F2081	F2089	F209	F21	F22	F23

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[Revised] Diagnosis Codes							
F24	F250	F251	F258	F259	F28	F29	F3010
F3011	F3012	F3013	F302	F303	F304	F309	F310
F3110	F3111	F3112	F3113	F312	F3130	F3131	F3132
F314	F315	F3160	F3161	F3162	F3163	F3164	F3170
F3171	F3172	F3173	F3174	F3175	F3176	F3177	F3178
F3181	F3189	F319	F320	F321	F322	F323	F324
F325	F3281	F3289	F329	F32A	F330	F331	F332
F333	F3340	F3341	F3342	F338	F339	F340	F341
F3481	F3489	F349	F39	F4000	F4001	F4002	F4010
F4011	F40210	F40218	F40220	F40228	F40230	F40231	F40232
F40233	F40240	F40241	F40242	F40243	F40248	F40290	F40291
F40298	F408	F409	F410	F411	F413	F418	F419
F422	F423	F424	F428	F429	F430	F4310	F4311
F4312	F4320	F4321	F4322	F4323	F4324	F4325	F4329
F4381	F4389	F439	F440	F441	F442	F444	F445
F446	F447	F4481	F4489	F449	F450	F451	F4520
F4521	F4522	F4529	F4541	F4542	F458	F459	F481
F482	F488	F489	F5000	F50010	F50011	F50012	F50013
F50014	F50019	F50020	F50021	F50022	F50023	F50024	F50029
F5020	F5021	F5022	F5023	F5024	F5025	F5020	F5021
F5022	F5023	F5024	F5025	F50810	F50811	F50812	F50813
F50814	F50819	F5082	F5083	F5084	F5089	F509	F5101
F5102	F5103	F5104	F5105	F5109	F5111	F5112	F5113
F5119	F513	F514	F515	F518	F519	F530	F531
F54	F600	F601	F602	F603	F604	F605	F606
F607	F6081	F6089	F609	F630	F631	F632	F633
F6381	F6389	F639	F640	F641	F642	F648	F649
F64A	F6810	F6811	F6812	F6813	F68A	F69	F8082
F900	F901	F902	F908	F909	F910	F911	F912
F913	F918	F919	F930	F938	F939	F940	F941
F942	F948	F949	F980	F981	F9821	F9829	F983
F984	F985	F988	F989	F99	O906	T7402XA	T7402XD
T7402XS	T7412XA	T7412XD	T7412XS	T7422XA	T7422XD	T7422XS	T7452XA
T7452XD	T7452XS	T7462XA	T7462XD	T7462XS	T7602XA	T7602XD	T7602XS
T7612XA	T7612XD	T7612XS	T7622XA	T7622XD	T7622XS	T7652XD	T7652XS
T7662XA	T7662XD	T7662XS					

No diagnosis is required for crisis intervention services (procedure code H2011); however, all CMS 1500 claim forms require a diagnosis.

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A Medicaid provider may only bill for medically necessary mental health rehabilitative services that are provided face-to-face to:

- A Medicaid-eligible person;
- The LAR of a Medicaid-eligible person who is 21 years of age and older (on behalf of the person); or
- The LAR or primary caregiver of a Medicaid-eligible person who is 20 years of age and younger (on behalf of the person).

Rehabilitative services delivered via group modality are limited to an 8-person maximum for adults and a 6-person maximum for children or adolescents (not including LARs or caregivers).

Note: *MHR claims submitted by non-LMHAs for dual-eligible persons will be processed by TMHP in the same manner that dual-eligible LMHA/LBHA claims are processed to pay cost-sharing. These claims will be carved-out of managed care and will not be sent to the person's MCO. MHR claims submitted by non-LMHAs for persons with Medicaid-only (all persons who are not dual-eligible) will be carved-in for managed care, meaning that FFS will pay the claims until the person chooses an MCO, and then the claims will be forwarded to the person's MCO for processing and reimbursement.*

5.2.3.1 Telemedicine and Telehealth

Providers of MHR services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered and primarily driven by the person's choice and not provider convenience.

Providers must provide MHR services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, MHR services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

5.2.3.1.1 Synchronous Audiovisual Technology

The following MHR services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR. In addition, except for crisis intervention services, approval to deliver the services by synchronous audiovisual technology must be documented in the plan of care of the person receiving services. MHR services provided by synchronous audiovisual technology must be billed using modifier 95.

- Medication training and support (procedure code H0034).
- Skills training and development (procedure code H2014).
- Psychosocial rehabilitation services (procedure code H2017).
- Crisis intervention services (procedure code H2011).
  - Documented approval of the mode of delivery in the plan of care is not required prior to the delivery of crisis intervention services by synchronous audiovisual technology.

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5.2.3.1.2 Synchronous Telephone (Audio-Only) Technology

The following MHR services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR. In addition, except for crisis intervention services, approval to deliver the services by synchronous telephone (audio-only) technology must be documented in the plan of care of the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of MHR services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. MHR services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

- Medication training and support (procedure code H0034)
- Skills training and development (procedure code H2014)
- Psychosocial rehabilitation services (procedure code H2017)
- Crisis intervention services (procedure code H2011)
    - Synchronous telephone (audio-only) technology may only be used for crisis intervention services as a back-up mode of delivery only, meaning if the person who is in crisis, not the billing provider, is unwilling or has limited technological capabilities that prevent them from using a synchronous audiovisual platform at the time the crisis intervention services are delivered. Also, the existing clinical relationship requirement is waived.
    - Documented approval of the use of synchronous telephone (audio-only) technology in the plan of care is not required prior to the delivery of crisis intervention services. However, providers must document the justification for using synchronous telephone (audio-only) technology to deliver crisis intervention services in the medical record.

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual MHR, MHTCM, or peer specialist service from the same billing provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous MHR, MHTCM, or peer specialist audiovisual service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

> ***Note:*** *"Same billing provider" refers to providers that are within the same entity, as identified by the entity's NPI number or numbers, if the entity has multiple locations (i.e., the same LMHA/LBHA or same non-LMHA/private provider).*

> ***Note:*** *The required in-person or synchronous audiovisual-delivered MHTCM, MHR, or peer specialist service may be delivered by another authorized professional or paraprofessional of the same LMHA/LBHA or the same non-LMHA as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

The billing provider is required to conduct at least one in-person or synchronous audiovisual MHR, MHTCM, or peer specialist service every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for

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the decision must be documented in the person's medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area.
- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person's condition(s).

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

Note: *The required in-person or synchronous audiovisual-delivered MHTCM, MHR, or peer specialist service may be delivered by another authorized professional or paraprofessional of the same LMHA/LBHA or the same non-LMHA as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

5.2.3.2 Eligibility and Service Determinations for Persons Who are 20 Years of Age and Younger

Certain mental health rehabilitative services (crisis intervention services, medication training and support, and skills training and development) are available to persons who are 20 years of age and younger with a diagnosis of mental illness or SED, as defined in the latest edition of APA's DSM and who:

- Have been determined via the uniform assessment process to have a serious functional impairment;
- Are at risk of disruption of a preferred living or child-care environment due to psychiatric symptoms; or
- Are enrolled in a school system's special education program because of a SED.

Functioning is assessed using the Child and Adolescent Needs and Strengths Assessment (CANS) standardized assessment tool for persons who are 17 years of age and younger and the Adult Needs and Strengths Assessment (ANSA) for persons who are 18 to 20 years of age, as well as any supplemental assessments, as needed.

Continued eligibility for mental health rehabilitative services for persons who are 17 years of age and younger is based on a reassessment at least every 90 calendar days, or more frequently if clinically indicated by the provider, and reauthorization of services by the provider using the CMBHS software system. Persons who are 18 years of age and older are reassessed every 180 calendar days, or more frequently if clinically indicated by the provider, and reauthorization of services by the provider using the CMBHS software system.

Assignment of diagnosis in the CMBHS software system is required at any time the APA DSM diagnosis changes and at least annually from the last diagnosis entered in the CMBHS software system.

The LPHA determination of diagnosis must include an interview with the child or youth conducted either in person or by telemedicine or telehealth.

To complete a comprehensive diagnosis for a child or youth, documentation of the required diagnostic criteria according to the latest version of the APA's DSM, as well as the specific level of functioning, must be included in the child's or youth's record. This information must be included as part of the required assessment information.

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5.2.3.3 Eligibility and Service Determinations for Persons Who Are 21 Years of Age and Older

Persons who are 21 years of age and older with SMI, determined to be medically necessary by a uniform assessment protocol, are eligible for mental health rehabilitative services if the adult is:

- A resident of the state of Texas;
- Determined by a uniform assessment and clinician observation to require mental health rehabilitative services; and
- An LPHA has determined that such services are medically necessary.

Mental health rehabilitative services are available to persons who are 21 years of age and older who have an SMI and significant functional impairments which require crisis resolution or ongoing treatment. Functioning is assessed using the ANSA standardized assessment tool.

Continued eligibility for adults for mental health rehabilitation services is based on a reassessment at least every 180 calendar days, or more frequently if clinically indicated by the provider, and reauthorization of services by the provider of mental health rehabilitation services using the CMBHS software system.

Assignment of diagnosis in the CMBHS software system is required at any time the APA DSM diagnosis changes and at least annually from the last diagnosis entered in the CMBHS software system.

The LPHA determination of diagnosis must include an interview with the adult conducted either in person or by telemedicine or telehealth.

To complete a comprehensive diagnosis for an adult, documentation of the required diagnostic criteria according to the latest version of the APA's DSM, as well as the specific level of functioning, must be included in the adult's record. This information must be included as part of the required assessment information.

Adults with a diagnosis of schizophrenia or bipolar disorder are automatically eligible for continued services. Adults with a diagnosis of major depressive disorder whose level of functioning qualified them initially are also automatically eligible for continued services, regardless of whether their level of functioning improved. Adults with any other mental health diagnosis are eligible should their level of functioning continue to be significantly impaired, as evidenced by the results of a standardized assessment tool called the ANSA.

5.2.3.4 Treatment Planning

Mental health rehabilitative services are part of a person's plan of care and are intended to:

- Reduce a person's functional impairments resulting from SMI for adults.
- Reduce SED in children or youth.
- Restore a person to their optimal functioning level in the community.

The treatment planning process for mental health rehabilitative services requires the active participation of the Medicaid eligible person or LAR when necessary due to the person's age or legal status. Plans of care are based on a comprehensive assessment and must address the person's strengths, areas of need, the person's preferences, and descriptions of the person's treatment goals.

5.2.3.5 Medication Training and Support

Medication training and support services consist of education and guidance about medications and their possible side effects. It is curriculum-based training and guidance that serves as an initial orientation for the person in understanding the nature of their mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and increased tenure in the community.

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Medication training and support includes:

- Assisting the person to manage symptomology and maximize functioning;
- Understanding the concepts of recovery and resilience within the context of the SMI or SED;
- Developing an understanding of the relationship between mental illness and the medications prescribed to treat the illness;
- The interaction of medication with other medications, diet, and mood altering substances;
- Understanding the overdose precautions of the person's medication;
- The identification and management of potential side effects;
- Learning self-administration of the person's medication and;
- Necessity of taking medications prescribed and following the physician's or other qualified health care professional's orders.

Medication training and support is available to eligible children, youth, and adults. The LAR or primary caregiver may receive medication training and support services on behalf of an eligible adult, child or youth.

5.2.3.6 Psychosocial Rehabilitative Services

Psychosocial rehabilitative services are social, behavioral, and cognitive interventions provided by members of a person's therapeutic team that build on strengths and focus on restoring the person's ability to develop and maintain social relationships, occupational or educational achievement, and other independent living skills that are affected by or the result of an SMI in persons who are 18 years of age and older.

Psychosocial rehabilitative services include independent living services, coordination services, and employment, housing, and medication-related services. Psychosocial rehabilitative services may also address the impact of co-occurring disorders upon the person's ability to reduce symptomology and increase daily functioning.

If psychosocial rehabilitative services are in the treatment plan, the treatment plan cannot simultaneously include skills training and development or targeted case management services.

Psychosocial rehabilitative services may not be provided to a person who is currently admitted to a crisis stabilization unit.

5.2.3.6.1 Independent Living Services

Independent living services assist a person in acquiring the most immediate, fundamental functional skills needed to enable the person to reside in the community and avoid more restrictive levels of treatment or reducing behaviors or symptoms that prevent successful functioning in the person's environment of choice.

Independent living services include skills training and/or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers.

Training for independent living includes skills related to:

- Personal hygiene.
- Transportation utilization.
- Money management.
- The development of natural supports.

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- Access to needed services in the community (e.g., medical care, substance use services, legal services, living accommodations).
- Social skills (e.g., communicating one's needs to strangers and making appropriate choices for the use of leisure time).

5.2.3.6.2 Coordination Services

Coordination services are training activities that assist a person in improving his or her ability to gain and coordinate access to necessary care and services appropriate to the needs of the person.

Training for coordination skills includes instruction and guidance in such areas as:

- Identifying areas of need across all life domains.
- Prioritizing needs and setting goals.
- Identifying potential service providers and support systems.
- Initiating contact with providers and support systems.
- Participating in the development and subsequent revisions of their plan of care.
- Coordinating their services and supports.
- Advocating for necessary changes and improvements to ensure that they obtain maximum benefit from their services and supports.

5.2.3.6.3 Employment-Related Services

Employment-related services provide supports and skills training that are not job-specific and focus on developing skills to reduce or manage the symptoms of SMI that interfere with a person's ability to make vocational choices or obtain or retain employment.

Included in employment-related services are activities such as:

- Skills training related to task focus, task completion, planning and managing activities to achieve outcomes, personal hygiene, grooming and communication, and skills training related to securing appropriate clothing, developing natural supports, and arranging transportation.
- Establishing supportive contacts related to the school or work-site situation to reduce or manage behaviors or symptoms related to the person's mental illness or emotional disturbance that interfere with job performance or progress towards the development of skills that would enable the person to obtain or retain employment.

5.2.3.6.4 Housing-Related Services

Housing-related services develop a person's strengths and abilities to manage the symptoms of the person's SMI that interfere with the person's capacity to obtain or maintain tenure in independent integrated housing.

Included in housing-related services are activities such as:

- Skills training related to home maintenance and cleanliness.
- Problem solving with landlord and other residents.
- Maintaining appropriate interpersonal boundaries.
- Establishing supportive contacts related to the housing situation to reduce or manage behaviors or symptoms related to the person's mental illness or emotional disturbance that interfere with maintaining independent integrated housing.

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5.2.3.6.5 Medication-Related Services

Medication-related services provide individualized training regarding the person's medication adherence and is different from medication-training and support.

Services consist of training and supportive interventions that focus on person-specific needs and goals regarding the administration of medication, monitoring efficacy and side effects of medication, and other nursing services that enable the person to attain or maintain an optimal level of functioning.

Medication-related services do not include services or activities that are incidental to services performed by a physician (or other qualified health care professional) during an evaluation and management services visit.

5.2.3.7 Skills Training and Development

Skills training and development is training provided to an eligible person, the LAR, or primary caregiver on behalf of an eligible adult, child, or youth.

The training addresses:

- SMI or SED and symptom-related problems that interfere with the person's functioning and living, working, and learning environment.
- Provides opportunities for the person to acquire and improve skills needed to function as appropriately and independently as possible in the community.
- The person's community integration and increases his or her community tenure.

Skills training and supportive interventions focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers.

Skills training and development may include:

- Skills related to personal hygiene.
- Pro-social skills.
- Assertiveness skills.
- Anger management skills.
- Stress reduction techniques.
- Communication skills.
- Transportation utilization.
- Money management.
- The development of natural supports.
- Access to needed services in the community, e.g., medical care, substance use services, legal services, living accommodations.
- Social skills (e.g., communicating one's needs to strangers and making appropriate choices for the use of leisure time).

Skills training and development services consist of increasing the LAR's or primary caregiver's understanding of and ability to respond to the person's needs identified in the uniform assessment or documented in the treatment plan.

Persons receiving skills training and development are not eligible to simultaneously receive psychosocial rehabilitative services and both services should not be simultaneously listed in the person's treatment plan.

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5.2.3.8 Crisis Intervention

Crisis intervention services are intensive community-based one-to-one services provided to persons who require services to control acute symptoms that place the person at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting.

This service includes assessment, behavioral skills training, problem-solving, and reality orientation to help a person identify and manage their symptoms of mental illness, and cope with stressors.

Crisis intervention services may be provided in extended observation or crisis residential units. Crisis intervention services may not be provided to a person who is currently admitted to a crisis stabilization unit.

Crisis intervention services consist of the following interventions:

- An assessment of dangerousness of the person to self or others
- The provision of emergency care services that include crisis screening and response, telephone access, emergency case services, urgent care services, routine care services, and access to emergency medical/crisis services
- Behavior skills training to assist the person in reducing distress and managing symptoms
- Problem-solving
- Reality orientation to help the person identify and manage his or her symptoms of SMI or SED
- Providing instruction, structure, and emotional support to the person in adapting to and coping with immediate stressors

Crisis intervention services are available to eligible children youth and adults.

5.2.3.9 Day Programs for Acute Needs

Day programs for acute needs provide short term, intensive treatment to an eligible persons who is 18 years of age or older and who requires multidisciplinary treatment to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. Day program services are a site-based treatment provided in a group modality.

Day programs for acute needs are provided in a highly structured and safe environment with constant supervision and ensure an opportunity for frequent interaction between the adult and staff members.

Day programs for acute needs must at all times have sufficient staff to ensure safety and program adequacy according to an established staffing ratio and staff response times. This service focuses on intensive, medically-oriented, multidisciplinary interventions such as behavior skills training, crisis management, and nursing services that are designed to stabilize acute psychiatric symptoms.

These services may be provided in a residential facility; however, none of the residential facilities can contain greater than 16 beds.

Day programs for acute needs include:

- Psychiatric nursing services.
- Pharmacological instruction that addresses medication issues related to the crisis precipitating the need for provision of day programs for acute needs.
- Symptom management training.
- Functional skills training.

Day programs for acute needs must, at all times, have a sufficient number of staff members to ensure safety and program adequacy, and, at a minimum, include:

- One RN for every 16 persons at the day program's location,

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- One physician to be available by phone, with a response time not to exceed 15 minutes,
- Two staff members who are QMHP-CSs, CSSPs, or peer providers at the day program's location,
- One additional QMHP-CS who is not assigned full-time to another day program to be physically available, with a response time not to exceed 30 minutes,
- Additional QMHP-CSs, CSSPs, or peer providers at the day program's location sufficient to maintain a ratio of one staff member to every four persons receiving care.

5.2.3.10 Prior Authorization Requirements

5.2.3.10.1 Initial Authorization

Except for crisis intervention services, providers of mental health rehabilitation services must not bill Texas Medicaid prior to the authorization or reauthorization of services.

Eligibility and continued eligibility determinations occur at the facility (provider) that is providing mental health rehabilitative services using the CMBHS software system.

Criteria used to make these service determinations are from the recommended LOC of the person generated by the CMBHS software system as derived from the uniform assessment, the needs of the person, and the Texas Resilience and Recovery (TRR) Utilization Management Guidelines.

Providers of mental health rehabilitative services must ensure the following:

- A QMHP-CS or LPHA performs a screening for eligibility using the uniform assessment;
- An LPHA determines the diagnosis which must include an interview with the person conducted either in-person or by telemedicine or telehealth;
- The clinical needs of the person are evaluated to determine if the amount of mental health rehabilitation services associated with the recommended LOC, described in the TRR Utilization Management Guidelines, is sufficient to meet those needs; and
- An LPHA reviews the recommended LOC and verifies whether the services are medically necessary.

If the provider determines that an LOC other than the recommended LOC is more appropriate for the person, then the provider must submit a prior authorization 'deviation' request that includes:

- The word 'Deviation' with a note that the request is for prior authorization of an LOC that is higher or lower than initially recommended and;
- The clinical justification for the request.

The clinical justification must include the specific reason(s) why the person requires interventions higher or lower than the recommended LOC. Refusal of recommended LOC by the person receiving services may be noted as part of the justification.

For persons enrolled in managed care, LMHAs/LBHAs and non-LMHAs (also referred to as private providers) contracted with MCOs must submit prior authorization requests to the MCO with whom the person is enrolled. MCOs must follow the requirements set forth in the Uniform Managed Care Manual regarding utilization management for mental health rehabilitation services. MCOs may choose to waive prior authorization submission requirements.

For persons in fee-for-service (FFS) Medicaid, LMHAs/LBHAs must obtain prior authorization from their internal utilization management department using the CMBHS software system. Non-LMHAs must obtain prior authorization from the TMHP Prior Authorization Department using the Special Medical Prior Authorization (SMPA) request form and the information obtained from the CMBHS software system. When completing the SMPA form for prior authorization, non-LMHAs must complete the following sections of the form as follows:

- Section A – Client information

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    - Complete as indicated in the form
- Section B - Requested procedure or service information
    - The type of request is 'Other'
    - The expected dates of service are the start and end dates provided by CMBHS
    - The procedure related CPT code is the code for the type of mental health rehabilitation service (e.g., medication training and support, psychosocial rehabilitation, and skills training and development) and the appropriate modifier(s)
    - The comments text box must indicate if the prior authorization request is an initial assessment or reassessment
- Section C – To be completed by requesting physician or requesting provider
    - The diagnosis(es) is/are the ICD-10 primary diagnosis and related ICD-10 diagnosis code(s)
    - The statement of medical necessity section must indicate the recommended LOC generated by CMBHS software system. If the request is a deviation from the recommended LOC, then the provider must include the following:
        - The word 'Deviation' with a note that the request is for prior authorization of a LOC that is higher or lower than recommended LOC;
        - The clinical justification for the request to include the specific reason(s) for why the person requires interventions outside the recommended LOC (refusal of recommended LOC by the person receiving services may be noted as part of the justification); and
        - If requested by the TMHP Prior Authorization Department, a copy of the CANS or ANSA functional assessment.
    - Complete provider information as indicated in the form
        - The SMPA form must be signed and dated within 30 calendar days of the expected start date of services.

Changes to the treatment plan regarding type, amount, or duration of services must be approved by an LPHA practicing within the scope of their licensure.

All plans of care are subject to retrospective review by the state.

5.2.3.10.2 Reauthorization Requirements

To determine the type, amount, and duration of mental health rehabilitation services, providers must ensure that, at a minimum, a QMHP-CS administers the uniform assessment and obtains a recommended LOC from the CMBHS software system for the person receiving mental health rehabilitation services:

- Every 90 calendar days for persons 20 years of age and younger; or
- Every 180 calendar days for persons 21 years of age and older.

Note: *Providers must follow the same process that is used for initial authorization for reauthorization of services at the specified intervals indicated above (i.e., every 90 or 180 calendar days, as applicable).*

Prior to the expiration of the authorization period or depletion of the amount of services authorized, providers must make a determination of whether the person continues to need mental health rehabilitative services. An LPHA must also determine whether the continuing need for mental health rehabilitative services meets the definition of medical necessity.

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If the determination is that the person continues to need mental health rehabilitative services and that such services are medically necessary, the provider must:

- Request another authorization for the same type and amount of mental health rehabilitative service previously authorized; or
- Submit a request, with documented clinical reasons for such request, to change the type or amount of mental health rehabilitative services previously authorized if:
  - The provider determines the type or amount of mental health rehabilitative services previously authorized is inappropriate to address the person's needs.
  - The criteria described in the TRR Utilization Management Guidelines for changing the type or amount of mental health rehabilitative services has been met.

5.2.3.11 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered. An LPHA must document in the person's medical record that mental health rehabilitative services are medically necessary when the services are authorized and reauthorized.

Persons determined to need mental health rehabilitative services must have a treatment plan developed by the Medicaid enrolled provider of mental health rehabilitative services that describes in writing the type, amount, and duration of mental health rehabilitative services determined to be medically necessary to meet the needs of the person.

A rehabilitative services provider must document the following for all mental health rehabilitative services:

- The name of the person to whom the service was provided
- The type of service provided
- The specific goal or objective addressed, and the modality and method used to provide the service
- The date the service was provided
- The start and end time of the service
- The location where the service was provided
- The signature of the staff member providing the service and a notation of their credentials
- Any pertinent event or behavior relating to the person's treatment which occurs during the provision of the service
- The outcome or progress in achieving treatment plan goals

In addition to the general requirements described above, when providing crisis services, a provider must document the following information:

- Risk of suicide or homicide
- Substance use
- Trauma, abuse, or neglect
- The outcome of the crisis (e.g., person in hospital, person with friend and scheduled to see doctor at 9:00 a.m. the following day)
- All actions (including rehabilitative interventions and referrals to other agencies) used by the provider to address the problems presented
- The response of the person, and if appropriate, the response of the LAR and family members

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- Any pertinent event or behavior relating to the person's treatment that occurs during the provision of the service
- Follow up activities that may include referral to another provider

Documentation for day programs for acute needs must be made daily. Documentation must be made after each face-to-face contact occurs to provide the mental health rehabilitative service for all other services.

An LPHA must, within two business days after crisis intervention services are provided, determine whether the crisis intervention services met the definition of medical necessity. If medical necessity is met then the LPHA must document the medical necessity.

Services are subject to retrospective review and recoupment if documentation does not support the service billed.

A provider must retain documentation in compliance with applicable federal and state laws, rules, and regulations.

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

5.2.3.12 Exclusions

Persons receiving psychosocial rehabilitation services are not eligible to simultaneously receive skills training and development or MHTCM services.

Mental health rehabilitative services do not include any of the following services that must be billed to Texas Medicaid:

- Rehabilitative services provided:
  - Before the establishment of a diagnosis of mental illness and authorization of services
  - To persons who reside in an institution for mental diseases
  - To general acute care hospital inpatients
- Services to residents of institutions that furnish food, shelter, and treatment to four or more unrelated persons
- Services to nursing facility residents who have not been identified through the PASSR process as needing specialized mental health services
- Services to inmates of public institutions
- Job task-specific vocational services
- Educational services
- Room and board residential costs
- Services that are an integral and inseparable part of another Medicaid-reimbursable service, including MHTCM services, residential rehabilitative behavioral health services, institutional and waiver services
- Services that are covered elsewhere in the state Medicaid plan
- Services to persons with a single diagnosis of intellectual or developmental disability or substance use disorder who do not have a co-occurring diagnosis of mental illness in adults or SED in children

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- Inpatient hospital services
- Respite services
- Family support services

5.2.3.13 Non-reimbursable Activities

A Medicaid provider will not be reimbursed for a mental health rehabilitative service:

- That is not included in the person's treatment plan (except for crisis intervention services and psychosocial rehabilitative services provided in a crisis situation.
- That is not authorized, except for crisis intervention services.
- Provided in excess of the amount authorized.
- Provided outside of the duration authorized.
- Provided to a person receiving MHTCM services.
- That is not documented.
- Provided to a person who does not meet the eligibility criteria.
- Provided to a person who does not have a current uniform assessment (except for crisis intervention services).
- Provided to a person who is not present, awake, and participating during such service.

A Medicaid provider will not be reimbursed for a crisis service provided to a person who does not have an SMI.

The cost of the following activities is included in the Medicaid mental health rehabilitative services reimbursement rate(s) and may not be directly billed by the Medicaid provider:

- Developing and revising the treatment plan and interventions that are appropriate to a person's needs.
- Staffing and team meetings to discuss the provision of mental health rehabilitative services to a specific person.
- Monitoring and evaluating outcomes of interventions, including contacts with a person other than the person receiving services.
- Documenting the provision of mental health rehabilitative services.
- A staff member's travel time to and from a location to provide mental health rehabilitative services.
- All services provided within a day program for acute needs that are delivered by a staff member, including services delivered in response to a crisis or an episode of acute psychiatric symptoms.
- Administering the uniform assessment to persons who are receiving mental health rehabilitative services.

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including MH and IDD services.

MH and IDD services are subject to retrospective review and recoupment if documentation does not support the service billed.

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5.4 Claims Filing and Reimbursement

IDD service coordination, MHTCM, and mental health rehabilitative services must be submitted to TMHP in an approved electronic claims 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 them.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Services are cost reimbursed in accordance with 1 TAC §§355.743, 355.746, and 355.781. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

5.4.1 Managed Care Clients

Claims for persons in managed care must be submitted to the client's MCO. Mental health targeted case management and mental health rehabilitative services that are funded by a criminal justice agency (submitted with modifier HZ) are carved out and must be submitted to TMHP.

5.4.2 Reimbursement Reductions

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement and the federal matching percentage.

6 Peer Specialist Services

6.1 Services, Benefits, Limitations, and Prior Authorization

Peer specialist services (procedure code H0038) for a mental health or substance use condition, or both, are a benefit of Texas Medicaid for persons who are 21 years of age and older, and who have peer specialist services included as a component of their person-centered recovery plan.

Peer specialist services are recovery-oriented, person-centered, relationship-focused, voluntary, and trauma-informed.

Peer specialist services include the following:

- Recovery and wellness support services, which include providing information and support for recovery planning.
- Mentoring, which includes serving as a role model and helping to find needed community resources and services.

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- Advocacy, which includes providing support during stressful or urgent situations and helping to ensure that the person's rights are respected. Advocacy may also include encouraging the person to advocate for him or herself to obtain services.

Peer specialist services are based on a mutual relationship between the peer specialist and the Medicaid eligible person. A peer specialist uses his or her lived experience to support the person with the following:

- Achieving the goals and objectives of the person's individualized recovery plan
- Skill development
- Problem solving strategies
- Coping mechanisms for stressors and barriers encountered when recovering from a mental health condition or a substance use disorder

Peer specialist services can be delivered individually or in a group setting.

6.1.1 Telehealth Service

Providers of peer specialist services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

Providers must provide peer specialist services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, peer specialist services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

6.1.1.1 Synchronous Audiovisual Technology

Peer specialist services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. In addition, approval to deliver the services by synchronous audiovisual technology must be documented in the person-centered recovery plan of the person receiving services. Peer specialist services provided by synchronous audiovisual technology must be billed using modifier 95.

6.1.1.2 Synchronous Telephone (Audio-Only) Technology

Peer specialist services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. In addition, approval to deliver the services by synchronous telephone (audio-only) technology must be documented in the person-centered recovery plan of the person receiving services.

Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of peer specialist services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. Peer specialist services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

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An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual peer specialist, MHTCM, or MHR service from the same billing provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual peer specialist, MHTCM, or MHR service from the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

Note: *"Same billing provider" refers to providers that are within the same entity or organization, as identified by the entity's or organization's NPI number or numbers, if the entity or organization has multiple locations (i.e., the same LMHA/LBHA, comprehensive provider agency of mental health targeted case management or rehabilitative services, clinic/group practice, FQHC, rural health clinic, or chemical dependency treatment facility, or opioid treatment provider) presuming all other applicable state and federal laws and regulations are followed.*

Note: *The required in-person or synchronous audiovisual delivered peer specialist, MHTCM, or MHR service may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

The billing provider is required to conduct at least one in-person or synchronous audiovisual peer specialist, MHTCM, or MHR service every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person's medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area.
- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person's condition.

Note: *The required in-person or synchronous audiovisual delivered peer specialist, MHTCM, or MHR service may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

6.2 Peer Specialist Requirements

Peer specialist services may be delivered as part of a coordinated, comprehensive, and individualized approach to treating a person's mental health or substance use condition, or both, if the peer specialist is employed by one of the following Medicaid-enrolled provider types:

- Clinic/group practices that treat behavioral health conditions
- Physicians (M.D.s), osteopaths (D.O.s), and nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) that treat behavioral health conditions
- Psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors
- Comprehensive provider agencies of targeted case management and mental health rehabilitative services

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- Local mental and behavioral health authorities
- Chemical dependency treatment facilities
- Federally qualified health centers (FQHCs)
- Rural health clinics (RHCs)
- Opioid Treatment Providers (OTPs)

Only clinic/group practices or behavioral health care individual providers (M.D., D.O., NP, CNS, and PA) with a behavioral health focus may be reimbursed for peer specialist services.

Peer specialists coordinate with all behavioral health service providers involved in the person's care and utilize a person-centered, recovery-oriented approach to treatment planning and service delivery.

Non-Medicaid enrolled providers that employ peer specialists can contract with one of the listed Medicaid-enrolled provider types to furnish peer specialist services as part of a continuum of comprehensive treatment services. Subcontracted peer specialist services must also be part of the coordinated, comprehensive, and individualized person-centered recovery plan.

A peer specialist must meet all of the following criteria:

- Be at least 18 years of age.
- Have lived experience with a mental health or substance use condition, or both.
- Have a high school diploma or General Equivalency Diploma (GED).
- Be willing to appropriately share his or her own recovery story with the person receiving services.
- Demonstrate current self-directed recovery.
- Pass criminal history and registry checks as described in 1 TAC §354.3201.

A peer specialist must not:

- Practice psychotherapy.
- Make clinical or diagnostic assessments.
- Dispense expert opinions.
- Engage in any service that requires a license.
- Falsify any documentation related to application, training, testing, certification, or services provided.

6.2.1 Certification

A peer specialist must complete all required training and certification before providing services. To be certified as a peer specialist as specified in 1 TAC §354.3155, a candidate must complete the following training:

- Required orientation
- Self-assessment activities
- Core training delivered by a certified training entity
- Supplemental training in one of two specialty areas:
  - Mental health peer specialist
  - Recovery support peer specialist

The candidate can apply for initial certification after successful completion of core and one supplemental training and a knowledge assessment.

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A peer specialist who is initially certified may begin to deliver Medicaid billable services, if participating in a supervised internship at their place of employment. The internship consists of 250 hours of supervised work experience to be completed within a 6-month period. An extension may be granted by the certification entity should a peer be unable to complete the required hours within the 6-month time frame.

Independent study, such as reading or watching instructional videos, does not count toward the required supervised work experience hours. Time spent receiving supervision, other than the observation of the peer specialist providing services, does not count toward the required hours.

After completing the required internship hours, certified peer specialists can apply for renewed certification through the approved certification entity. Peer specialists must renew their certification every two years, which requires continuing education hours.

Certified peer specialists should only deliver services in their specialty area.

6.2.2 Supervision

As defined in 1 TAC §354.3003, providers may be reimbursed for peer specialist services rendered under the supervision of one of the following:

- Qualified credentialed counselor (QCC)
- Licensed practitioner of the healing arts (LPHA)
- Qualified mental health professional (QMHP), with a QCC or LPHA supervising the QMHP
- Qualified peer supervisor (QPS), with a QCC or LPHA supervising the QPS

Supervision must focus on a peer specialist's provision of services, including:

- Review of cases and activities
- Skill building
- Problem resolution
- Professional growth

Supervision may also include aspects specific to the organization, such as following organizational policy or other administrative matters.

Peer specialist supervision may be provided as follows:

- Individually
- In a group setting
- Face-to-face
- By teleconference
- Through observation of the peer specialist providing services

Supervision must occur at least once weekly for a peer specialist with an initial certification, at least once monthly for a peer specialist with a two-year certification, or more frequently at the request of the peer specialist.

A QCC or LPHA who supervises a QMHP or QPS must provide individual or group supervision at least once monthly and conduct an observation of the QMHP or QPS supervising the peer specialist at a self-determined frequency based on the QMHP's or QPS's skill level.

A supervisor must successfully complete supervisory training for peer specialist services and the recovery model from a certified training entity before supervising a peer specialist. Supervisor training must include instruction about:

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- The distinction between peer support and therapy.
- The role of peer support in building and sustaining recovery goals.
- Advocacy for peer specialists and peer specialist services.
- Job performance review, including strengths-based, timely, and respectful feedback.
- Supervisory skills, such as how to work with a variety of personality types and communication styles.

After completing training, each candidate must successfully complete a knowledge assessment before receiving approval to supervise a peer specialist from a certified training entity. Peer specialist supervisor certification must be renewed every two years, which requires continuing education hours.

6.3 Prior Authorization Requirements

Prior authorization is not required for the first 104 units of peer specialist services in a rolling 6-month period. Prior authorization is required once a person exceeds 104 units of individual or group peer specialist services in a rolling 6-month period.

Prior authorization requests for procedure code H0038 must be submitted to TMHP using the Special Medical Prior Authorization (SMPA) Request Form. Providers must retain a copy of the signed and dated prior authorization form in the person's medical record. Requests for continued services must demonstrate all of the following:

- The person continues to meet eligibility criteria as outlined in the statement of benefits above, including current DSM diagnoses
- The current person-centered recovery plan and goals
- The progress made relative to the goals outlined in the person-centered recovery plan
- The need for continued services

Requests must indicate how many additional units of service are being requested (up to 30 units are allowed per request) and the type (individual or group), as well as the expected time frame when services will be delivered.

Note: *The requesting provider may be asked for additional information to clarify or complete a request.*

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the requested service.

Refer to: "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*)for more information on submitting prior authorization methods.

6.4 Documentation Requirements

The Medicaid-enrolled provider must ensure proper documentation of all peer specialist services that are rendered. Documentation of peer specialist services must:

- Indicate the date, time, and place of service.
- Summarize the purpose and content of the services.
- Include the specific strategies and activities utilized as related to the goals of the person's plan of care.

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Peer specialist supervisors must document all supervisory sessions and maintain the records in the peer specialist's employee personnel file. Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

6.4.1 Reimbursement

Reimbursement for procedure code H0038 is limited to substance use disorders and mental health conditions, including, but not limited to:

- Schizophrenia spectrum and other psychotic disorders.
- Bipolar and related disorders.
- Depressive disorders.
- Anxiety disorders.
- Obsessive-compulsive and related disorders.
- Trauma and stressor related disorders.
- Feeding and eating disorders.

Procedure code H0038 is limited to 104 units in a rolling six-month period. This limitation may be exceeded with documentation of medical necessity for the additional services.

Peer specialist services will also be limited as follows:

- Must not be delivered simultaneously with other behavioral health services that are delivered to the person or group of persons receiving services
- Must be delivered in person and not through advanced telecommunications technology
- Limited to 12 total persons per group session

6.4.2 Claim Filing

Procedure code H0038 must be submitted with one of the following specialty modifiers:

- Modifier HE-mental health
- Modifier HF-substance use

If services are provided in a group setting, procedure code H0038 must also be submitted with modifier HQ.

Mental health rehabilitative services must be billed separately from peer specialist services.

FQHCs and RHCs should submit claims using procedure code H0038 for informational purposes only.

Modifier	Description
95	Delivered by synchronous audiovisual technology
FQ	Delivered by synchronous telephone (audio-only) technology
HE	Mental health program
HF	Substance abuse program
HQ	Group setting

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6.5 Exclusions

The following services are not a benefit of Texas Medicaid:

- Record keeping or documentation activities
- Services that are not provided directly to the person receiving services

7 Certified Family Partners

7.1 Services, Benefits, Limitations, and Prior Authorization

Certified family partner (CFP) services, also referred to as family partner support services or family peer support services, are benefits of Texas Medicaid for parents (birth, adoptive, and foster), legally authorized representatives (LARs), or primary caregivers of a Medicaid eligible child or youth (20 years of age and younger) who is diagnosed with a serious emotional disturbance (SED) or a mental health or substance use condition, as defined in the current edition of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, and who has CFP services included as a component in their person-centered and trauma-informed recovery plan (henceforth, referred to as the plan of care).

CFPs provide services directly to the parents, LARs, or primary caregivers, not to the Medicaid eligible child or youth.

CFP services are an array of formal and informal services and supports that include:

- Introducing parents, LARs, or primary caregivers to the mental health and substance use system
- Modeling advocacy skills
- Providing education and information
- Making referrals
- Providing skills training
- Assisting in identifying supports
- Conducting support groups
- Helping with navigating systems, e.g., juvenile justice, child protective services, independent school districts

CFP services may be provided in an office, home, outpatient hospital, other locations, and by telehealth if certain conditions are met.

Refer to: Section 7.1.4, "Telehealth" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*)for more information.

CFP services may be delivered as part of a coordinated, comprehensive, and individualized approach to treating a Medicaid eligible child's or youth's SED or mental health or substance use condition. CFPs may not bill Medicaid directly for family partner support services. CFPs must be employed by one of the following Medicaid enrolled provider types that may submit claims for CFP services rendered:

- Clinic and group practices treating behavioral health conditions
- Physicians, APRNs, and PAs treating behavioral health conditions
- Licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors
- Comprehensive provider agencies of mental health targeted case management and mental health rehabilitative services

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- LMHAs/LBHAs
- Chemical dependency treatment facilities
- FQHCs
- RHCs
- Opioid treatment providers

Providers of CFP services must coordinate with all behavioral health service providers involved in the care of the Medicaid eligible child or youth, and utilize a person and family-centered, recovery-oriented approach to recovery planning and service delivery.

Non-Medicaid enrolled providers who employ CFPs may choose to contract with one of the above Medicaid enrolled providers to furnish the services as part of a continuum of comprehensive treatment services. Subcontracted CFP services must also be part of the coordinated, comprehensive, and individualized plan of care of the Medicaid eligible child or youth.

7.1.1 Certification Requirements

A CFP is a parent (birth, adoptive, or foster), LAR, or primary caregiver with lived experience parenting or raising a child or youth with a SED or mental or substance use condition and who has received specialized training and passed a certification exam to provide CFP services.

A CFP must:

- Be 18 years of age or older.
- Have a high school diploma or high school equivalency certificate issued in accordance with the law of the issuing state.
- Have lived experience navigating a child-service system, such as a mental health, juvenile justice, social security, or special education system, as a parent, LAR, or primary caregiver of a child or youth with a SED or mental health or substance use condition.
- Be willing to appropriately share their own recovery story with recipients of CFP services.
- Have successfully completed and passed the Texas Health and Human Services (HHSC) approved certification process.

A CFP must also:

- Satisfy and complete all staff credentialing, competency, training, and supervision requirements, prior to delivering CFP services, as required by the HHSC approved designated certifying entity in Texas.
- Pass criminal history and registry checks, as described in 1 TAC §354.3201.

A CFP certification is issued for a period of two years. A CFP must renew their certification every two years through the HHSC-approved designated certifying entity in Texas. Recertification requires a minimum number of continuing education hours, as required by the HHSC-approved designated certifying entity in Texas

A CFP may not:

- Deliver family partner support services to a child or youth of whom they are a parent (birth, adoptive, and foster), LAR, or primary caregiver.
- Practice psychotherapy.
- Make clinical or diagnostic assessments or dispense expert opinions.
- Engage in any service that requires a license.

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- Falsify any documentation related to application, training, testing, certification, or services provided.

7.1.2 Supervision Requirements

Providers may be reimbursed for CFP services that are rendered under the supervision of one of the following, as defined in 1 TAC §354.3003:

- Qualified Credential Counselor (QCC)
- Licensed Practitioner of the Healing Arts (LPHA)
- Qualified Mental Health Professional-Community Services (QMHP-CS) with a QCC or LPHA supervising the QMHP
- Qualified Peer Supervisor (QPS) with a QCC or LPHA supervising the QPS

Supervision must occur at least once weekly for a CFP with an initial certification, at least once monthly for a CFP with a two-year certification, or more frequently at the request of the CFP.

A QCC or LPHA who supervises a QMHP-CS or QPS must provide individual or group supervision at least once monthly and conduct an observation of the QMHP-CS or QPS supervising the CFP at a self-determined frequency based on the skill level of the QMHP-CS or QPS.

A supervisor must successfully complete and pass the HHSC-approved certification process for supervision of CFP services and the recovery model from a certified training entity before supervising a CFP. Supervisor training must include instruction about:

- The distinction between CFP services and therapy.
- The role of CFP services in building and sustaining recovery goals.
- Advocacy for CFPs and CFP services.
- Job performance review, including strengths-based, timely, and respectful feedback.
- Supervisory skills, such as how to work with a variety of personality types and communication styles.

After completing training, each candidate must successfully complete a knowledge assessment before receiving approval to supervise a CFP from the designated certifying entity in Texas.

Supervision of CFPs must focus on the provision of services to include:

- Review of cases and activities.
- Skill building.
- Problem resolution.
- Professional growth.

Supervision of CFPs may be delivered:

- Individually.
- In a group setting.
- Face-to-face.
- By teleconference.
- Through observation of the CFP providing services.

Supervision of CFPs may also include aspects specific to the organization, such as following organizational policy or other administrative matters.

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7.1.3 Reimbursement

CFP services must be included in the plan of care of the Medical eligible child or youth to be reimbursed. A billable unit of CFP services is 15 minutes of continuous contact.

Procedure code S9482 may be reimbursed for CFP services. The following modifiers may be submitted with procedure code S9482 for CFP services as appropriate:

Modifier	Description
95	Delivered by synchronous audiovisual technology
FQ	Delivered by synchronous audio-only technology
HE	Mental health program
HF	Substance use program
HQ	Group-delivered services

Claims for CFP services using procedure code S9482 must be submitted with modifier HE or HF, as appropriate.

Claims for CFP services delivered in a group setting must also be submitted with modifier HQ. CFP services delivered in a group setting are limited to 12 persons per group session.

CFP services are limited to 104 units in a rolling 6-month period. This limit may be exceeded with prior authorization.

CFP services may not be delivered simultaneous to other behavioral health services being delivered to a person or group of persons receiving services.

Mental health rehabilitative services delivered by family partners must be billed separately from CFP services.

FQHCs and RHCs should submit claims for CFP services using procedure code S9482 for informational purposes only.

Only clinic and group practices or individual health care providers (e.g., physicians, APRNs, and PAs) with a behavioral health focus are eligible for reimbursement of CFP services.

7.1.4 Telehealth

Providers of CFP services must defer to the needs of the parent(s), LAR(s), or primary caregiver(s) receiving the services, allowing the mode of service delivery to be accessible and family-centered, and primarily driven by the parent', LARs', or primary caregivers' choice and not provider convenience.

Providers must provide CFP services to the parent(s), LAR(s), or primary caregiver(s) of the Medicaid eligible child or youth in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 TAC §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, CFP services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

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7.1.4.1 Synchronous Audiovisual Technology

CFP services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the parent(s), LAR(s), or primary caregiver(s) receiving services. In addition, approval to deliver the services by synchronous audiovisual technology must be documented in the plan of care of the Medicaid eligible child or youth receiving services. CFP services provided by synchronous audiovisual technology must be billed using modifier 95.

7.1.4.2 Synchronous Telephone (Audio-Only) Technology

CFP services may be provided by synchronous telephone (audio-only) technology to the parent(s), LAR(s), or primary caregiver(s) of the Medicaid eligible child or youth with whom the billing provider has an 'existing clinical relationship' and if clinically appropriate and safe, as determined by the billing provider, and agreed to by the parent(s), LAR(s), or primary caregiver(s) receiving services. In addition, approval to deliver the services by synchronous telephone (audio-only) technology must be documented in the plan of care of the Medicaid eligible child or youth whose parent(s), LAR(s), or primary caregiver(s) are receiving CFP services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of CFP services must document in the medical record of the Medicaid eligible child or youth the reason(s) for why the services were delivered by synchronous telephone (audio-only) technology. CFP services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

An 'existing clinical relationship' occurs when the parent(s), LAR(s), or primary caregiver(s) have received at least one in-person or synchronous audiovisual CFP service or, on behalf of the Medicaid eligible child or youth, has received a mental health targeted case management (MHTCM) or mental health rehabilitative (MHR) service from the same billing provider within the six months prior to the initial CFP service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual CFP, MHTCM, or MHR service from the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

> ***Note:*** *'Same billing provider' refers to providers within the same entity (i.e., same National Provider Identification (NPI) number), e.g., same LMHA/LBHA, comprehensive provider agency of MHTCM or MHR services, clinic, or group practice, FQHC, RHC, chemical dependency treatment facility, or opioid treatment provider presuming all other applicable state and federal laws and regulations are followed. The required in-person or synchronous audiovisual delivered CFP service may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

The billing provider is required to conduct at least one in-person or synchronous audiovisual CFP service or, on behalf of the Medicaid eligible child or youth, MHTCM or MHR service every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the parent(s), LAR(s), or caregiver(s) receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the medical record of the Medicaid eligible child or youth. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The parent(s), LAR(s), or caregiver(s) receiving services are located at a qualifying originating site in an eligible geographic area (e.g., a practitioner office in a rural health professional shortage area).

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- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the condition of the Medicaid eligible child or youth or the family unit.

Note: *The required in-person or synchronous audiovisual delivered CFP service or, on behalf of the Medicaid eligible child or youth, MHTCM or MHR service may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth requirements, including informed consent and privacy and security requirements.

7.1.5 Prior Authorization

Prior authorization is not required for the first 104 units (26 hours) of CFP services in a rolling six-month period. A billable unit of CFP services is 15 minutes of continuous contact. Prior authorization is required once the 104 units (26 hours) of CFP services (individual or group) in a rolling six-month period is exceeded. A billable unit of CFP services is 15 minutes of continuous contact.

Note: *Prior authorization is a condition of reimbursement, not a guarantee of payment.*

Prior authorization requests are considered on a case-by-case basis with documentation supporting medical necessity for additional units of CFP services.

Prior authorization requests must include the following documentation:

- The Medicaid-eligible child or youth continues to meet eligibility criteria, as outlined in the Benefits section of this handbook, including current APA DSM diagnosis or diagnoses.
- The current plan of care to include goal(s) and objective(s) for the Medicaid-eligible child or youth.
- The progress made to date relative to the goal(s) and objective(s) outlined in the plan of care of the Medicaid-eligible child or youth.
- The need for continued services.

Prior authorization requests must be submitted to the TMHP Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. The form must include the following information:

- Section A - Client Information:
  - Identifying information for the Medicaid eligible child or youth (i.e., name, date of birth, and Medicaid number).
- Section B - Requested Procedure or Service Information:
  - Type of request is 'Other.'
  - Expected dates of service.
  - Procedure code (S9482) and description (CFP services).
  - Identifying information (full name) for the parent(s), LAR(s), or primary caregiver(s) receiving CFP services in the comments text box.
- Section C - Requesting Provider Information:
  - ICD-10 primary diagnosis and related ICD-10 diagnosis code(s) of the Medicaid eligible child or youth.
  - Medical necessity information to include:
    - The number of additional units being requested (up to 30 units allowed per request) and the type of units requested (i.e., individual, group, or both).

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  - The need for continued CFP services.
  - Progress made to the goal(s) and objective(s) that are outlined in the plan of care of the Medicaid eligible child or youth.
- Information about the requesting physician or provider, as indicated on the form (e.g., name, physical address, telephone, etc.).
- Signature of the requesting physician or provider, and the signature date of the request.

Note: *The form must be signed, dated, and submitted within 30 calendar days prior to the expected start date of additional CFP services.*

The requesting physician or provider may be asked for additional information to clarify or complete a request. Retrospective review may be performed to ensure documentation supports the medical necessity of the requested service.

Prior authorization requests must be submitted to the TMHP Prior Authorization Department via 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 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.

To complete the prior authorization process by paper, the provider must fax or mail the completed SMPA Request Form to the TMHP Prior Authorization Department and retain a copy of the signed and dated SMPA Request Form in the medical record of the Medicaid eligible child or youth.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated SMPA Request Form in the medical record of the Medicaid eligible child or youth.

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 services requested. The physician must maintain documentation of medical necessity in the medical record of the Medicaid eligible child or youth.

The requesting provider may be asked for additional information to clarify or complete a request.

7.2 Documentation Requirements

In addition to prior authorization documentation requirements outlined in this handbook, the following requirements apply:

- All services outlined in the Benefits section of this handbook are subject to retrospective review to ensure that the documentation in the medical record of the Medicaid-eligible child or youth supports the medical necessity of the services provided.
- The enrolled provider shall ensure proper documentation of all CFP services delivered.

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- Documentation of CFP services must indicate the date, time, and place of service, and must summarize the purpose and content of the services, along with specific strategies and activities utilized, as related to the goal(s) and objective(s) in the plan of care of the Medicaid-eligible child or youth.
- CFP supervisors must document all supervisory sessions and maintain records in the employee personnel file of the CFP.

Documentation requirements for telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements, including requirements for informed consent.

7.3 Exclusions

The following services are not benefits of the Texas Medicaid program:

- Record-keeping or documentation activities
- Services that are not provided directly to the person receiving services
- Children or youth with a single diagnosis of an intellectual and developmental disability

8 Inpatient Psychiatric Services

Admissions to acute care hospitals for inpatient psychiatric services are a benefit of Texas Medicaid for persons of all ages in fee-for-service Medicaid or managed care.

Admissions to psychiatric facilities, i.e. Institutions for Mental Disease (IMD), for inpatient psychiatric services are a benefit of Texas Medicaid for:

- Persons 20 years of age and younger and 65 years of age and older in fee-for-service Medicaid.
- Persons 21 through 64 years of age enrolled in managed care as an in lieu of service if the MCO and the person receiving services agree to an IMD as the setting for inpatient psychiatric services. The benefit is for a maximum of 15 calendar days per month, not per stay.

  Note: *In lieu of services are services substituted for Medicaid State Plan services or settings, as allowed by 42 CFR §438.3(e).*

Refer to: Section 3.4, "Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

9 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for persons who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders. SBIRT is used for intervention directed to a person and not for group intervention.

SBIRT services can be provided by physicians, registered nurses, advanced practice nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics

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(RHCs). Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the scope of practice for that licensed provider. The same SBIRT training requirements apply to non-licensed providers.

A person may have a maximum of two screening only sessions per rolling year, and up to four combined screening and brief intervention sessions per rolling year. Providers must refer the person to treatment if the screening results reveal severe risk of alcohol or substance use.

Refer to: Section 10, "Substance Use Disorder (SUD) Services" in this handbook for additional information on SUD treatment.

9.1 SBIRT Training

Providers that perform SBIRT services must be trained in the correct practice of this method and will be required to complete at least four hours of training. Proof of completion of SBIRT training must be maintained in an accessible manner at the provider's place of service.

Information regarding available trainings and standardized screening tools can be found through the Substance Abuse and Mental Health Services Administration.

9.2 Screening

Screening persons for problems related to alcohol or substance use identifies the person's level of risk and determines the appropriate level of intervention indicated for the person. Providers must explain the screening results to the person, and if the results are positive, be prepared to subsequently deliver, or delegate to another provider, brief intervention services. Screening must be conducted using a standardized screening tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, annoyed, guilty, eye-opener (CAGE) questionnaire
- Car, relax, alone, forget, family or friends, trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

Results obtained through blood alcohol content (BAC) or through toxicology screening may also be used to screen for alcohol or substance use risk.

9.3 Brief Intervention

Brief intervention is performed following a positive screen or a finding of at least a mild to moderate risk for alcohol or substance use. During the session, brief intervention involves motivational interviewing techniques (such as the Brief Negotiated Interview) that is focused on raising the person's awareness of his or her alcohol or substance use and its consequences. The session is also focused on motivating the person toward behavioral change.

Subsequent screening and brief intervention sessions within the allowable annual limitations may be indicated to assess for behavior change and further explore a person's readiness to make behavioral changes related to their alcohol or substance use.

Note: *Providers may choose to schedule multiple screening and brief intervention sessions in a rolling year in order to provide ongoing support to a person at risk for substance use who is receptive to behavior change.*

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9.4 Referral to Treatment

If the provider determines that the person is in need of more extensive treatment or has a severe risk for alcohol or substance use, the person must be referred to an appropriate substance use treatment provider.

Referral to more extensive treatment is a proactive process that facilitates access to care for persons who require a more extensive level of service than SBIRT provides. Referral is an essential component of the SBIRT intervention because it ensures that all persons who are screened have access to the appropriate level of care.

Note: *If the person is currently under the care of a behavioral health provider, the person must be referred to that provider.*

9.5 Telemedicine and Telehealth Services

Providers must defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

Providers must provide SBIRT services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, SBIRT services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

9.5.1 Synchronous Audiovisual Technology

SBIRT services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. SBIRT services provided by synchronous audiovisual technology must be billed using modifier 95.

9.5.2 Synchronous Telephone (Audio-only Technology)

SBIRT services may be provided by synchronous telephone (audio-only) technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. SBIRT services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

Modifier	Description
95	Delivered by synchronous audiovisual technology
FQ	Delivered by synchronous telephone (audio-only) technology

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9.6 Reimbursement and Limitations

SBIRT services are limited to persons who are 10 years of age and older.

SBIRT services are limited to up to two screening sessions per rolling year. A screening that results in a negative result does not require a brief intervention. In these instances procedure code H0049 should be used. A provider may re-screen a person within the same rolling year to determine whether their substance use behavior has changed.

Procedure code 99408 or G2011 should be used when a brief intervention follows an SBIRT screening. Procedure code 99408 is limited to once per day. SBIRT services are limited to four sessions per rolling year when it constitutes a screening followed by a brief intervention.

If a person requires more than four combined screening and brief intervention sessions per rolling year, the person must be referred for substance use disorder treatment.

SBIRT services are not reimbursable to providers (whether licensed or non-licensed) who have not completed the required number of training hours in SBIRT methodology.

Procedure codes 99408, G2011, and H0049 will be denied if billed for the same date of service as any of the following procedure codes:

Procedure Codes									
90791	90792	90832	90833	90834	90836	90837	90838	90847	90853
90865	90870	96130	96131	96132	96133	96136	96137		

Procedure codes 99408 and H0049 cannot both be billed on the same date.

Physicians and other qualified health care professionals that bill an Evaluation and Management (E/M) code for a visit where SBIRT occurred must use modifier 25 to identify a significant, separately identifiable E/M service rendered by the same provider on the same date of service.

> ***Note:*** *FQHCs and RHCs should submit claims using SBIRT procedure codes for informational purposes only.*

9.7 Documentation Requirements

A person's record documentation must support medical necessity for the SBIRT services provided and must be maintained by the SBIRT provider and made readily available for review when requested by the Health and Human Services Commission (HHSC) or its designee. SBIRT documentation for screening must include the following:

- The provider who performed the SBIRT screening; and
- Screening results from a standardized screening tool or laboratory results such as BAC, toxicology screen, or other measures showing risk for alcohol or substance use and the specific screening tool used.

Documentation for SBIRT brief intervention sessions must include a person-centered plan for the delivery of medically necessary services that supports the use of procedure code 99408. The plan must include the following:

- The provider who performed the SBIRT brief intervention, if different from the provider who screened the person
- Start and stop time of the session, or the total time spent providing SBIRT services to the person
- Goals established
- Specific strategies to achieve the goals

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- The person's support system such as family members, a legal guardian, or friends.

  Note: *If subsequent sessions are indicated, the provider who performed the SBIRT session must document that a follow up SBIRT appointment was made and with whom, or document another mechanism established to reassess progress*

- The name, address, and phone number of the provider that the person has been referred to for substance use disorder treatment

Services are subject to retrospective review to ensure that the documentation in the person's medical record supports the medical necessity of the services provided.

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

9.8 Claims Filing and Reimbursement

SBIRT services 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. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Texas Medicaid rates for Hospitals are calculated according to 1 TAC §355.8061.

According to 1 TAC §355.8091, the Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8085.

Texas Medicaid rates for physicians and certain other practitioners are calculated in accordance with TAC §355.8085.

Texas Medicaid rates for Nurse Practitioners and Clinical Nurse Specialists are calculated in accordance with TAC §355.8281.

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. Services performed by a PA and billed under a physician's or RHC's NPI are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM) for physician services.

Note: *For more information about Texas Medicaid rates for the provider types above, refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.*

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

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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.*

10 Substance Use Disorder (SUD) Services

10.1 Overview

SUDs are chronic, relapsing medical illnesses that require an array of best practice medical and psychosocial interventions of sufficient intensity and duration to achieve and maintain remission and support progress toward recovery. SUD may include problematic use of alcohol, prescription drugs, illegal drugs (e.g., cannabis, opioids, stimulants, inhalants, hallucinogens, "club" drugs, other synthetic euphoriants), and other substances that may be identified in the future.

Treatment for SUD is a benefit of Texas Medicaid for persons who meet the criteria for a substance-related disorder, as outlined in the current edition of the American Psychiatric Association's (APA's) Diagnostic Statistical Manual of Mental Disorders (DSM).

SUD treatment services are individualized, age-appropriate medical and psychosocial interventions designed to treat a person's problematic use of alcohol or other drugs, including prescription medication.

SUD services include:

- Withdrawal management services.
- Individual and group SUD counseling in an outpatient setting.
- Residential treatment services.
- Medication assisted treatment.
- Evaluation and treatment (or referral for treatment) for co-occurring physical and behavioral health conditions.

Level of care (e.g., outpatient, residential, inpatient hospital) and specific services provided must adhere to current evidence-based industry standards and guidelines for SUD treatment, such as those outlined in the current edition of the American Society of Addiction Medicine's Treatment Criteria for Addictive Substance-Related and Co-Occurring Conditions, as well as the licensure requirements outlined in 25 TAC §448 pertaining to standards of care.

SUD outpatient or residential treatment services may only be delivered in a licensed chemical dependency treatment facility (CDTF). Medication assisted treatment (MAT) may also be delivered in the office setting by appropriately trained physicians, physician assistants (PAs), and advanced practice registered nurses (APRNs) who are recognized by the Texas Board of Nursing as either nurse practitioners (NPs), clinical nurse specialists (CNSs), nurse anesthetists (CRNAs), or nurse midwives (CNMs), provided that the APRN is a qualifying practitioner and possesses the Drug Addiction Treatment Act (DATA) waiver.

SUD withdrawal management in an inpatient hospital setting may be provided for persons who meet hospital level of care requirements as a result of the severity of their withdrawal syndrome or the severity of their co-occurring conditions. These services may be reimbursed as general hospital inpatient services.

The treatment setting and the intensity or level of services will vary depending on the severity of the person's SUD and what is clinically appropriate. The intensity or level of services refers to the number of hours of services per week, as well as the types of services the person receives. Early Intervention

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services are part of the spectrum of SUD treatment and are a benefit in Texas Medicaid. Early intervention services target persons who are at risk of developing a substance related problem but may not have a diagnosed SUD.

Refer to: Subsection 9, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" in this handbook for further information on early intervention services.

Upon admission into a treatment setting, a multi-dimensional assessment (procedure code H0001) must be conducted by a qualified credentialed counselor (QCC) or intern as defined in Department of State Health Services (DSHS) TAC §441.101 to determine a course of treatment that is medically necessary and clinically appropriate. The assessment must be signed off by a QCC.

10.2 Evaluation, Treatment, or Referral for Co-Occurring Conditions

CDTFs shall facilitate access to physical health, mental health, and ancillary services if those services are not available through the program and are necessary to meet treatment goals or needs of the person receiving services.

Persons in residential CDTFs commonly require medications unrelated to their SUD treatment for which costs are not covered in the reimbursement for SUD or MAT services. These medications, if included in the Medicaid formulary, may be obtained and reimbursed through the person's Medicaid pharmacy benefit.

Persons in residential CDTFs also commonly require other services that are benefits of Texas Medicaid, but not included in the CDTF rate. Claims for these services can be submitted by the appropriate providers.

CDTFs should screen each person for risk for contracting tuberculosis, Hepatitis B and C, HIV antibody, and sexually transmitted infections, and if appropriate, provide access to testing and follow up. Testing may be performed on site and billed by the ordering provider if appropriate testing facilities are available that are compliant with the rules and regulations for the Clinical Laboratory Improvement Amendments (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

10.3 Withdrawal Management Services

Withdrawal management, formerly known as detoxification, is the medical and behavioral treatment of persons experiencing or potentially experiencing withdrawal symptoms as a result of ceasing or reducing substance use.

Withdrawal management involving opioids, alcohol, sedatives, hypnotics, or anxiolytics will vary depending on the severity of the withdrawal symptoms experienced but will typically involve medications to treat symptoms in addition to supportive care, observation, and monitoring. Withdrawal management involving stimulants, inhalants, and cannabis typically involves supportive care, observation and monitoring, and medications to treat withdrawal symptoms as required.

Withdrawal management may be performed in an outpatient setting for persons experiencing mild to moderate withdrawal symptoms that can be successfully, as well as safely, managed outside of a residential setting or an inpatient hospital. Withdrawal management in a residential setting may be required for persons whose multidimensional assessment indicates one or more of the following circumstances that would make outpatient withdrawal management unsafe or unsuccessful:

- A level of severity of withdrawal, medical, or mental health complication
- Sufficient challenges with readiness to change, ability to stop using, or social support

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Withdrawal management in an inpatient hospital setting may be required for persons whose severity of medical withdrawal (e.g., impending delirium tremens, severe withdrawal seizures), comorbid medical conditions (e.g., severe liver impairment, acute pneumonia, endocarditis, dementia), or comorbid psychiatric conditions (e.g., severe suicidality, acute and unstable psychosis or mania) requires a hospital level of care.

10.4 Individual and Group SUD Counseling Services in an Outpatient Setting

Counseling for SUDs is designed to assist persons in developing a better understanding of their SUD, help to establish treatment goals and plans for achieving those goals, and provide interventions to assist persons in accordance with the plan. The overall intent of the service is to assist persons in understanding their SUD and developing the skills and supports needed to address their SUD over time. Counseling may be done individually or in a group setting with multiple members. Group counseling sessions are limited to a total of 16 persons per session.

Outpatient counseling services are appropriate for the following:

- Persons with less severe disorders
- Persons who are in the early stages of change
- As a step down from more intensive services
- Persons who are stable but for whom ongoing monitoring is appropriate

> ***Note:*** *For persons unable or unwilling to access SUD treatment services at a CDTF, psychotherapy delivered by a licensed practitioner of the healing arts (LPHA) may be an alternative treatment option to address a person's SUD.*

Outpatient services may be appropriate at the start of treatment, throughout treatment, or after an episode of residential or inpatient treatment, depending on the person's acuity, severity, comorbidity, needs, or preferences. Outpatient services can address active symptoms as well as provide ongoing treatment for persons in partial or full remission who need continuing help to maintain progress.

Abstinence should not necessarily be a requirement for participation in outpatient services.

10.5 Residential Treatment Services

Residential treatment programs provide a structured therapeutic environment where persons reside with staff support and deliver comprehensive SUD treatment with attention to co-occurring conditions as appropriate. The frequency and duration of services should be based on meeting the person's needs and achieving the person's treatment goals.

Residential services are appropriate for persons who require a structured therapeutic environment to stabilize SUD and develop coping and recovery skills. Residential treatment programs may specialize in the unique needs of a specific population such as adolescents, or pregnant or parenting women with children.

Episodes of residential treatment may be required for persons with more severe SUD, more significant medical or psychiatric comorbidities, more significant challenges with sustaining motivation, maintaining control in an outpatient setting, or a living environment that jeopardizes their current ability to be successful in outpatient treatment.

Residential SUD treatment services may only be provided by a licensed CDTF.

10.6 Outpatient Treatment Services

Outpatient treatment services must be billed with procedure codes H0004 or H0005.

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Procedure codes H0004 and H0005 are limited to the following diagnosis codes:

Diagnosis Codes							
F1010	F1011	F10120	F10121	F10129	F10130	F10131	F10132
F10139	F1014	F10150	F10151	F10159	F10180	F10181	F10182
F10188	F1019	F1020	F1021	F10220	F10221	F10229	F10230
F10231	F10232	F10239	F1024	F10250	F10251	F10259	F1026
F1027	F10280	F10281	F10282	F10288	F1029	F1090	F1091
F10920	F10921	F10929	F10930	F10931	F10932	F10939	F1094
F10950	F10951	F10959	F1096	F1097	F10980	F10981	F10982
F10988	F1099	F1110	F1111	F11120	F11121	F11122	F11129
F1113	F1114	F11150	F11151	F11159	F11181	F11182	F11188
F1119	F1120	F1121	F11220	F11221	F11222	F11229	F1123
F1124	F11250	F11251	F11259	F11281	F11282	F11288	F1129
F1190	F1191	F11920	F11921	F11922	F11929	F1193	F1194
F11950	F11951	F11959	F11981	F11982	F11988	F1199	F1210
F1211	F12120	F12121	F12122	F12129	F1213	F12150	F12151
F12159	F12180	F12188	F1219	F1220	F1221	F12220	F12221
F12222	F12229	F1223	F12250	F12251	F12259	F12280	F12288
F1229	F1290	F1291	F1293	F12920	F12921	F12922	F12929
F12950	F12951	F12959	F12980	F12988	F1299	F1310	F1311
F13120	F13121	F13129	F13130	F13131	F13132	F13139	F1314
F13150	F13151	F13159	F13180	F13181	F13182	F13188	F1319
F1320	F1321	F13220	F13221	F13229	F13230	F13231	F13232
F13239	F1324	F13250	F13251	F13259	F1326	F1327	F13280
F13281	F13282	F13288	F1329	F1390	F1391	F13920	F13921
F13929	F13930	F13931	F13932	F13939	F1394	F13950	F13951
F13959	F1396	F1397	F13980	F13981	F13982	F13988	F1399
F1410	F1411	F14120	F14121	F14122	F14129	F1413	F1414
F14150	F14151	F14159	F14180	F14181	F14182	F14188	F1419
F1420	F1421	F14220	F14221	F14222	F14229	F1423	F1424
F14250	F14251	F14259	F14280	F14281	F14282	F14288	F1429
F1490	F1491	F14920	F14921	F14922	F14929	F1493	F1494
F14950	F14951	F14959	F14980	F14981	F14982	F14988	F1499
F1510	F1511	F15120	F15121	F15122	F15129	F1513	F1514
F15150	F15151	F15159	F15180	F15181	F15182	F15188	F1519
F1520	F1521	F15220	F15221	F15222	F15229	F1523	F1524
F15250	F15251	F15259	F15280	F15281	F15282	F15288	F1529
F1590	F1591	F15920	F15921	F15922	F15929	F1593	F1594
F15950	F15951	F15959	F15980	F15981	F15982	F15988	F1599
F1610	F1611	F16120	F16121	F16122	F16129	F1614	F16150
F16151	F16159	F16180	F16183	F16188	F1619	F1620	F1621

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Diagnosis Codes							
F16220	F16221	F16229	F1624	F16250	F16251	F16259	F16280
F16283	F16288	F1629	F1690	F1691	F16920	F16921	F16929
F1694	F16950	F16951	F16959	F16980	F16983	F16988	F1699
F1810	F1811	F18120	F18121	F18129	F1814	F18150	F18151
F18159	F1817	F18180	F18188	F1819	F1820	F1821	F18220
F18221	F18229	F1824	F18250	F18251	F18259	F1827	F18280
F18288	F1829	F1890	F1891	F18920	F18921	F18929	F1894
F18950	F18951	F18959	F1897	F18980	F18988	F1899	F1910
F1911	F19120	F19121	F19122	F19129	F19130	F19131	F19132
F19139	F1914	F19150	F19151	F19159	F1916	F1917	F19180
F19181	F19182	F19188	F1919	F1920	F1921	F19220	F192221
F19222	F19229	F19230	F19231	F19232	F19239	F1924	F19250
F19251	F19259	F1926	F1927	F19280	F19281	F19282	F19288
F1929	F1990	F1991	F19920	F19221	F19922	F19929	F19930
F19931	F19932	F19939	F1994	F19950	F19951	F19959	F1996
F1997	F19980	F19981	F19982	F19988	F1999	F551	F553

10.7 Medication Assisted Treatment Services

MAT is the use of FDA-approved medications in combination with psychosocial treatment to treat SUDs, particularly alcohol and opioid use disorders (OUD).

MAT is a recognized best practice for alcohol use disorder (AUD) and OUD. All persons with AUD and OUD should be educated about the availability of MAT and the evidence supporting MAT, and have the opportunity to receive MAT regardless of where they are receiving SUD services. This could be accomplished on site or through a written agreement with a collaborating opioid treatment program (OTP) or office-based opioid treatment (OBOT) program.

Initiation or induction of MAT can appropriately occur in lieu of withdrawal management for OUDs, may begin early in withdrawal management for either AUD or OUD, and can be initiated as appropriate at any point in time during the course of treatment. Duration of MAT is determined on an person basis, depending on the person's unique needs and treatment goals.

Determination of which MAT medication to use is also an individualized treatment decision based on provider assessment and the person's needs and treatment goals. Providers are encouraged to offer as many treatment options as possible (within the parameters of their licensing and scope of practice) to maximize the person's choice and access to care.

MAT may be utilized as appropriate, as part of the service array delivered by outpatient providers or residential treatment services programs at CDTFs.

Opioid treatment programs (also referred to as narcotic treatment programs) are the only settings permitted by law to provide methadone for OUD and must comply with additional federal and state requirements, rules on licensure and scope of practice, including physician delegation, supervision, and prescriptive authority. Opioid treatment programs can also provide or administer other forms of MAT.

CDTFs, physicians, NPs, and PAs may prescribe and provide for the administration of long-acting injectable naltrexone (Vivitrol) to treat cravings associated with either OUD or AUD.

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Physicians, PAs, and APRNs who are recognized by the Texas Board of Nursing as either NPs, CNSs, APRNs, or CNMs who have received a federal waiver to dispense buprenorphine may choose to incorporate this form of MAT into their medical practice while also providing or referring for other types of treatment services (also referred to as OBOT).

Certain MAT medications to treat alcohol and opioid use disorders (such as buprenorphine, disulfiram, acamprosate, and naltrexone), are available as a pharmacy benefit and may be prescribed to a person by their physician or other qualified health care professional. Providers may refer to the Vendor Drug Program Formulary for additional information on covered medications.

A prescription for an opioid antagonist (e.g., naloxone) should be given to all persons receiving treatment for OUD, and instruction should be provided on how to administer if needed.

Claims for urinalysis drug screens ordered by a physician, NP, or CNS to monitor compliance with MAT may be submitted by the individually-enrolled physician or APRN.

The following MAT procedure codes may be separately reimbursed from withdrawal management and treatment services in the outpatient or residential setting:

Procedure Codes									
H0020	H0033	J0570	J0577	J0578	J2315	Q9991	Q9992		

10.7.1 Opioid Treatment Providers

Substance Abuse and Mental Health Services Administration certified (SAMHSA-certified) opioid treatment providers (OTPs) that are also licensed as narcotic treatment programs in Texas are required to enroll in Medicare before enrolling with Texas Medicaid as OTPs. Providers billing claims for persons who have dual eligibility for Medicaid and Medicare must first submit their claims to Medicare.

The following procedure codes may be reimbursed to Opioid Treatment Providers:

Procedure Codes									
H0001	H0004	H0005	H0020	H0033	J0577	J0578	J2315	Q9991	Q9992

Important: *CDTFs cannot bill for OTP services through Medicare, as CDTFs are not Substance Abuse and Mental Health Services Administration certified (SAMHSA-certified) OTPs.*

A comprehensive assessment (procedure code H0001) is limited to once per day, any provider. An assessment is also limited to once per episode of care and should be performed at the start of each new episode of care.

10.8 Telemedicine and Telehealth Services

Providers of SUD services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered and primarily driven by the person's choice and not provider convenience.

Providers must provide SUD services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, SUD services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances

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described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

10.8.1 Synchronous Audiovisual Technology

The following SUD services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. SUD services provided by synchronous audiovisual technology must be billed using modifier 95.

- Comprehensive assessment (procedure code H0001)
- Individual and group counseling (procedure codes H0004 and H0005)
- MAT services - Prescribing of certain MAT medications may be done via telemedicine presuming all other applicable state and federal laws and regulations are followed.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about prescriptions generated from a telemedicine medical service.

10.8.2 Synchronous Telephone (Audio-only) Technology

The following SUD services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of SUD services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. SUD services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

- Comprehensive assessment (procedure code H0001) - Only during certain public health emergencies or natural disasters; to the extent allowed by federal law (assessments for withdrawal management services are excluded); and the existing clinical relationship requirement is waived.
- Individual and group counseling (procedure codes H0004 and H0005)

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) from the same provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

Note: *"Same billing provider" refers to providers within the same entity or organization, as identified by the entity's or organization's NPI number or numbers, if the entity or organization has multiple locations (i.e., CDTF, OTP or clinic, or group practice).*

Note: *The required in-person or synchronous audiovisual-delivered SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology, presuming all other applicable state and federal laws and regulations are followed.*

The billing provider is required to conduct at least 1 in-person or synchronous audiovisual SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving

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services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person's medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area.
- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person's condition(s).

Note: *The required in-person or synchronous audiovisual-delivered SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) may be delivered by another authorized professional, or paraprofessional, of the same billing provider as the professional, or paraprofessional, who delivers the service by synchronous telephone (audio-only) technology, presuming all other applicable state and federal laws and regulations are followed.*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

Modifier	Description
95	Delivered by synchronous audiovisual technology
FQ	Delivered by synchronous telephone (audio-only) technology

10.9 Exclusions

SUD treatment services for tobacco use disorder as the primary diagnosis are not a covered benefit, although a comprehensive SUD treatment approach should address tobacco use if reducing or eliminating this substance is part of the person's treatment goal.

10.10 Prior Authorization

The following services do not require prior authorization:

- Assessment
- Outpatient treatment services
- MAT

Exception: *Outpatient treatment services require prior authorization if the calendar year hours/units are exceeded. Those limits are 135 units of group services and 26 hours of individual services per calendar year.*

The following services require prior authorization:

- Outpatient withdrawal management services
- Outpatient treatment for persons who exceed the benefit limitation
- Residential withdrawal management services
- Residential treatment services

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Providers must submit the appropriate prior authorization request form for the initial or continuation of outpatient or residential withdrawal management treatment and residential treatment services. A QCC (as defined by the DSHS licensure standard) must complete and sign the prior authorization request forms.

Providers must submit one of the following forms to obtain prior authorization:

- Outpatient Withdrawal Management Authorization Request Form
- Outpatient Substance Use Disorder Counseling Extension Request Form
- Residential Withdrawal Management Authorization Request Form
- Residential Substance Use Disorder Treatment Request Form

Prior authorization will be considered for the least restrictive environment appropriate to the person's medical need as determined in the person's plan of care (POC), based on national standards.

Prior authorization requests for services beyond the limitations outlined in this section, may be considered with documentation supporting the medical necessity for continuation of the treatment.

10.10.1 Prior Authorization to Persons with Fee-For-Service Benefits

Prior authorization requests for persons with fee-for-service benefits may be submitted to the TMHP Prior Authorization Unit online at www.tmhp.com, by fax at 512-514-4211, or by mail to:

Texas Medicaid & Healthcare Partnership
TMHP Prior Authorization Department
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods. Providers must retain a copy of the signed and dated prior authorization form in the person's medical record.

Providers may contact the TMHP Prior Authorization Unit by telephone at 800-213-8877, Option 2, to obtain information about substance use disorder benefits, the prior authorization process, or the status of a prior authorization request. Prior authorization for substance use disorder services cannot be obtained through this line.

Prior authorization for outpatient withdrawal management, residential treatment, or residential withdrawal management services will be considered when requested within three business days after the date of admission.

Prior authorization may be considered for persons who are enrolled in a Medicaid MCO when they are admitted to SUD services and whose eligibility changes to fee-for-service during treatment. Requests must be submitted within three business days of the date on which the fee-for-service eligibility started.

10.10.2 Prior Authorization for Outpatient Withdrawal Management Treatment Services

Outpatient withdrawal management services may be prior authorized for up to 21 days. The level of service and number of days that are prior authorized will be based on the substances that are used, level of intoxication and withdrawal potential, and the person's medical needs. Providers may submit requests for services using the Outpatient Withdrawal Management Authorization Request Form.

10.10.2.1 Admission Criteria for Outpatient Withdrawal Management Treatment Services

The admission criteria for outpatient withdrawal management treatment services follow the existing Texas Department of Insurance licensure requirements and standards that are specified in 28 TAC §3.8001–§3.8030.

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To be considered eligible for treatment for outpatient withdrawal management services, the person must meet the following conditions:

- Chemical Substance Withdrawal—The person must meet all of the following criteria with regard to chemical substance withdrawal:
  - The person is expected to have a stable withdrawal from alcohol or drugs.
  - The diagnosis must meet the criteria for the definition of SUD or the most current revision of the APA's DSM accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
- Medical Functioning—The person must meet all of the following criteria with regard to medical functioning:
  - No history of recent seizures or past history of seizures during withdrawal.
  - No clinical evidence of altered mental state as manifested by disorientation to self, alcoholic hallucinations, toxic psychosis, or altered level of consciousness (clinically significant obtundation, stupor, or coma).
  - The symptoms are due to withdrawal and not due to a general medical condition. Absence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb coordination).
  - Stable vital signs as interpreted by a physician. The person must also be without a previous history of complications from acute chemical substance withdrawal and judged to be free of a health risk as determined by a physician.
  - No evidence of a coexisting serious injury or systemic illness either newly discovered or progressive in nature.
  - Absence of serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.
  - Clinical condition that allows for a comprehensive and satisfactory assessment.
- Family, Social, or Academic Dysfunction—The person must meet at least one of the following criteria with regard to family, social, or academic dysfunction:
  - The person's social system and significant others are supportive of recovery to the extent that the person can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the person's SUD.
  - The person's family or significant others are willing to participate in the outpatient withdrawal management treatment program.
  - The person may or may not have a primary or social support system to assist with immediate recovery, but the person has the social skills to obtain such a support system or to become involved in a self-help fellowship.
  - The person does not live in an environment where licit or illicit mood-altering substances are being used. A person living in an environment where licit or illicit mood-altering substances are being used may not be a candidate for this level of care.
- Emotional and Behavioral Status—The person must meet all of the following criteria with regard to emotional and behavioral status:
  - The person is coherent, rational, and oriented for treatment.

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- The mental state of the person does not preclude the person's ability to comprehend and understand the materials presented, and the person is able to participate in the outpatient withdrawal management treatment process.
- Documentation exists in the medical record that the person expresses an interest to work toward outpatient withdrawal management treatment goals.
- The person has no neuropsychiatric condition that places the person at imminent risk of harming self or others (e.g. pathological intoxication or alcohol idiosyncratic intoxication).
- The person has no neurological, psychological, or uncontrolled behavior that places the person at imminent risk of harming self or others (depression, anguish, mood fluctuations, overreactions to stress, lower stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, negative emotions, or anxiety).
- The person has no documented DSM condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the person.
- The person has no mental confusion or fluctuating orientation.

- Chemical Substance Use—The person must meet the criteria in at least one of the following conditions with regard to recent chemical substance use:
  - The person's chemical substance use is excessive, and the person has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).
  - The person is motivated to stop using alcohol or drugs and is in need of a supportive, structured treatment program to facilitate withdrawal from chemical substances.

10.10.2.2 Continued Stay Criteria for Outpatient Withdrawal Management Treatment Services

A person is considered eligible for continued stay in the outpatient withdrawal management treatment service when the person meets at least one of the conditions for either chemical substance withdrawal or psychiatric or medical complications. Requests for extension of services must be received on or before the last date authorized or denied. The prior authorization unit will notify the provider by fax or electronic portal. If the date of the prior authorization unit determination letter is on or after the last date authorized or denied or if the last date falls on a holiday or weekend, the request for extension of services is due by 5 p.m. of the next business day. Documentation in the person's medical record must support either Chemical Substance Withdrawal or Psychiatric or Medical Complications.

Chemical Substance Withdrawal

The person must meet at least one of the following conditions with regard to chemical substance withdrawal complications:

- The person, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol or drugs, as evidenced by psychological and physical cravings.
- The person, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol or drugs, as evidenced by significant drug levels.

Psychiatric or Medical Complications

The person must meet both of the following psychiatric or medical complication conditions:

- The intervening medical or psychiatric event was serious enough to interrupt the outpatient withdrawal management treatment.
- Evidence that the person is progressing in treatment again.

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10.10.3 Prior Authorization for Residential Withdrawal Management Treatment Services

Withdrawal management services may be prior authorized for up to 21 days. The level of service and number of prior authorized days will be based on the substances that are used, level of intoxication and withdrawal potential, and the person's medical needs. Providers may submit requests for services using the Residential Withdrawal Management Authorization Request form.

Requests for withdrawal management services for persons who need more than 21 days of residential withdrawal management require review of documentation of medical necessity from a provider who is familiar with the person.

10.10.3.1 Admission Criteria for Residential Withdrawal Management Treatment Services

The admission criteria for residential withdrawal management treatment services follow the existing Texas Department of Insurance licensure requirements and standards that are specified in 28 TAC §3.8001–§3.8030.

A person is eligible for admission to a residential withdrawal management service when they have failed two previous individual treatment episodes of outpatient withdrawal management or when they have a diagnosis that meets the criteria for the definition of SUD in the most current revision of the APA's DSM.

The person must also meet at least one of the following criteria for admission to residential withdrawal management treatment:

- Chemical Substance Withdrawal—The person must have impaired neurological functions as evidenced by:
  - Extreme depression (e.g., suicidal).
  - Altered mental state with or without delirium as manifested by disorientation to self; alcoholic hallucinosis, toxic psychosis, altered level of consciousness, as manifested by clinically significant obtundation, stupor, or coma.
  - History of recent seizures or past history of seizures on withdrawal.
  - The presence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb incoordination).
  - Unstable vital signs combined with a history of past acute withdrawal syndromes that are interpreted by a physician to be indication of acute alcohol or drug withdrawal.
  - Evidence of coexisting serious injury or systemic illness, newly discovered or progressive.
  - Clinical condition (e.g., agitation, intoxication, or confusion) that prevents satisfactory assessment of the above conditions and indicates placement in residential withdrawal management service may be justified.
  - Neuropsychiatric changes of such severity and nature that they put the person at imminent risk of harming self or others (e.g., pathological intoxication or alcohol idiosyncratic intoxication).
  - Serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.
- Major Medical Complications—The person must present a documented condition or disorder that, in combination with alcohol or drug use, presents a determined health risk (e.g., gastrointestinal bleeding, gastritis, severe anemia, uncontrolled diabetes mellitus, hepatitis, malnutrition, cardiac disease, hypertension).

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- Major Psychiatric Illness—The person must meet at least one of the following conditions with regard to major psychiatric illness:
  - Documented APA DSM condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the person.
  - Severe neurological and psychological symptoms: (e.g., anguish, mood fluctuations, overreactions to stress, lowered stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, extreme negative emotions, or extreme anxiety).
  - Danger to others or homicidal.
  - Uncontrolled behavior that endangers self or others, or documented neuropsychiatric changes of a severity and nature that place the person at imminent risk of harming self or others.
  - Mental confusion or fluctuating orientation.

10.10.3.2 Continued Stay Criteria for Residential Withdrawal Management Treatment Services

Eligibility for continued stay for residential withdrawal management services is based on the person meeting at least one of the criteria for chemical substance withdrawal, major medical complications, or major psychiatric complications.

Chemical Substance Withdrawal

The person must exhibit one of the following conditions with regard to chemical substance withdrawal complications:

- Incomplete medically stable withdrawal from alcohol or drugs, as evidenced by documentation of at least one of the following conditions:
  - Unstable vital signs
  - Continued disorientation
  - Abnormal laboratory findings related to chemical dependency
  - Continued cognitive deficit related to withdrawal so that the person is unable to recognize alcohol or drug use as a problem
- Laboratory finding that, based on the judgment of a physician, indicates that a drug has not sufficiently cleared the person's system

Major Medical Complications

For major medical complications, the person must have documentation in the medical record that indicates that a medical condition or disorder (e.g., uncontrolled diabetes mellitus) continues to present a health risk and is being actively treated.

Major Psychiatric Complications

The person must meet at least one of the following with regard to major psychiatric complications:

- Documentation in the medical record that a psychiatric condition or disorder that, in combination with alcohol or drug use, continues to present a major health risk, is actively being treated.
- Documentation in the medical record that severe neurological or psychological symptoms have not been satisfactorily reduced but are actively being treated.

10.10.4 Prior Authorization for Residential Treatment Services

Residential treatment may be prior authorized for up to 35 days per episode of care, with a maximum of two episodes of care per rolling six-month period and four episodes of care per rolling year.

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Providers can use the Residential Substance Use Disorder Treatment Request form to submit authorization requests for persons who require additional episodes within the 6- or 12-month time frame.

10.10.4.1 Admission Criteria for Residential Treatment Services

The admission criteria for residential treatment services follow the existing Texas Department of Insurance licensure requirements and standards that are specified in 28 TAC §3.8001-§3.8030.

The diagnosis must meet the criteria for the definition of an SUD in the most current version of the APA's DSM.

All persons must meet the following conditions to receive treatment in a residential treatment service program:

- Medical Functioning—The following must be present with regard to medical functioning:
  - Documented medical assessment following admission (except in instances where the person is being referred from an inpatient service) indicates that the person is medically stable and not in acute withdrawal.
  - The person is not bed-confined and has no medical complications that would hamper participation in the residential service.
- Family, Social, or Academic Dysfunction and Logistic Impairments—At least one of the following must be present with regard to family, social, or academic dysfunction and logistic impairments:
  - The person manifests severe social isolation or withdrawal from social contacts.
  - The person lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g., a chaotic family dominated by interpersonal conflict, which undermines person's efforts to change).
  - The person's family or significant others are opposed to the person's treatment efforts and are not willing to participate in the treatment process.
  - Family members or significant others living with the person manifest current SUDs and are likely to undermine treatment.
  - Logistic impairments (e.g., distance from treatment facility or mobility limitations) preclude participation in an outpatient treatment setting.
- Emotional and Behavioral Status—The person must meet all three of the following criteria with regard to emotional and behavioral status:
  - The person is coherent, rational, and oriented for treatment.
  - Mental state of the person does not preclude the person's ability to comprehend and understand the materials presented and participate in rehabilitation or the treatment process.
  - The medical record contains documentation that with continued treatment the person will be able to improve or internalize the person's motivation toward recovery within the recommended length of stay time frames (e.g., becoming less defensive, verbalizing, and working on alcohol or drug related issues). Interventions, treatment goals, or contracts are in place to help the person deal with or confront the blocks to treatment (e.g., family intervention or employee counseling confrontation).
- Chemical Substance Use—The person must meet at least one of the following criteria with regard to chemical substance use:
  - The person's chemical substance use is excessive, and the person has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).

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- Virtually all of the person's daily activities revolve around obtaining, using, or recuperating from the effects of chemical substances, and the person requires a secured environment to control the person's access to chemical substances.

10.10.4.2 Residential Treatment Services for Adolescents

Adolescents who are 13 through 17 years of age must meet all above conditions and the following conditions to receive treatment in an adolescent residential treatment service program:

- At the maturation level, the adolescent must meet both of the following criteria:
  - The adolescent is assessed as manifesting physical maturation at least in middle adolescent range (i.e., post-pubescent).
  - The history of the adolescent reflects cognitive development of at least 11 years of age.
- The adolescent must display at least one of the following with regard to developmental status:
  - Documented history of inability to function within the expected age norms despite normal cognitive and physical maturation (e.g., refusal to interact with family members, overt prostitution, felony, or other criminal charges).
  - A recent history of moderate to severe conduct disorder, as defined in the APA's DSM, or impulsive disregard for social norms and rights of others.
  - Documented difficulty in meeting developmental expectations in a major area of functioning (e.g., social, academic, or psychosexual) to an extent that interferes with the capacity to remain behaviorally stable.

10.10.4.3 Continued Stay Criteria for Residential Treatment Services

At least one of the following conditions must be present for continued stay in a residential treatment program:

- Chemical Dependency Rehabilitation or Treatment Complications:
  - The person recognizes or identifies with the severity of the alcohol or drug problem but demonstrates minimal insight into the person's defeating the use of alcohol or drugs. However, documentation in the medical record indicates that the person is progressing in treatment.
  - The person identifies with the severity of the alcohol or drug problem and manifests insight into the person's personal relationship with mood-altering chemicals, yet does not demonstrate behaviors that indicate the development of problem-solving skills that are necessary to cope with the problem.
  - The person would predictably relapse if moved to a lesser level of care.
- Psychiatric or Medical Complications:
  - Documentation in the medical record indicates an intervening medical or psychiatric event that was serious enough to interrupt rehabilitation or treatment, but the person is again progressing in treatment.
  - Documentation in the medical record indicates that the person is being held pending an immediate transfer to a psychiatric, acute medical service, or inpatient withdrawal management alcohol or drug service.

10.10.5 Prior Authorization for Outpatient Treatment Services

Prior authorization for outpatient treatment services beyond the annual limitation of 135 units of group services and 26 hours of individual services per calendar year, may be considered with documentation supporting medical necessity for continued treatment services. Providers may submit requests requiring additional services using the Outpatient Substance Use Disorder Counseling Extension request form.

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Requests must be submitted before providing the extended services. The documentation must include the following information:

- The person is meeting treatment goals.
- The person demonstrates insight and understanding into relationship with mood-altering chemicals, but continues to present with issues addressing the life functions of work, social, or primary relationships without the use of mood-altering chemicals.
- The person is physically abstinent from chemical substance use, but remains mentally preoccupied with such use to the extent that the person is unable to adequately address primary relationships, or social or work tasks, but there are indications that, with continued treatment, the person will effectively address these issues.
- Although other psychiatric or medical complications exist that affect the person's treatment, there is documentation to support the person continues to show treatment progress and there is evidence to support the benefits of continued treatment.

10.11 Documentation Requirements

To facilitate determination of medical necessity and avoid unnecessary denials, the provider must provide correct and complete information, including documentation for medical necessity for the services requested. The provider must maintain documentation of medical necessity in the person's medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services.

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

10.12 Reimbursement and Limitations

10.12.1 Withdrawal Management Services

Inpatient hospital-based withdrawal management is reimbursed by the reimbursement methodology specific to the inpatient hospital. Separate reimbursement may be provided for physician services performed during an inpatient stay.

Residential withdrawal management and treatment services are considered outpatient services for the purposes of reimbursement and should be billed accordingly.

Residential withdrawal management services (procedure codes H0012, H0031, S9445, and T1007) are limited to once per day, any provider.

Residential withdrawal management services (procedure codes H0031, H0047, S9445, or T1007) will be denied if billed without lead procedure code H0012 on the same day, same provider.

Room and board for residential withdrawal management and treatment (procedure code H0047) is limited to once per date of service, any provider. Procedure code H0047 is reimbursed for persons who are 21 years of age and older as an access-based fee and as an informational detail for persons who are 20 years of age and younger.

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Outpatient withdrawal management (procedure codes H0016, H0050, and S9445) is limited to once per day, any provider and may be reimbursed on the same date of service as outpatient SUD treatment by the same or different provider when medically necessary and identified in the person's treatment plan.

Outpatient withdrawal management (procedure codes H0050 and S9445) will be denied if billed without lead procedure code H0016 on the same day, same provider.

Separate reimbursement may be provided for physician services during a residential stay.

10.12.1.1 Treatment Services

Outpatient treatment services are limited to 135 units of group counseling and 26 hours of individual counseling per calendar year when provided by a CDTF. Providers may submit requests requiring additional services using the Outpatient Substance Use Disorder Counseling Extension request form.

Residential treatment services (procedure code H2035) are limited to one per day and are allowed up to a maximum of 35 days.

Outpatient treatment (procedure codes H0004 and H0005) will be denied if billed on the same date of service as residential withdrawal management (procedure codes H0012, H0031, H0047, S9445, and T1007) or residential treatment (procedure code H2035).

Procedure code H0047 will be denied if billed without lead procedure code H2035 or H0012 on the same day, same provider.

Refer to: Subsection 6.4.1, "National Correct Coding Initiative (NCCI) Guidelines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about NCCI MUE guidelines.

10.12.2 MAT Services

Claims billed for MAT must include the person's substance use disorder diagnosis. MAT billing may include billing for induction as well as maintenance.

Methadone administration (procedure code H0020) for opioid disorder must be submitted with the following modifiers:

- When methadone is administered with supervision in a facility the provider must submit claims using the UA modifier to indicate the facility administered doses
- When methadone is dispensed without supervision as a take home dose the provider must submit claims using the U1 modifier to indicate take home doses

Methadone provided in an outpatient setting (procedure code H0020) is limited to once per date of service, by any provider and is reimbursed at a fixed daily rate. Reimbursement for procedure code H0020 with modifier U1 is limited to a quantity of 30 per 30 days, any provider.

Providers that allow take-home doses must submit procedure code H0020 with modifier U1 for each date of service for which a take-home dose is dispensed. Methadone that is dispensed for unsupervised take-home use should be dispensed in alignment with the federal opioid treatment standards in Title 42 Code of Federal Regulations (CFR) §8.12.

Methadone administration (procedure code H0020) submitted without a modifier will be denied.

Non-methadone (e.g., buprenorphine) administration (procedure code H0033) for opioid disorder must be submitted with the following modifiers:

- When non-methadone is administered with supervision in a facility the provider must submit claims using the modifier UA to indicate opioid disorder treatment facility doses or claims will be denied
- When non-methadone is dispensed without supervision as a take home dose the provider must submit claims using the modifier U1 to indicate opioid disorder take home doses or claims will be denied

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Non-methadone provided in an outpatient setting (procedure code H0033) is limited to once per date of service, by any provider. Reimbursement for procedure code H0033 with modifier U1 is limited to a quantity of 30 per 30 days, any provider.

Providers that allow take-home doses must submit procedure code H0033 with modifier U1 for each date of service for which a take-home dose is dispensed. Non-methadone that is dispensed for unsupervised take-home use should be dispensed in alignment with the federal opioid treatment standards in Title 42 Code of Federal Regulations (CFR) §8.12.

When non-methadone is administered in a facility for a non-opioid treatment, providers must use procedure code H0033 to indicate non-opioid treatment in a facility.

Non-methadone administration (procedure code H0033) submitted without a modifier will be denied. Physician and physician extenders may be reimbursed separately using the appropriate evaluation and management procedure codes.

Injectable administration is considered part of MAT and is not reimbursed separately. Procedure code 96372 will be denied when billed for the same date of service by any provider as procedure code H0020 or H0033.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.*

10.13 Claims Filing

Claims for SUD services 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. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

11 Collaborative Care Model (CoCM)

The Collaborative Care Model (CoCM) is a systematic approach to the treatment of behavioral health conditions (mental health or substance use) in primary care settings. The model integrates the services of behavioral health care managers (BHCMs) and psychiatric consultants with primary care provider oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.

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CoCM services are benefits of Texas Medicaid for persons of all ages who have a mental health or substance use condition to include a pre-existing or suspected mental health or substance use condition, when provided by a physician, physician assistant, nurse practitioner, or clinic/group practice, federally qualified health center (FQHC), or rural health clinic (RHC) (henceforth referred to as the primary care provider).

Prior to delivering CoCM services, the primary care provider must attest in the Provider Enrollment and Management System (PEMS) that their practice location has an established CoCM program, as described in this handbook. To ensure continued adherence to the CoCM core principles and the specific functional requirements of the model, the primary care provider must also re-attest in PEMS at the time of enrollment revalidation.

CoCM services must be provided under the direction of the primary care provider and are benefits when provided in an office, outpatient hospital, inpatient hospital, skilled nursing facility or intermediate care facility, extended care facility, or other locations.

Refer to: Subsection 9.3, "Collaborative Care Model (CoCM)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

12 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

13 Contact TMHP

Providers can call the TMHP Contact Center at 800-925-9126 from Monday through Friday, 7 a.m. to 7 p.m., Central Time.

14 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Attestation Form for Collaborative Care Model (CoCM) in Texas Medicaid

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Forms
Outpatient Withdrawal Management Authorization Request Form
Outpatient Substance Use Disorder Counseling Extension Request Form
Outpatient Mental Health Services Request Form
Residential Withdrawal Management Authorization Request Form
Residential Substance Use Disorder Treatment Request Form

15 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Blind Children's Vocational Discovery and Development Program (BCVDDP)
Case Management for Children and Pregnant Women
Licensed Clinical Social Worker (LCSW)
Licensed Marriage and Family Therapist (LMFT)
Licensed Professional Counselor (LPC)
Mental Health Case Management
Psychologist
Psychotherapy with Evaluation and Management (E/M)

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CERTIFIED RESPIRATORY CARE PRACTITIONER (CRCP) SERVICES HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human Services

CERTIFIED RESPIRATORY CARE PRACTITIONER (CRCP) SERVICES

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1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

The information in this handbook is intended for CRCP services and provides information about Texas Medicaid's benefits, policies, and procedures applicable to these therapies.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

2 Enrollment

Refer to: Subsection 1.7.17, "Certified Respiratory Care Practitioner (CRCP) Services" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for additional information about enrollment.

3 CRCP Services

3.1 Services, Benefits, Limitations, and Prior Authorization

Certified respiratory care practitioner services are a benefit of Texas Medicaid when provided in the home setting for ventilator-dependent clients by providers enrolled in Texas Medicaid as respiratory therapists.

Subject to the following specifications, conditions, and limitations, in-home certified respiratory care practitioner services are available to eligible clients who:

- Are ventilator-dependent for life support at least six hours per day.
- Have been ventilator-dependent for at least 30 consecutive days as an inpatient in one or more hospitals, skilled nursing facilities (SNF), or intermediate care facilities (ICF).
- But for the availability of these respiratory care services at home, would require respiratory care as an inpatient in a hospital, SNF, or ICF.
- Would be eligible to have reimbursement made for such inpatient care under the state Medicaid plan.
- Have adequate social support services to be cared for at home.

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- Wish to be cared for at home.
- Require professional respiratory therapy services in addition to those respiratory therapy services that are provided through the Home Health durable medical equipment (DME) lease of a ventilator.

Note: *For clients who are birth through 20 years of age who do not meet the criteria above, services to be performed by a certified respiratory care practitioner may be considered through the Comprehensive Care Program (CCP).*

Benefits include:

- Respiratory therapy services and treatments prescribed by a physician or allowed practitioner who is familiar with the client's medical history and care, and who has medically determined that in-home care is safe and feasible for the client.
- Education of the client, the appropriate family members, or support persons regarding the in-home respiratory care. Education must include the use and maintenance of required supplies, equipment, and techniques appropriate to the situation.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or clinical nurse specialist (CNS).*

Providers must use procedure code 99504 for in-home respiratory services.

Providers of respiratory therapy services must meet the following requirements:

- Be certified by the Texas Medical Board to practice under Chapter 604 of the Texas Occupations Code.
- Be enrolled and approved for participation in the Texas Medical Assistance Program.
- Bill for benefit services in the manner and format prescribed by HHSC or its designee.
- Comply with all applicable federal, state, and local laws and regulations.

The professional service may be billed by the certified respiratory care practitioner for services provided in the client's home (procedure code 99504). The professional service will be allowed once per day up to a limit of 24 visits per year. The recommended schedule includes 7 visits during the first week, a total of 6 visits during the second through fourth week, and 11 monthly visits for the second through the 12th month.

Providers will not be reimbursed for procedure codes 99503 and 99504 on the same date of service, any provider.

Disposable respiratory supplies are a benefit through Texas Medicaid Title XIX Home Health Services and are not reimbursed to the certified respiratory therapist.

3.1.1 Authorization Requirements

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

Prior authorization is required for in-home certified respiratory care practitioner services (procedure code 99504).

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A completed Special Medical Prior Authorization (SMPA) Request Form prescribing the service must be signed and dated by a physician or allowed practitioner familiar with the client before requesting prior authorization for respiratory care services. The completed SMPA Request Form must include the procedure codes and quantities for services requested. Without this information, requests will be considered incomplete.

To complete the prior authorization or authorization process by paper, the requesting provider must fax or mail the completed SMPA Request Form to the SMPA department and retain a copy of the signed and dated SMPA Request Form in the client's medical record.

To complete the prior authorization or authorization process electronically, the requesting provider must complete the prior authorization or authorization requirements through any approved electronic methods and retain a copy of the signed and dated SMPA Request Form in the client's medical record.

A copy of the completed, signed, and dated SMPA form must be maintained by the certified respiratory care practitioner in the client's medical record.

Refer to: Special Medical Prior Authorization (SMPA) Request Form on the TMHP website at www.tmhp.com.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment or supplies requested. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the service.

The SMPA Request Form must be submitted with the following documentation supporting medical necessity for the requested procedure:

- The client is on a ventilator at least six hours per day.
- The client has been ventilator dependent for 30 consecutive days or more as an inpatient in one or more hospitals, SNF, or ICF.
- The respiratory therapy services are in lieu of respiratory services requiring the client to remain in an inpatient care setting.
- Identification of the adequate support services in place that allow the client to be cared for at home.
- The respiratory services and goals for the services that will be provided by the certified respiratory care practitioner.
- The frequency and number of home visits requested by the certified respiratory care practitioner.
- The client's wish to be cared for at home.
- Documentation supporting why the respiratory therapy visits included in the Home Health DME rental of a ventilator would not meet the client's medical needs.

The request may be authorized for up to a 12-month period. Requests for more than 24 visits in a 12-month period will be referred for the medical director to review and a determination will be based on the individual client's medical needs.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when billing the claim for the procedure codes listed within the policy.

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4 CRCP-CCP Services

4.1 Services, Benefits, Limitations, and Prior Authorization

In-home respiratory services by a licensed certified respiratory care practitioner are a benefit of the Texas Medicaid Comprehensive Care Program (CCP) for non-ventilator dependent clients who are birth through 20 years of age when rendered by providers who are enrolled with Texas Medicaid as follows:

- Respiratory Therapist
- Physicians
- Home Health Agency

CRCP services are a benefit when provided in the home setting for a client with a chronic underlying respiratory illness, or a newly diagnosed long-term respiratory condition that is currently resulting in a suboptimal respiratory status.

The services provided through this policy are designed to maximize the client or caregiver's ability to self-manage the client's disease when the physician or allowed practitioner deems the client or caregiver will benefit from the expertise of a respiratory care practitioner for the provision of respiratory care or education. Respiratory therapy care services that do not require the specialty of a certified respiratory care practitioner are not a benefit. The certified respiratory care practitioner's services allow for the performance of pulmonary care, when required, and the education of the client or caregivers in:

- Disease management.
- Prevention of infections and/or complications.
- Proper use of medications and respiratory equipment which the client is using.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or clinical nurse specialist (CNS).*

Refer to: Section 3, "CRCP Services" in this handbook for respiratory care practitioner services for clients who are ventilator-dependent.

Providers must use procedure codes S9441, 98960, and 99503 for in-home respiratory services.

A certified respiratory care practitioner must hold a certificate or temporary permit in compliance with the *Texas Occupations Code* §604.105a.

A certified respiratory care practitioner must meet the following requirements:

- Be enrolled and approved for participation with Texas Medicaid as an independent practitioner or be employed by a physician, physicians group, or home health agency.
- Submit claims for covered services in the manner and format prescribed by HHSC or its designee
- Comply with all applicable federal, state, and local laws and regulations

Procedure codes S9441, 98960, and 99503 are each limited to once per day, by any provider, and twice per lifetime. Additional visits may be reimbursed when additional prior authorization criteria have been met.

Providers will not be reimbursed for procedure codes S9441, 98960, 99503, or 99504, in any combination, if submitted on the same date of service, by any provider.

Disposable respiratory supplies are a benefit through Texas Medicaid Title XIX Home Health Services and are not reimbursed to the certified respiratory therapist.

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4.1.1 Authorization Requirements

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

Prior authorization is required for in-home certified respiratory care practitioner's services.

A completed CRCP Prior Authorization Request Form requesting respiratory care services must be signed and dated by a physician or allowed practitioner familiar with the client, before requesting prior authorization for respiratory care services. The completed CRCP Prior Authorization Request Form must include the procedure codes and quantities for services requested.

The completed CRCP Prior Authorization Request Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the certified respiratory care practitioner in the client's medical record.

Refer to: CRCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.

To complete the prior authorization or authorization process by paper, the provider must fax or mail the completed CRCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CRCP Prior Authorization Request Form in the client's medical record.

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

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the services requested. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the service.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies.

The following documentation must be submitted to the CCP Prior Authorization Unit for prior authorization:

- A physician or allowed practitioner's order
- Client's primary diagnosis with details of current suboptimal respiratory status and history of more than one emergency room or acute care clinic visits within the last three months
- The services the certified respiratory care practitioner will provide
- Reason this service or education needs to be provided in the home setting and cannot be provided in the office or facility setting. These may include, but are not limited to:
    - Testing of home equipment.
    - Evaluation of the patient or caregiver's technique with home respiratory care equipment.
    - Evaluation of caregiver's ability to assess the client's respiratory status and intervene appropriately if necessary.

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  - Home environment assessment.
- The goals of the services to be provided in the home and the estimated length of time to attain these goals

Prior authorization is required for procedure code S9441, and services must be performed by a certified respiratory care practitioner who has been certified by the National Asthma Educator Certification Board (NAECB) as a certified asthma educator. Certification documentation must be provided with the CRCP Prior Authorization Request Form in order to be considered for prior authorization.

Asthma conditions may include, but are not limited to:

- Extrinsic asthma
- Intrinsic asthma
- Chronic obstructive asthma
- Exercise-induced asthma

Prior authorization is required for procedure codes 98960 and 99503. Respiratory conditions may include, but are not limited to:

- Cystic fibrosis
- Obstructive sleep apnea (use of CPAP or BiPAP)
- Chronic respiratory insufficiency

Prior authorization will not be considered for certified respiratory care practitioners to perform routine respiratory treatment or services in the home.

Prior authorization requests for conditions or quantities beyond those limits established in this policy (two per lifetime) will be considered on a case-by-case basis upon review by the Texas Medicaid & Healthcare Partnership (TMHP) Medical Director. The following additional information must be provided:

- Documentation of how the objectives of prior visits have not been achieved to support the need for additional visits beyond those limits established in this policy.
- Reason these additional services need to be provided in the home setting.
- The goals of these services and the estimated length of time to attain these goals.
- The frequency and number of home visits requested by the certified respiratory care practitioner.

5 Documentation Requirements

All supporting documentation must be included with the request for prior authorization. Providers can submit requests to TMHP as follows:

- TMHP Prior Authorization on the Portal: www.tmhp.com/topics/prior-authorization

  Note: *The above link is to the TMHP Prior Authorization web page. From the TMHP Prior Authorization web page, click "PA On the Portal" to access the TMHP PA on the Portal application.*
- CCP requests, Fax to: 1-512-514-4212
- Non-CCP requests, Fax to: 1-512-514-4213

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6 Prescribed Pediatric Extended Care Center (PPECC) Services

CRCP services may be reimbursed when provided in a PPECC setting. When services are rendered in a PPECC setting, the PPECC's name and NPI number must appear on the professional claim, in addition to the certified respiratory care provider's NPI. The certified respiratory care practitioner must also indicate outpatient hospital as the place of service when rendering services in a PPECC, or the claim will be denied.

When certified respiratory care services are rendered in a PPECC, the certified respiratory care provider must document coordination with the PPECC.

The PPECC and the certified respiratory care practitioner must have a written agreement for each client related to the provision of respiratory care practitioner services provided at the PPECC. The written agreement must address responsibilities of both parties, and how the parties will coordinate related to the client's plan of care. The written agreement must be maintained in the client's medical record.

7 Claims Filing and Reimbursement

7.1 Claims Information

CRCP services must be submitted to the Texas Medicaid & Healthcare Partnership (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.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Electronic billers must submit the prior authorization number (PAN) on the electronic claim form.

Providers should consult the software vendor for the location of this field in the software.

7.2 Reimbursement

Respiratory therapy services provided by a participating CRCP are reimbursed the lesser of the provider's billed charges or the rate calculated in accordance with 1 TAC §355.8089.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

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Providers will not be reimbursed for procedure codes 99503 and 99504 on the same date of service, any provider.

The professional service may be billed by the CRCP for services provided in the client's home (procedure code 99504). The professional service will be allowed once per day up to a limit of 24 visits per year. The recommended frequency for CRCP services is as follows: 7 visits during the first week, a total of 6 visits during the second through fourth weeks, and 11 monthly visits for the second through the 12th month.

Disposable respiratory supplies and respiratory equipment rental or purchase are a home health services benefit and are not reimbursed to the certified respiratory therapist.

Refer to: Subsection 2.2, "Services, Benefits, Limitations and Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for more information about DME or medical supplies prior authorization information.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when claims are submitted for the procedure codes listed within this handbook.

The *Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT)* codes included in this policy are subject to National Correct Coding Initiative (NCCI) relationships. Any exceptions to NCCI code relationships are specifically noted in the policy. Providers should refer to NCCI for correct coding guidelines and specific applicable code combinations.

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Children's Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

November 2026

TEXAS
Health and Human Services

CHILDREN'S SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for dentists, school districts, physicians, physician assistants (PAs), rural health clinics (RHCs), federally qualified health centers (FQHCs), advanced practice registered nurses (APRNs), home health agencies (HHAs), durable medical equipment (DME) suppliers, hospitals, and clinics. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.7, "Provider Responsibilities" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

1.1 Medical Transportation Program

The Medical Transportation Program (MTP) is funded with federal and state dollars to arrange nonemergency transportation to medical or dental appointments for eligible clients and their attendants.

The Health and Human Services Commission (HHSC) administrative rules govern parental accompaniment of children who receive Medicaid screenings, treatments, and MTP services.

Titles 1 Texas Administrative Code (TAC), Part 15, §380.207 allows parents or guardians to authorize one adult and one alternate adult to accompany their children on MTP rides when the parent or guardian is unable to do so. The parent or guardian is required to designate the other adult on a form prescribed by HHSC in accordance with section §380.207(4).

An adult who is authorized by a parent or guardian may not be a provider or an employee or affiliate of a provider that submits claims for services.

Refer to: The *Medical Transportation Program Handbook* (*Vol. 2, Provider Handbooks*) for more information.

1.2 Rates Reduction

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the Texas Medicaid & Healthcare Partnership (TMHP) website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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1.3 NP, CNS, PA, and CNM Claims Submitted by a Physician

Physicians will be reimbursed 92 percent of the established reimbursement rate for services provided by an NP, CNS, PA, or CNM if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. Physicians who submit a claim using the physician's own National Provider Identifier (NPI) for the services that were provided by the NP, CNS, PA, or CNM must submit one of the following modifiers on each claim detail:

- SA—Services were provided by an NP or CNS
- U7—Services were provided by a PA
- SB—Services were provided by a CNM

Exception: *The 92 percent reimbursement rate does not apply to laboratory services, radiology services, or injections provided by an NP, CNS, PA, or CNM.*

1.4 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated time frame of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- Services are rendered at a federally qualified health center (FQHC) or rural health clinic (RHC).
- Services are for a THSteps medical checkup.
- Professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

These reimbursement guidelines do not apply for FQHC, RHC, THSteps, and professional services that are rendered in the inpatient hospital setting.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Medicaid Children's Services Comprehensive Care Program (CCP)

2.1 CCP Overview

CCP is an expansion of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) service as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1989, which requires all states to provide all medically necessary treatment for correction of physical or mental problems to Texas Health Steps (THSteps)-eligible clients when federal financial participation (FFP) is available, even if the services are not covered under the state's Medicaid plan.

Under the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) regulation, known in Texas as Texas Health Steps (THSteps), Section 1905(r) of the Social Security Act mandates that all Medicaid-eligible beneficiaries who are birth through 20 years of age receive medically necessary services to treat, correct and ameliorate illnesses and conditions identified if the service is covered in the state's Medicaid

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plan or is an optional Medicaid service. It is the responsibility of the state to determine medical necessity on a case specific basis. No arbitrary limitations on services are allowed (e.g., one pair of eyeglasses or 10 therapy sessions per year) if determined to be medically necessary.

Services not covered under this section include:

- Experimental or investigational treatment.
- Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.
- Services for the caregiver or provider convenience.

All EPSDT requirements must be adhered to for beneficiaries who receive services under managed care arrangements.

The following CCP provider sections describe the specific requirements of each area of responsibility:

- Subsection 2.6, "Clinician-Directed Care Coordination Services (CCP)" in this handbook.
- Subsection 2.11, "Medical Nutrition Counseling Services (CCP)" in this handbook.
- Subsection 2.9, "Early Childhood Intervention (ECI) Services" in this handbook.
- Subsection 2.12, "Personal Care Services (PCS) (CCP)" in this handbook.
- Subsection 2.17, "Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP)" in this handbook.
- Subsection 2.18, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in this handbook.

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about comprehensive outpatient rehabilitation facilities (CORFs) and outpatient rehabilitation facilities (ORFs).

The *Home Health Nursing and Private Duty Nursing Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about private duty nursing (PDN) services.

The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about CCP therapy services.

The *Certified Respiratory Care Practitioner (CRCP) Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about CRCP CCP services.

2.1.1 Client Eligibility

The client must be birth through 20 years of age and eligible for THSteps on the date of service. If the client's Your Texas Benefits Medicaid card states "Emergency," "PE," or "QMB," the client is not eligible for CCP benefits.

Clients are ineligible for CCP services beginning the day of their 21st birthday.

2.1.2 Enrollment

Refer to: Subsection 1.7.19, "Children's Services Comprehensive Care Program (CCP)" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for enrollment information.

2.1.3 Services, Benefits, and Limitations

Payment is considered for any health-care service that is medically necessary and for which FFP is available. CCP benefits are allowable services not currently covered under Texas Medicaid (e.g., speech-language pathology [SLP] services for nonacute conditions, PDN, prosthetics, orthotics, apnea monitors and some DME, some specific medical nutritional products, medical nutrition services, inpatient

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rehabilitation, travel strollers, and special needs car seats). CCP benefits also include expanded coverage of current Texas Medicaid services where services are subject to limitations (e.g., diagnosis restrictions for total parenteral nutrition [TPN] or diagnosis restrictions for attendant care services).

Requests for services that require a prior authorization must be submitted to TMHP. Prior authorization is a condition for reimbursement, not a guarantee of payment. For information about specific benefits, providers can refer to provider-specific sections of this manual.

Payment cannot be made for any service, supply, or equipment for which FFP is not available. The following are some examples:

- Vehicle modification, mechanical, or structural (such as wheelchair lifts).
- Structural changes to homes, domiciles, or other living arrangements.
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, filters, space heaters, fans, water purification systems, vacuum cleaners, and treatments for dust mites, rodents, and insects.
- Ancillary power sources and other types of standby equipment (except for technology-dependent clients such as those who are ventilator-dependent for more than six hours per day).
- Educational programs, supplies, or equipment (such as a personal computer or software).
- Equine or hippotherapy.
- Exercise equipment, home spas or gyms, toys, therapeutic balls, or tricycles.
- Tennis shoes.
- Respite care (relief to caregivers).
- Aids for daily living (toothbrushes, spoons, reachers, and foot stools).
- Take-home drugs from hospitals (Eligible hospitals may enroll in and bill Vendor Drug Program (VDP). Pharmacies that want to enroll should call 512-491-1429.
- Therapy involving any breed of animal.

2.1.4 Prior Authorization and Documentation Requirements

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. A prior authorization number (PAN) is a TMHP-assigned number establishing that a service or supply has been determined to be medically necessary and for which FFP is available. It is each provider's responsibility to verify the client's eligibility at the time each service is provided. Any service provided while the client is not eligible cannot be reimbursed by TMHP. The responsibility for payment of services is determined by private arrangements made between the provider and client.

Prior authorization of CCP services may be requested in writing by completing the appropriate request form, attaching any necessary supportive documentation, and submitting them by mail, fax, or the electronic portal to the TMHP-CCP department. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Providers who fax new prior authorization requests, resubmitted requests, or additional information to complete a request must include:

- A working fax number on the prior authorization form, so that they can receive faxed responses and correspondence from TMHP.
- The last four digits of the client's Medicaid identification number on the fax coversheet.

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Prior authorization may also be requested through the TMHP website. (Providers can refer to Subsection 5.5.1, "Prior Authorization Requests Through the TMHP Website" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information to include mandatory documentation and retention requirements). All requested information on the form must be completed, or the request is returned to the provider. Incomplete forms are not accepted. If prior authorization is granted, the potential service provider (such as the DME supplier, pharmacy, registered nurse (RN), or physical therapist) receives a letter that includes the PAN, the procedures prior authorized, and the length of the authorization. Providers are notified in writing when additional information is needed to process the request for services.

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

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

Refer to: CCP provider-specific sections for prior authorization requirements of specific services, including the appropriate prior authorization request forms.

2.1.4.1 Incomplete Prior Authorization Requests

Providers must respond to an incomplete prior authorization request within 14 business days of the request receipt date. Incomplete prior authorization requests are requests that are received by TMHP with missing, incomplete, or illegible information.

Prior to denying an incomplete request, TMHP's Prior Authorization department will attempt to get the correct information from the requesting provider. The Prior Authorization department will make a minimum of three attempts to contact the requesting provider before sending a letter to the client about the status of the request and the need for additional information.

If the necessary information to make a prior authorization determination is not received within 14 business days of the request receipt date, the request will be denied as "incomplete." To ensure timely processing, providers should respond to requests for missing or incomplete information as quickly as possible.

For fee-for-service (FFS) Medicaid requests that require a physician review before a final determination can be made, TMHP's Physician Reviewer will complete the review within three business days of receipt of the completed prior authorization request. An additional three business days will be allowed for requests that require a peer-to-peer review with the client's prescribing physician.

2.1.4.2 Diagnosis Coding

All providers must obtain the client's medical diagnosis from the physician. This information must be reflected on each claim submitted to TMHP.

2.1.4.3 Drug and Medical Device Approval

Manufacturers may request to have drug or medical device products added as a CCP benefit by sending the information in writing to the following address:

HHSC
1100 West 49th Street
Austin, TX 78756-3179

HHSC reviews the information. Requests for consideration must *not* be sent to TMHP.

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2.1.4.4 Physician Signature

The dated signature of the physician (M.D. or D.O.) on a prescription or CCP Authorization Request Form must be current to the service date(s) of the request, i.e., the signature must always be on or before the service start date and no older than three months before the current date(s) of service requested. Physician signatures dated after the service start date on initial requests cannot be accepted as documentation supporting medical necessity for dates of service prior to the signature date. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. If services begin as a result of a verbal order before the physician's dated signature, proof of the verbal order must be submitted with the request.

Stamped signatures and dates are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services, supplies, or equipment. Verbal orders must be cosigned and dated by a physician (M.D. or D.O.) within two weeks, per provider policy. Signatures of chiropractors or doctors of philosophy (PhDs) are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services.

Certified nurse midwife (CNM), clinical nurse specialist (CNS), nurse practitioner (NP), and PA providers may sign on behalf of the physician for private duty nursing, physical, occupational and speech therapy services when the physician delegates this authority.

Physician prescriptions must be specific to the type of service requested.

2.2 Managed Care Organization (MCO) Clients Who Transition to Medicaid Fee-For-Service (FFS)

When clients transition from an MCO to FFS, providers can request that previously approved authorizations for Comprehensive Care Program (CCP) services, occupational therapy (OT), physical therapy (PT), private duty nursing (PDN), and speech therapy (ST) be transferred from the MCO to FFS.

2.2.1 Submission Guidelines

TMHP will consider the reimbursement of claims for services that were rendered on or after the MCO's disenrollment date only when the provider submits a request to TMHP to transfer the previously approved authorization for CCP services.

The request to TMHP must be received on or before the end date of the previously approved MCO authorization. Any requests submitted after the MCO's authorization end date will have to meet the regular submission guidelines for the specific service type.

2.2.2 Documentation Requirements

All of the requests to transfer the authorizations from the MCO to FFS must include:

- A copy of the previously approved authorization letter.
- All of the documentation that was sent in the original authorization request, including any physician orders that were used to determine the start of care. TMHP will accept the physician orders as the required documentation for the requested services.
- The completed CCP Prior Authorization Request form, Special Medical Prior Authorization (SMPA) form, Home Health Plan of Care, or Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form, whichever is applicable for the requested service. The form must include the dates of service and quantities that are being requested from TMHP, which must match the dates of service and quantities that were approved in the original authorization.

Note: *It is not necessary to obtain signatures or dates on the forms listed above when submitted to TMHP for the purpose of transferring an authorization from an MCO to FFS Medicaid.*

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Authorizations for services transferred from an MCO to FFS Medicaid are subject to retrospective review.

TMHP will verify the client's eligibility, the dates of service, and the quantities requested.

TMHP will process reimbursement claims as follows:

- Claims for services that were rendered before the date on which the transfer request was received will be denied as a late submission, and the provider will be notified of their administrative appeal rights through the Health and Human Services Commission (HHSC).
- Claims for services that were rendered on or after the date of receipt use the required information from the transferred authorization and will be processed as if the request was received in a timely manner.
- Claims for services that were paid by an MCO and then recouped must contain the recoupment EOB from the MCO for consideration of payment. The claims must meet the 95-day deadline from the recoupment disposition date.

  Note: *Letter requests for refunds will not be accepted. A recoupment EOB with a disposition date is required.*

If a request to transfer an MCO authorization is submitted after the end date of the MCO authorization or the provider does not have an authorization letter from the MCO, TMHP will process the request to transfer the authorization based on established TMHP authorization submission guidelines for CCP services, PDN, OT, PT, and ST.

All new requests for rendered services must meet the documentation requirements.

2.2.3 New Services and Extension of Services

For new services that occur after the client's MCO disenrollment change date, the provider is responsible for submitting all TMHP required paperwork and meeting all established submission guidelines for prior authorization.

Requests for the extension of services that occur after the MCO disenrollment change date must include all of the paperwork that is required by TMHP and meet all established submission guidelines for prior authorization.

2.2.4 Loss of Eligibility

If an MCO disenrolled a client and the client also loses Medicaid eligibility, providers must anticipate, if and when Medicaid eligibility is restored, that the client will initially be considered a Medicaid FFS client and will have a retroactive eligibility period.

All requests for services that require prior authorization and that occur during the client's retroactive eligibility period, must be submitted to TMHP following the process that is outlined in subsection 5.1.1, "Prior Authorization Requests for Clients with Retroactive Eligibility" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*).

If a client is retroactively disenrolled by an MCO, all of the services that are rendered by the provider during this retroactive disenrollment period (specifically from the date on which the client was eligible for FFS to the date of the client's MCO eligibility change) will be denied by TMHP, and the provider will be notified of their administrative appeal rights.

TMHP may consider services for the MCO transition beginning on the date of the client's MCO eligibility change date and going forward. TMHP uses the MCO transition process for the submission of paperwork and the processing of provider requests.

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2.3 Autism Services

Autism services are a benefit of the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) for Medicaid children or youth who are 20 years of age or younger and meet the criteria outlined in this section.

2.3.1 Autism Spectrum Disorder (ASD)

Autism spectrum disorder (ASD) is a condition characterized by restricted, repetitive patterns of behavior, interests, or activities and deficits in social communication and social interaction, with onset of symptoms occurring in early childhood.

Texas Medicaid acknowledges that research and clinical practices in interventions for ASD are an evolving and dynamic field. As such, documentation to support the medical need for ASD services, including applied behavior analysis (ABA) services, may include intervention techniques with a sound basis in discipline-specific peer-reviewed literature when available, interventions with specific applicability to the person's clinical and functional profile (including comorbid conditions), and an individualized, person-centered treatment plan that aligns with the values and preferences of the person with ASD and their family.

2.3.2 Comprehensive Diagnostic Evaluation

A comprehensive diagnostic evaluation is required to diagnose ASD. A comprehensive diagnostic evaluation is the entire process of gathering information to determine a diagnosis, which must include a reliable, valid, standardized diagnostic assessment tool(s). Each element must be conducted by appropriately trained, specialized or certified providers. Diagnosis of ASD may be made by any one of the following providers or utilizing an interdisciplinary diagnostic team approach:

- A developmental pediatrician
- A neurologist
- A psychiatrist
- A licensed psychologist
- Interdisciplinary Diagnostic Team
    - Members of an interdisciplinary diagnostic team administer the elements required for the diagnosis of ASD. Each provider must be qualified by licensure to use the reliable, valid, standardized diagnostic assessment tool(s).
    - An interdisciplinary diagnostic team may be composed of a physician or allowed diagnosing provider who may coordinate with providers specializing in autism for consultation as listed under the Interdisciplinary Diagnostic Team. Providers of the interdisciplinary diagnostic team must be qualified child specialists and have expertise in autism. The prescribing provider may use the documented results of a reliable, valid, standardized diagnostic assessment tool or combination of tools from the following disciplines:
        - Any provider listed above
        - Licensed clinical social worker
        - Licensed professional counselor
        - Licensed psychological associate
        - Licensed specialist in school psychology
        - Occupational therapist (OT)

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- Speech-language pathologist (SLP)

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (NP), or clinical nurse specialist (CNS).*

The comprehensive diagnostic evaluation must include all of the following to support a diagnosis of ASD:

- Diagnostic criteria and symptom severity level according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- A reliable, valid, standardized diagnostic assessment tool or combination of tools, using the most current editions or versions of the tools, as age and clinically appropriate, such as the Autism Diagnostic Observation Schedule, the Autism Diagnostic Interview-Revised (ADI-R), the Childhood Autism Rating Scale, or another validated diagnostic assessment tool, as clinically appropriate. The diagnostic assessment tool must be indicated for diagnostic purposes by the publisher.
  - Screening tools such as the Screening Tool for Autism in Toddlers and Young Children (STAT) or the Modified Checklist for Autism in Toddlers (M-CHAT-R) or M-CHAT Revised with Follow-Up (M-CHAT-R/F) may not replace the use of validated diagnostic assessment tools.
- Documentation of diagnosis must include:
  - Age of the child or youth
  - Date of the initial ASD diagnosis
  - Documentation of any known comorbid behavioral or physical health disorders
  - Documentation of trauma history

To be eligible for the ABA services outlined in this section, a diagnosis of ASD complete with diagnostic criteria and symptom severity level from the current DSM must be made or reconfirmed within 3 years of initiation or recertification of ABA services.

To be eligible for ABA services outlined in this section more than 3 years after initial ASD comprehensive diagnosis, a comprehensive re-evaluation of ASD symptom severity levels per DSM criteria must be made by qualifying diagnostic providers, as listed above. A re-evaluation consists of the same components as an initial comprehensive diagnostic evaluation.

2.3.3 Comprehensive Service Array

Texas Medicaid offers an array of medically necessary services to support individualized treatment plans for children or youth who are 20 years of age or younger with ASD.

These services may be covered benefits when matched with an individualized treatment plan tailored to the specific needs of the child or youth who are 20 years of age or younger and their caregivers and documented as medically necessary and effective. Not all services may be clinically appropriate for all people, families, or situations.

Services must be evidence-based, person-centered, delivered by personnel of appropriate training and credentialing, and oriented to functional, attainable, and measurable goals.

These services may include one or more of the following but are not limited to:

- Applied behavior analysis (ABA)
- Case management/service coordination (with parent permission)
- Early Childhood Intervention (ECI)
- Nutrition, when provided by a licensed dietitian
- Occupational therapy (OT)

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- Outpatient behavioral health services
- Physician services, including medication management
- Physical therapy (PT)
- Speech-language pathology (SLP); also called speech therapy (ST)

Nonphysician qualified health-care professionals who are enrolled in Texas Medicaid may be reimbursed up to 2 times per rolling year for participation in interdisciplinary team meetings (procedure code 99366) for the coordination of care for children or youth who are 20 years of age or younger with ASD and have a prior authorization for ABA evaluation or treatment services. The Licensed Behavior Analyst (LBA) is required to participate in interdisciplinary treatment team meetings. Interdisciplinary team meetings are not required for a child or youth for access to any service but are highly encouraged for a collaborative approach to treatment, which is considered the gold standard for care of people with ASD.

Interdisciplinary team meetings must include the LBA and at least 2 other licensed professionals meeting simultaneously with the parent or caregiver. The child or youth may optionally attend the meeting.

Additional members may attend, such as assistants, paraprofessionals, or others the family chooses, but these participants may not seek Medicaid reimbursement or count toward the required members of the interdisciplinary team meeting.

Non-Medicaid enrolled licensed professionals who work directly with the child or youth and would otherwise be eligible for reimbursement for interdisciplinary team meetings except that they are not Medicaid-enrolled may not receive Medicaid reimbursement for participation in team meetings. However, they may be considered as a participating team member for the purpose of meeting the minimum number of licensed provider participants.

Regardless of Medicaid enrollment, licensed assistants, nonclinical social workers, case managers, and paraprofessionals may not count toward the minimum number of licensed professionals present at the interdisciplinary team meeting.

Team members may include licensed Medicaid-enrolled practitioners of the following disciplines:

- Licensed clinical social worker (LCSW)
- Licensed behavior analyst (required team member)
- Licensed dietitian (LD)
- Licensed professional counselor (LPC)
- Licensed psychologist (LP)
- Occupational therapist (OT)
- Physical therapist (PT)
- Physician, physician assistant, or nurse practitioner
- Speech-language pathologist (SLP)

Note: *The physician, physician assistant, or nurse practitioner may bill a standard evaluation and management code (i.e., established patient visit) based on the counseling and coordination of care time spent in the team conference.*

To be reimbursed for the interdisciplinary team meeting (procedure code 99366), each participating licensed team member must have individually evaluated or provided direct services to the child or youth within the previous 180 days.

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For a change of provider, the new provider must follow requirements in the Change of Provider section to begin services prior to attendance at the interdisciplinary team meeting.

Team members, including the child or youth, their family, or their caregiver, may participate via remote technology, which meets standards of care for telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth and technology requirements.

Medicaid-enrolled providers must designate remote delivery with modifier 95 on the claim.

Team members may include representatives from the child or youth's school, but school districts are not eligible for direct reimbursement for the interdisciplinary team meeting.

No more than one individual from the same specialty may receive Medicaid reimbursement for the team meeting.

School personnel of the same discipline as Medicaid-enrolled providers who are participating to coordinate care are not considered duplicates of the same specialty and may count toward the 3-participant licensed professional minimum.

2.3.4 Applied Behavior Analysis (ABA)

Behavior analysis is the scientific study of the principles of learning and behavior, specifically about how behavior affects, and is affected by, past and current environmental events in conjunction with biological variables.

ABA refers to the application of current, evidence-based specialized principles of the applied behavior analysis discipline by a provider, such as a licensed and certified behavior analyst (LBA), trained in this intervention.

The intent of ABA therapy is to effect meaningful changes, which are durable and generalizable, in socially significant behaviors in everyday settings. ABA focuses on treating behavior difficulties and shaping behavior patterns through environmental adaptations and consistent reinforcement and consequences across settings and situations.

Intensive behavioral intervention (IBI) is a high-intensity application of ABA therapy.

ABA services must be medically necessary to treat, correct, or ameliorate the individual's condition. A diagnosis alone is not sufficient documentation to support the medical necessity of ABA.

Physical restraint is not appropriate during any service provided to Medicaid children or youth under the Autism Services benefit except in emergency instances of threat of physical harm to the child or youth or others around them.

Physical restraint may only be implemented by a person trained in the type of restraint being implemented.

Restraint must be limited to the use of such reasonable force as is necessary to address the emergency.

Restraint must be discontinued at the point at which the emergency no longer exists.

Restraint must be implemented in such a way as to protect the health and safety of the child or youth and others.

Restraint must not deprive the child or youth of basic human necessities.

Documentation must be kept of the up-to-date training for all staff members involved and of each incident that resulted in restraint.

Use of ABA in no way precludes other medically necessary treatment interventions for ASD, such as ST, OT, and other forms of behavioral therapy, family therapy, parent-implemented models that use a developmental relationship-based approach, or medication management.

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Texas Medicaid strongly encourages, and in some circumstances requires, interdisciplinary collaboration of care.

2.3.5 Parent or Caregiver Involvement

For fidelity to the ABA treatment model for children or youth who meet eligibility requirements, an effective course of ABA typically requires active parent or caregiver participation and involvement to increase the potential for behavior changes in the specific behaviors identified as causing limitations or deficits in functional skills expected for the child or youth.

Parent or caregiver training is considered a separate component of the individualized treatment plan from the direct services provided to the child or youth, and documentation of parent progress on goals is required.

Parent or caregivers ideally must be able to participate in ABA therapy and implement ABA techniques in the home and community environment as instructed by the LBA or licensed assistant behavior analyst (LaBA) for behavior changes to prove to be durable and generalizable. Individual family circumstances are necessary criteria when designing the individualized treatment plan.

Participation by the parents or caregivers are expected, and continued authorization for ABA services will take consideration of their involvement and ability to reinforce behavior changes over time and across settings.

Exceptions to this general expectation may be considered on a case-by-case basis. For example: for children or youth in residential placement through the Department of Family and Protective Services conservatorship who have a treatment plan designed to address this limitation. In these cases, persons involved in the child or youth's care are encouraged to be involved in implementation of the therapeutic interventions in the home and community.

ABA services will not be denied solely on the basis of lack of parent or caregiver involvement; however, parent or caregiver involvement may affect the effectiveness, durability, and generalizability to natural settings of the treatment and may be considered when making determinations regarding effectiveness of the treatment requested.

2.3.5.1 Treatment Planning

Treatment planning requires that the LBA collaborate with and obtain documentation of determinations from the prescribing provider or other appropriate providers for elements of the treatment plan that are not within the LBA scope of practice.

ABA treatment plans, including group treatment, require goals that relate to the child or youth's individual functional contexts.

Functional context refers to everyday environments for behaviors or skills that allow the child or youth to achieve an outcome relevant to their health, safety, or independence.

Goals to address behaviors that result in deficits in social communication and social interaction relating to the child or youth's health, safety, or independence in functional contexts may be considered medically necessary.

Treatment plan goals (to include parent or caregiver training) may target a specific behavior interfering with activities of daily living (ADLs) use the principles of ABA (i.e., backward chaining, schedules of reinforcement, etc.) to teach parents or caregivers on supporting ADLs.

- General goals addressing ADL skill acquisition are excluded.

Functional goals must be specific to the child or youth, objectively measurable within a specified time frame, attainable in relation to the child or youth's prognosis and developmental status, both important to and relevant to the child or youth and their family, and directly related to the core symptoms of ASD as defined by the current version of DSM.

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The treatment plan may also include goals to specifically address challenging behaviors, such as aggression, in the creation of a Behavior Support Plan (BSP).

BSPs may not include the use of aversive interventions, including but not limited to the use of pain, discomfort, social humiliation, seclusion, or restraints.

The treatment plan must include separate goals specific to parent or caregiver training.

The child or youth must be able to participate in sessions as outlined in the individualized treatment plan.

This section addresses ABA services provided by Texas LBAs as well as by an LaBA or behavior technician (BT) working under the supervision of an LBA in office, home, clinic, and community settings.

All LBAs and their supervisees must provide services in a way that is consistent with the physician's orders, commonly accepted practice standards, licensing requirements, and within their scope of practice.

Services must be provided in compliance with the Texas Health Step-Comprehensive Care Program, medical standards for telehealth, and these Medicaid Autism Services requirements, which may be more restrictive than general ABA practice.

The LBA must determine whether services are clinically appropriate, effective, and not contraindicated for the child or youth, their family, or particular situation.

> ***Note:*** *Remote delivery as specified for this service will supersede that of the Telecommunication Services Handbook.*

ABA therapy addresses the behaviors associated with the core symptoms of ASD that impact attainment of individualized functional goals. It is out of scope for an ABA provider to attempt to remediate underlying or associated medical conditions that may impact progress toward individualized functional goals or to formulate a treatment plan without appropriate collaboration with other health-care disciplines, as appropriate.

LBAs and the staff they supervise are expected to have training and knowledge of typical development for children or youth who are 20 years of age or younger in order to provide medically necessary services.

When evaluating and treating children and youth with suspected or diagnosed comorbid genetic, physical, or behavioral health conditions or trauma history, the LBA is expected to coordinate with the appropriate skilled and licensed professionals. Co-occurring conditions may mimic or exacerbate ASD symptoms.

Diagnosis and treatment of physical health conditions, including developmental delays in children, would require collaboration with additional professionals.

- For example, a child or youth with a co-morbid diagnosis of a motor disorder who has treatment plan goals addressing speech or motor skill development would require coordination with an SLP, OT, or PT, as appropriate.
- For example, a child or youth with a diagnosis of a seizure disorder would require close coordination with the physician treating the condition.
- A child with a co-morbid diagnosis of a feeding disorder who has treatment plan goals addressing feeding would require coordination with the appropriate medical provider, including but not limited to a physician, dietitian, OT, or SLP, as appropriate.
- LBAs are not permitted as the sole provider of a feeding treatment plan.

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Diagnosis and treatment of co-occurring behavioral health conditions require the input of and coordination with behavioral health professionals specifically trained and educated in this scope of practice.

- For example, a child or youth with a co-morbid diagnosis of anxiety would require coordination with the appropriate behavioral health provider.

It is out of scope for an LBA to dictate the provision of other medically necessary treatments, including requiring a child or youth and their family to drop other services in order to access ABA.

The following ABA services may be authorized for eligible children or youth who have been diagnosed with ASD according to guidelines:

- An initial ABA evaluation (procedure code 97151) to include development of an individualized treatment plan and a BSP, as appropriate
- An initial 90-day course of ABA treatment with medical necessity documentation from the ABA evaluation. Treatment may include the following with documented medical necessity:
  - Provision of one-on-one ABA services delivered directly by the LBA or delivered by the supervised LaBA, BT, or both (procedure codes 97153, 97155)
  - Provision of group ABA services delivered directly by the LBA or delivered by the supervised LaBA, BT, or both (procedure codes 97154, 97158)
  - One-on-one services delivered directly to the child or youth with ASD by a BT or LaBA must be delivered in person. Use of telehealth in one-on-one, direct service delivery with the child or youth by a BT or LaBA is prohibited.
  - Providing training to family members or caregivers by the LBA or delegated supervised LaBA in accordance with the child or youth's individualized treatment plan (procedure code 97156). The child or youth with ASD is not required to be present for this family or caregiver training.
- A 90-day extension of medically necessary ABA treatment with supportive documentation of the extension from submission of an attendance log that also includes a calculation of the percentage of planned sessions completed for the child or youth and their parent or caregiver, and a progress summary
- An ABA re-evaluation (procedure code 97151), to include an attendance log that also includes a calculation of the percentage of planned sessions completed for the child or youth and their parent or caregiver
- A 180-day recertification of ABA treatment with medical necessity documentation from the ABA re-evaluation and related documents

All ABA treatment and evaluation services require a signed and dated referral from the child or youth's prescribing provider.

2.3.6 ABA Provider Requirements

2.3.6.1 Licensed Behavior Analysts (LBA)

Licensed behavior analysts (LBA) must meet all of the following requirements:

- Have a current, unrestricted state-issued license and meet all applicable Texas licensure requirements.
- If applicable, employ directly or contract with LaBAs or BTs or both.
- Have training and knowledge of typical development for children or youth who are 20 years of age or younger.

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LBAs serve as direct supervisors of the LaBAs and BTs and must ensure that the quality of the ABA services provided by LaBAs and BTs meets the minimum standards promulgated by the applicable certifying body's recommendations, rules, and regulations as well as Medicaid requirements.

LBAs are ultimately responsible for the delivery of ABA care including the treatment plan.

Direct supervision must be provided in accordance with Texas state licensure.

Only direct supervision, where the LBA directly observes the LaBA or the BT providing services with the child or youth, or the child or youth's parents or caregivers, will be reimbursed by Texas Medicaid (procedure code 97155). Indirect supervision, including but not limited to a review and discussion of case load, data collection procedures, and professional development, is not reimbursable under Texas Medicaid. See the Reimbursement and Billing Guidelines section.

ABA treatment will ideally be delivered in the primary language used at home or the primary language of the child or youth with ASD.

Translation or interpretation services, when and as required for effective service delivery, must be offered if providers are not able to deliver the treatment in the child or youth's primary language.

The LBA is responsible for provision of services within Medicaid requirements.

2.3.6.2 Licensed Assistant Behavior Analysts (LaBA)

LaBAs must have a current, unrestricted state-issued license and meet all applicable Texas licensure requirements.

A supervised LaBA working within the scope of their training, practice, and competence may assist the LBA in various roles and responsibilities as determined appropriate by the LBA and delegated to the LaBA, consistent with the Texas state licensure requirements and Medicaid requirements.

LaBAs must have training and knowledge of typical development for children or youth who are 20 years of age or younger.

LaBAs may not enroll in Texas Medicaid.

2.3.6.3 Behavior Technicians (BT)

A BT refers to a high school graduate-level paraprofessional who delivers ABA services under the supervision of an LBA or an LBA and an LaBA.

All BTs must have certification as one of the following:

- Registered Behavior Technician (RBT®)
- Board Certified Autism Technician (BCAT)
- Applied Behavior Analysis Technician (ABAT®)

Behavior technicians may not enroll in Texas Medicaid.

Behavior technicians may not use the term "therapist" or be referred to as a "therapist" in their job title when interacting with Medicaid-enrolled children or youth families, or caregivers or with professionals who also serve the child or youth, such as school staff or physicians.

BTs may not amend the treatment plan or interpret the treatment plan to family, caregivers, or professionals who also serve the child or youth, such as school staff or physicians.

A BT may not conduct the ABA assessment or establish a child or youth's ABA treatment plan.

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2.3.7 Documentation Requirements

2.3.7.1 Submission Documentation

All of the following elements must be submitted with the authorization request.

Note: *"Days" refers to calendar days unless otherwise specified.*

2.3.7.2 Documentation Required for Authorization of an ABA Initial Evaluation

The referral for ABA services must be submitted with the authorization request and must contain documentation from the diagnosing or prescribing provider of the following:

- Age of the child or youth and year of the initial ASD diagnosis
- Any co-morbid behavioral health or physical conditions, including trauma history
- Level of symptom severity as per DSM criteria under ASD
- Diagnosis of ASD or re-evaluation of ASD diagnosis must have been made within the past 3 years, including the diagnostic criteria and symptom severity level per DSM criteria. A reliable, valid, standardized diagnostic tool or combination of tools must have been a part of the initial evaluation or re-evaluation.
- A signed and dated referral from the prescribing provider for an evaluation for ABA services
  - This referral may originate from the primary care provider.
  - The referral may originate from the diagnosing provider who is a physician, or allowed practitioner.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (NP), or clinical nurse specialist (CNS).*

2.3.7.3 Documentation Required for Authorization of Initiation of Treatment with ABA

All of the following elements must be submitted with the authorization request:

- A signed and dated referral from a physician or allowed practitioner outlining the frequency and duration of treatment based on recommendations made in the ABA evaluation as well as the prescribing provider's own clinical judgement.
- The LBA must coordinate with the prescribing or other appropriate physician to document elements for initiation of ABA treatment that are not within the LBA's scope of practice.

To document medical necessity for ABA, the following elements are required in the ABA assessment documentation:

- A complete developmental history, including:
  - Relevant co-morbid conditions, including trauma history.
  - Vision and hearing or audiologic screening, as age and clinically appropriate.

Note: *If age and clinically appropriate, Texas Health Steps required screenings are acceptable. Results of further evaluations may be required if those screenings indicated deficits.*

  - One-on-one observations of the child or youth, including at least one natural setting.
  - Documentation of interviews with parents or caregivers to further identify and define lack of adaptive behaviors and presence of maladaptive behaviors, to include any linguistic or cultural factors that may impact treatment.
  - Family history.
  - Primary language used by the child or youth with ASD and their family.

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- Document whether the child or youth has a previous history of ABA. When prior history exists, include how long the child or youth has been receiving ABA services (include any gaps in treatment) and their responses to previous interventions.
- Prognosis based on evidence from the evaluation regarding the individual's capacity to make behavioral gains.
- Validated assessments of cognitive abilities and adaptive behaviors, such as the Vineland Adaptive Behavior Scales.
    - An estimate of the child or youth's cognitive abilities may be provided when a validated assessment of cognitive abilities is not possible due to the child or youth's level of ASD or behaviors or both.
    - Limited cognitive ability or other co-occurring disability does not preclude the child or youth from consideration for medically necessary ABA evaluation and treatment services provided the treatment plan is realistic for the child or youth.
- A functional behavior assessment, related to specific behaviors of concern, to be addressed in a BSP, as clinically indicated.

Individualized ABA treatment plans must include:

- Identification of specific targeted behaviors/skills related to the child or youth's health, safety, or independence that will be addressed in treatment.
- Treatment goals must directly relate to the core symptoms of ASD as defined by the DSM.
- Goals and protocols must be selected by the LBA in collaboration with the parents or caregivers, consistent with person-centered and family-centered practice.
- Functional goals must be specific to the child or youth, objectively measurable within a specified time frame, attainable in relation to the child or youth's prognosis and developmental status, both important to and relevant to the child or youth and their family, and directly related to the core symptoms of ASD as defined by the DSM.
- Baseline data for all behaviors and skills identified for intervention across settings (e.g., home, school, community) where treatment will occur.
- A BSP, if appropriate.
    - BSPs must include an operational, behavioral definition of the target behavior excesses and deficits, prevention and intervention strategies, schedules of reinforcement, and functional alternative responses.
- The planned frequency (intensity) and duration of treatment across all settings to reflect the severity of the impairments, goals of treatment, expected response to treatment, and specific individual variables, including availability of appropriately trained and certified ABA staff, that may affect the recommended treatment dosage.

    Refer to: Frequency and Duration Guidelines for ABA services section for guidelines to determine medical necessity.
- Measurable parent or caregiver goals pertaining to learning the basic behavioral principles of ABA and applicability of these behavioral interventions in the home and community.
- The planned frequency and duration of parent or caregiver training. Participation by the parents or caregivers are expected, and continued authorization for ABA services will take consideration of their participation in at least 85% of planned sessions.
    - Parent or caregiver training must be conducted by an LBA or LaBA.

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- The formal design of treatment plan must be followed by all ABA service providers, including the supervised LaBAs and/or BTs.
- If group treatment is planned, the treatment plan must include clearly defined, measurable goals for the group therapy that are specific to the individual and their targeted behaviors/skills.
- A plan to ensure maintenance and generalization of skills.
- Clearly defined, measurable, realistic discharge criteria and a transition plan across all treatment environments.
- A clear plan to coordinate care with other providers and with school services.
    - This is contingent upon a signed release of information from parent or guardian. Documentation of parent or guardian refusal to sign consent should be documented in these situations but should not preclude access to treatment.

ABA Assessments and treatment plans completed by the LBA must include:

- The child or youth's name
- Date of birth
- Date the initial ABA evaluation and treatment plan was completed
- Name of the referring prescribing provider
- Signature with date by the LBA
- Signature with date by the parent or caregiver

Initial requests for ABA will be authorized for 90 days and may be extended for an additional 90 days contingent upon submission of an attendance log and progress summary that support an extension of treatment.

2.3.7.4 Documentation Required for Authorization of 90-day Extension of Initial ABA Authorization

All of the following elements must be submitted with the authorization request:

- Attendance log for the child or youth
- Attendance log for the parent or caregiver
- Progress summary

2.3.7.5 Attendance Log and Progress Summary

Attendance logs that include a calculation of the percentage of scheduled sessions successfully completed must be maintained for the child or youth receiving treatment and for responsible parent or caregiver participation. If attendance falls below 85% of approved hours per authorization period as outlined in the individualized treatment plan and parent or caregiver education plan, additional documentation must be submitted by the LBA to substantiate need for continued ABA services at the previously approved level. All documentation must be submitted to the child or youth's health plan.

- Attendance logs will record all scheduled and completed sessions and the percent of scheduled sessions attended by child or youth and the parent or caregiver for their scheduled respective sessions.
- Attendance logs must be submitted after the first 90 days of initiating ABA treatment.
- Attendance logs must be submitted with each request for extension or recertification.

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- Children or youth and parents or caregivers are expected to have attended a minimum of 85% of their respective sessions agreed upon within the approved treatment plan to substantiate the need for continuing at the previously approved frequency and duration of ABA services.
- In cases where either the child or youth or the parent or caregiver has not met the 85% attendance expectation, the ABA provider must submit justification to continue services at the previously approved frequency to the health plan for physician review.

2.3.7.6 Progress Summary

A progress summary is made in the format of a treatment note and must be:

- Submitted after the first 90 days of initiating ABA treatment.
- Billed as procedure code 97155.
- Signed and dated by the LBA.
- Signed and dated by the parent or caregiver.

2.3.7.7 Documentation Required for Recertification for Treatment with ABA

Subsequent requests after the initial total 180-day authorization may be approved for an additional 180-day period.

Requests for recertification of ABA treatment must include:

- Documentation of the comprehensive ASD diagnosis within the 3 years prior to the date of the ABA re-evaluation.
- Attendance log that includes a calculation of the percentage of scheduled sessions that were completed.
    - For recertifications, children or youth and parents or caregivers are expected to have attended a minimum of 85% of their respective sessions agreed upon within the approved treatment plan in order to continue at the previously approved frequency and duration of ABA services. Recertification requests not meeting this requirement will require submission of additional documentation and must be sent for physician review.
- ABA re-evaluation.

2.3.7.8 ABA Re-evaluation

Re-evaluation may be performed no earlier than within the last 60 days of an authorization period.

A re-evaluation includes all of the following:

- All components of an initial evaluation that are within the scope of practice of an LBA.
- The LBA shall maintain documentation of all elements of the initial ABA assessment that have been conducted by or coordinated with another provider.
- An updated BSP for the child or youth, if applicable.
- Baseline, current, and interim data for all behaviors and skills identified for intervention to demonstrate degree of progress toward mastering the functional treatment goals.
- Documentation to allow reviewers to assess whether the child or youth's behavior and skills have improved to a clinically meaningful extent in at least two settings (e.g., home, community, or with different family members or peers) and to demonstrate that the LBA appropriately recorded and tracked progress and made protocol modifications as needed for effective service delivery.
- Individual considerations should be given on a case-by-case basis for those with unusual or complex circumstances that may impact functional goal achievement (e.g., children or youth in residential placement through the Department of Family and Protective Services conservatorship).

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- The child or youth's treatment plan updated and modification of the treatment protocol, as appropriate, to include clearly defined, measurable, functional goals for addressing behaviors and ensuring maintenance and generalization of acquired skills.
- Documentation of the child or youth's status using a reliable, valid standardized assessment tool.
- Discharge plan, to include fading and generalization plan.
- For children or youth with additional diagnoses/co-morbid conditions, LBAs must address the impact of those conditions on ABA progress and collaborate with other disciplines as appropriate.
- Date and time the re-evaluation and treatment plan update was completed.
- LBA signature and date.

The LBA must submit documentation attesting that:

- The family, caregiver, or responsible adult has agreed to the treatment plan, including:
  - The frequency specified on the treatment plan.
  - All places of service specified on the treatment plan.
  - That the specific goals and prioritization of the identified goals on the treatment plan align with the child or youth and their family values and preferences.
  - That the provider has access to sufficient staff to deliver the treatment plan frequency, duration, and in all places of service specified to allow accurate assessment of attendance in scheduled sessions.

2.3.7.9 Client Record Documentation

In addition to documentation requirements outlined in the Submission Documentation section, all services outlined in this section are subject to retrospective review to ensure that the documentation in the child or youth's medical record supports the medical necessity of the services provided as well as adherence to Medicaid requirements.

This documentation does not need to be submitted for the purposes of prior authorization.

2.3.7.10 Comprehensive Diagnostic Evaluation

All required elements of the comprehensive evaluation must be retained by the diagnosing provider in the child or youth's medical record.

2.3.7.11 Interdisciplinary Team Meeting

For procedure code 99366, each rendering provider must document the following:

- Start and stop time of team meeting (minimum 30 minutes)
- Date of most recent evaluation or re-evaluation
- Names, disciplines, and organizational affiliation of other attendees
- Brief narrative of reports to parents or guardians and the child or youth with ASD
- Summary of decisions made
- Action items
- Signature and date of the provider

Licensed assistants, nonclinical social workers, or paraprofessionals may not represent their supervisors at interdisciplinary team meetings.

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2.3.7.12 Consent

Formal documentation of signed consent to ABA treatment signed by the child or youth's legally authorized representative must be kept in the child or youth's file.

2.3.7.13 Treatment Note

For procedure codes 97153 (individual treatment) and 97154 (group treatment), the following documentation must be kept on file by the treating provider and be available when requested:

- Child or youth's name.
- Date of service.
- Start and stop time of each treatment session.
- Treatment plan goals addressed, and progress noted, if applicable.
- A summary of the covered ABA services attempted during the session to include the activities or interventions delivered during the session and time allotted for them.
    - This summary should include direct observation measures that record data during every treatment session to allow the LBA to graph data across time for analysis.
- Rendering ABA providers must sign each entry with full signature and credentials.
    - Additional supervisory signatures must be made in accordance with state licensure requirements and professional standards of care for the delivery of medically necessary services.

For procedure codes 97155 (individual treatment with protocol modification) and 97158 (group treatment with protocol modification) the documentation should include all required treatment note elements listed for procedure codes 97153 and 97154 as well as:

- Description of protocol modification decision points (may include supervision of BT or LaBA for procedure code 97155).
- Assessments of child or youth's progress or lack of progress.
- Treatment plan, such as updated goals.

For procedure code 97156 (parent or caregiver training and guidance, with or without the child or youth present), the following documentation in the treatment note must be kept on file by the treating provider and be available when requested:

- Child or youth's name
- Date of service
- Start and stop time of each parent or caregiver education session
- Treatment plan goals addressed, and progress noted, if applicable
- A summary of the covered parent or caregiver training during the session
- Rendering ABA providers must sign each entry with a full signature and credentials

2.3.7.14 Frequency and Duration Guidelines for ABA services

Frequency must always be commensurate with the child or youth's clinical needs and level of disability, as well as evidence-based standards of practice; it is not for the convenience of the responsible parents or caregivers or the provider.

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LBA recommendations for frequency and duration on the ABA treatment plan are expected to reflect the LBA's skilled analysis of the optimal dose-response relationship for the child or youth and their family. Therefore, the child or youth and family attendance at the recommended frequency and duration levels is critical in following evidence-based treatment recommendations. Poor or sporadic attendance may impact the effectiveness, durability, or generalizability of the treatments that are delivered.

An effective course of ABA typically requires active parent or caregiver involvement to increase the potential for durable and generalizable behavior changes in the specific behaviors identified as causing limitations or deficits in functional skills expected for the child or youth based on personal and environmental factors unique to that individual. Exceptions to this are made only as determined on a case-by-case basis.

ABA treatment (not inclusive of procedure code 97156) may be delivered at the following frequency and duration levels without requiring additional submission of documentation or review by a physician for medical necessity. Medical necessity is related to symptom severity as defined by the current version of the DSM in addition to guidelines in this section. All levels of intensity of ABA treatment services may be considered depending upon individual case consideration. The following are guidelines. The objectives of ABA therapy will vary per child or youth, and frequency and duration should be based upon the functional goals of treatment, specific needs of the child or youth, response to treatment, and availability of appropriately trained and certified ABA staff. Treatment plans in which the requested frequency exceeds the following service level guidelines will be sent for physician review to determine medical necessity.

- High frequency IBI (greater than 20 hours/week) may be considered when documentation shows two or more of the following:
  - 6 years of age or younger
  - Autism Severity Level 2 or 3 (per DSM-V criteria)
  - Goals related to elopement, aggression, or self-injury that are severely impairing
  - Within the first 2 years of initiating ABA
- Moderate frequency (6 to 20 hours/week) may be considered when documentation shows two or more of the following:
  - 12 years of age or younger
  - Autism Severity Level 2 or 3 (per DSM-V criteria)
  - Goals related to elopement, aggression, or self-injury that are moderately impairing
  - Within the first 4 years of initiating ABA therapy
- Targeted/focused frequency (5 hours or less/week or 20 hours or less/month in some other increment) may be considered when documentation shows two or more of the following:
  - 20 years of age or younger
  - Autism Severity Level 1, 2, or 3 (per DSM-V criteria)
  - Focused on specific targeted clinical issues or goals related to specific targeted skills
- Maintenance/consultative level (2-4 hours per week or less) may be considered when documentation shows all of the following:
  - Ages 1 through 20 years of age
  - Autism Severity Level 1, 2, or 3 (per DSM-V criteria)
  - Goals related to integration of specific skills into daily functioning

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- Documentation substantiates the risk for regression after completion of more intense ABA intervention

2.3.7.15 Discharge or Discontinuation Criteria

The ABA provider may discharge the child or youth from treatment, or ABA prior authorizations may be discontinued, when documentation submitted indicates one or more of the following:

- The child or youth has met ABA treatment plan goals and is no longer in need of ABA services.
- The child or youth has not made clinically significant progress toward meeting goals identified on the ABA treatment plan after successive progress review periods and repeated modifications to the treatment plan.
- Health-care services that do not demonstrate effectiveness as consistent with Medicaid autism service requirements must be modified or discontinued.
- ABA treatment plan gains are not generalizable or durable over time and do not transfer to the larger community setting after successive progress review periods and repeated modifications to the treatment plan.
- The child or youth can no longer participate in ABA services because of medical factors, family factors, or other factors that prohibit participation.
- Parent or caregiver opts to discontinue.
- Attendance falls below 85% of scheduled sessions without documentation supporting the medical necessity of continued treatment.
- The ABA providers do not appropriately collect, track, or review progress or outcomes data, or do not make appropriate treatment plan modifications for effective service delivery.

2.3.8 Exclusions

The following services are not a benefit of Texas Medicaid:

- ABA addressing academic goals
- ABA addressing goals only related to performative social norms that do not significantly impact health, safety, or independence
- Treatment other than at the maintenance or consultative level not expected to result in improvements in the child or youth's level of functioning
- Services that do not require the supervision of or specific skills and judgment of a LBA to perform
- Services that do not meet accepted standards of practice for specific and effective treatment of ASD
- Services delivered by a BT in the school setting as a shadow, or an aide, or to provide general support to the child or youth
- Equipment and supplies used during ABA services are not reimbursed separately; they are considered part of the services provided
- ABA evaluation or intervention services provided by a clinic or agency owned or partially owned by the child or youth's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage)
- ABA evaluation or intervention services provided directly by the child or youth's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage)
- Experimental or investigational treatment

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- Services or items not generally accepted as effective or not within the normal course and duration of treatment
- Services for the caregiver or provider convenience (e.g., as respite care or limiting treatment to a setting chosen by provider for convenience)

2.3.9 Change of Provider

If a provider or client discontinues therapy during an existing prior authorized period, and the client requests services through a new provider outside the current group, the new provider must start a new request for authorization and submit all documentation required for an initial evaluation, including the following:

- A change-of-therapy provider letter, signed by the responsible adult.
- The letter must document the date that the client ended therapy (effective date of change) with the previous provider, or the last date of service.
- The name of the new provider and previous provider.

When a client transfers to a new performing provider within the same group, the new provider must use the same evaluation and plan of care.

The authorization period will not change when the provider changes in this situation.

2.3.10 Prior Authorization/Authorization Requirements

Prior authorization is required for an ABA evaluation (procedure code 97151), an initial course of ABA treatment, and for subsequent recertifications for treatment (procedure codes 97153, 97154, 97155, 97156, 97158). Re-evaluations (procedure code 97151) for recertification of treatment require authorization.

Essential elements for prior authorization are listed in the Submission Documentation section.

Prior authorization/authorization requests may be submitted to the TMHP Prior Authorization Department through 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, and 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 use 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/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/authorization forms and supporting documentation using electronic or wet signatures.

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

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

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To facilitate determination of medical necessity and avoid unnecessary denials, the prescribing provider and the LBA 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.

The prescribing provider or the LBA may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure that documentation supports the medical necessity of the requested services, equipment, or supplies, as well as to determine compliance with all Medicaid requirements.

2.3.11 Submission Guidelines

2.3.11.1 Timelines and Required Items

The completed CCP Prior Authorization Request Form and submitter certification statement are required with every submission for authorization or prior authorization.

TMHP will accept the prescribing provider's signature on the CCP Prior Authorization Request Form as a statement that the client's Texas Health Steps (THSteps) screenings are current unless otherwise stated by the provider.

2.3.11.2 ABA Initial Evaluation

To request prior authorization for an ABA initial evaluation, LBAs or prescribing providers must submit the following:

- Documentation of comprehensive diagnostic evaluation or re-evaluation of diagnosis for ASD signed and dated by the diagnosing physician and dated within 3 years prior to the date that the PA request for ABA initial evaluation is received.
- A completed CCP Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to or on the anticipated evaluation date requested.
    - The authorization for the initial ABA evaluation (procedure code 97151) is valid for 60 days from the requested evaluation date.
    - When the request for prior authorization is signed and dated after the requested evaluation date, dates of service prior to the prescribing provider's signature date will be denied.

A request for prior authorization for an ABA initial evaluation must be submitted within 60 days prior to or on the requested evaluation date.

When the request for prior authorization is submitted after the requested evaluation date, dates of service prior to the receive date will be denied.

2.3.11.3 Initial 90-day ABA Treatment

To request prior authorization for an initial 90-day ABA treatment, providers must submit the following:

- Completed ABA evaluation and treatment plan signed and dated by the LBA
    - An ABA evaluation is considered current when it is performed within 60 days prior to the start of care date on the prior authorization request form.
- A completed CCP Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to the requested ABA treatment start date, including the requested procedure codes and maximum units requested

Providers may be authorized for units of procedure codes 97153, 97154, 97155, 97156, or 97158 for up to 90 days from the start date of service requested on the CCP Prior Authorization Request Form.

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Providers must obtain authorization within 3 business days of the start of care (SOC) date for services that have not been prior authorized. During the authorization process, providers are required to deliver the requested services from the SOC date. Requests received after the 3-business day period will be denied for services prior to the date that the request was received.

Late submissions: Requests for initial 90-day ABA treatment submitted 60 days after the completed ABA evaluation date and within 180 days after the evaluation date will require a progress summary signed and dated by the LBA.

For late submissions submitted after 180 days from the evaluation date, a re-evaluation must be completed.

2.3.11.4 ABA 90-day Treatment Extension

To request prior authorization for an ABA 90-day treatment extension, providers must submit the following:

- Attendance log that also includes a calculation of the percentage of scheduled sessions attended by the:
  - Child or youth and
  - Parent or caregiver for family education
- Progress summary signed by LBA and parent or caregiver.
- A completed CCP Prior Authorization Request Form (prescribing provider signature not necessary).

  Note: *The initial treatment plan must be signed and dated by a prescribing provider for the full 180 days. The 90-day treatment extension is to continue the same treatment frequency or submit new goals if needed.*
- A 90-day recertification request is considered timely when it is submitted within 30 days prior to the end of the current authorization period. Providers may be authorized for units of procedure codes 97153, 97154, 97155, 97156, or 97158 for up to 90 days from the initiation of services.
- A request for prior authorization that is submitted after the current authorization end date is denied for all dates of service prior to the date the request is received.

2.3.11.5 ABA Re-evaluation

To request authorization for an ABA re-evaluation, providers must submit the following:

- Completed ABA re-evaluation and treatment plan signed and dated by the LBA.
- Re-evaluations do not require prior authorization (procedure code 97151). Re-evaluation will be reviewed for authorization upon submission.
- Providers must have a signed referral from the prescribing provider for an ABA re-evaluation in the client's file.
  - A re-evaluation may occur as early as 60 days prior to the end of the current authorization period.
  - An ABA re-evaluation is considered current when it is performed within 60 days before the end of the current authorization period.

Procedure code 97151 should be listed on the CCP Prior Authorization Request Form with date span to include dates the re-evaluation was performed.

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2.3.11.6 ABA 180-day Recertification

Prior authorization for documented medically necessary recertification requests may be considered for increments up to 180 days for each request following the initial total of 180-day (two 90-day) authorization periods.

To request prior authorization for an ABA 180-day recertification, providers must submit the following:

- Attendance log that also includes a calculation of the percentage of scheduled sessions attended by the:
  - Child or youth
  - Parent or caregiver for family education
- ABA re-evaluation and treatment plan signed by LBA
  - An ABA re-evaluation is considered current when it is performed within 60 days before the current prior authorization end date.
- A completed CCP Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to the requested ABA treatment recertification start date, including the requested procedure codes and maximum number of units.

Providers may be authorized for units of procedure codes 97153, 97154, 97155, 97156, or 97158 for up to 180 days from the start date of service requested on the CCP Prior Authorization Request Form.

Late submissions: Requests submitted 60 days after the completed ABA evaluation date and within 180 days after the evaluation will require a review of current progress summary signed and dated by the LBA.

For requests submitted more than 180 days after the re-evaluation date, a new re-evaluation must be completed.

A request for prior authorization for recertification of treatment that is submitted after the current authorization end date is denied for all dates of service after that end date and prior to the date the request is received.

A complete request must be received no earlier than 60 days before the current authorization period expires.

A gap in service is defined as not receiving ABA treatment or re-evaluation for 180 days or more. When a gap in service is identified, the provider must submit the request as an initial request and all documentation related with an initial request is required.

2.3.12 Reimbursement and Billing Guidelines

If services billed exceed the limitations outlined in this section, the claim will be denied, and may be appealed.

Autism services are reimbursed in accordance with Title 1 Texas Administrative Code § 355.

Direct treatment for the child or youth is limited to a total of 8 hours per day, inclusive of procedure codes 97153, 97154, 97155, and 97158.

The following modifiers may be required for ABA services:

Modifier	Description
HO	Licensed behavior analyst
HN	Licensed assistant behavioral analyst
HM	Behavior technician
95	Telehealth

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For clients who are 20 years of age or younger, the limitations listed below may be exceeded with evidence of medical necessity.

The following procedure codes will be authorized for a 30-day authorization period for ABA evaluation or re-evaluation:

ABA Initial Evaluation		
Procedure Code	**Limitations**	**Modifier Options**
97151	Limited to 6 hours (24 units)	HO only

ABA Re-evaluation		
Procedure Code	**Limitations**	**Modifier Options**
97151	Limited to 6 hours (24 units)	HO only

The following procedure codes may be reimbursed for ABA individual treatment:

ABA Services	
Procedure Code	**Modifier Options**
97153	No modifier required
97155	HO HN

The following procedure codes may be reimbursed for ABA group treatment services:

ABA Services	
Procedure Code	**Modifier Options**
97154	No modifier required
97158	HO HN

The following procedure codes may be reimbursed for ABA parent or caregiver, family education, and training services:

ABA Services	
Procedure Code	**Modifier Options**
97156	HO HN

The following procedure codes may be reimbursed for interdisciplinary team meetings attended by qualified nonphysician health-care providers:

Interdisciplinary Team Meeting	
Procedure Code	**Modifier Options**
99366	No modifier required

Each claim submitted with procedure code 97151 requires the following modifier:

Evaluation and Re-evaluation	
Modifier	**Description**

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Evaluation and Re-evaluation	
HO	Licensed behavior analyst

Each claim submitted with procedure codes 97155, 97156, and 97158 requires one of the following modifiers:

ABA Services	
Modifier	**Description**
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst

Claims submitted with procedure codes 97153 and 97154 may include the following modifiers for information purposes:

Behavior Technician Level Services	
Modifier	**Description**
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst
HM	Behavior technician

Reimbursement for procedure code 99366 is limited to autism diagnosis code F84 and is contingent upon prior authorization of ABA evaluation, re-evaluation, or treatment services.

Texas Medicaid will not reimburse multiple ABA providers during one ABA session with a child or youth when more than one ABA provider is present (concurrent billing).

Concurrent billing is excluded except when the family and the child or youth with ASD are receiving separate services and the child or youth is not present in the family session.

Texas Medicaid will not reimburse for ABA treatment services when the child or youth or family is not present and engaged in a therapeutic relationship.

Reimbursement for covered ABA procedure codes are for the direct service time. Pre- and post-work for the session are not reimbursed separately. Separate reimbursement for treatment planning, note documentation, report writing, or updating of charts and data sheet is prohibited (other than what is allowable under procedure code 97151).

2.3.12.1 Telehealth Service Delivery

Some service delivery to children or youth and to the parents or caregivers may be delivered remotely. It is the LBA's responsibility to ensure that remotely delivered telehealth services are within scope of practice, are not contraindicated for the child or youth, family, or particular situation, are clinically appropriate and effective, and are in compliance with Texas licensure and standards for telehealth as well as follow all Medicaid, Texas Health Steps-CCP and the Medicaid Autism Services requirements.

ABA evaluation and treatment services may only be delivered via telehealth using synchronous audio-visual technology.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth and technology requirements.

The following procedure codes may be delivered via telehealth:

Procedure Codes	Required Modifier to Designate Remote Delivery
97151	95

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Procedure Codes	Required Modifier to Designate Remote Delivery
97155	95
97156	95
97158	95
99366	95

LaBAs and RBTs may not deliver any service remotely.

Reimbursable remote delivery services must include synchronous audiovisual interaction between the distant site provider and the child or youth or parent or caregiver in another location.

2.3.12.2 ABA Services

Procedure code 97151 is intended for conducting and reporting initial evaluations and treatment plans as well as re-evaluations by the LBA once every 180 days.

Procedure code 97151 is reimbursed per authorized units provided by an LBA.

Procedure code 97151 will be authorized for up to 24 units (six hours) for the initial request of ABA services to complete an initial ABA evaluation and develop a treatment plan, including data analysis and report writing.

Procedure code 97151 must be used within 30 calendar days of the first date of service for procedure code 97151 and is not reimbursable unless evaluation was submitted for authorization of payment.

Procedure code 97151 is eligible for reimbursement upon submission and approval of completed evaluation or re-evaluation.

After the initial evaluation, procedure code 97151 will be authorized for up to 24 units (six hours) for re-evaluations for every subsequent authorization.

Procedure code 97153 is intended to be used for direct one-on-one ABA services delivered per ABA treatment plan protocol to the child or youth.

Procedure code 97153 designates a service of the complexity level appropriate for the delivery by a BT.

Procedure code 97155 is used by the LBA (or as delegated to an LaBA) for direct one-on-one time with one child or youth to develop a new or modified protocol.

Procedure code 97155 may also be used to demonstrate a new or modified protocol to a BT, LaBA, and parents or caregivers with the child or youth with ASD present. The focus of this code is the skilled determination to make an addition or change to the protocol.

Procedure code 97155 may be used when directly supervising the BT or LaBA while working directly with the child or youth.

Either procedure code 97153 or 97155 may be used to request total hours of direct individual ABA treatment for the authorization period. Providers may then bill the code that reflects the treatment delivered.

Procedure code 97154 is intended to be used for direct group ABA services delivered per ABA treatment plan protocol to the child or youth.

Procedure code 97154 designates a service of the complexity level appropriate for the delivery by a BT.

A group includes at least 2 children or youth but no more than 8.

Procedure code 97158 is used by the LBA (or as delegated to an LaBA) for direct group time to develop a new or modified group treatment protocol.

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Either procedure code 97154 or 97158 may be used to request total hours of direct group ABA treatment for the authorization period. Providers may then bill the code that reflects the treatment delivered.

Procedure code 97156 is used by the LBA (or as delegated to an LaBA) for guiding the parents or caregivers (with or without the child or youth with ASD present) to use the ABA treatment plan protocols to reinforce adaptive behaviors for durability and generalizability. LBAs may delegate parent or caregiver teaching to LaBAs working under their supervision. LaBAs may not deliver services remotely via telehealth.

2.3.12.3 Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units

All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to zero units of service if they are seven or fewer minutes.

For example: 68 total billable minutes/15 = 4 units + 8 minutes. Because the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

When providers are counting minutes for timed procedure codes, the time intervals for 1 through 8 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

2.4 Breastfeeding Support Services

Refer to: Section 3, "Breastfeeding Support Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about breastfeeding support services.

2.5 Certified Respiratory Care Practitioner Services (CCP)

Refer to: The *Certified Respiratory Care Practitioner (CRCP) Services Handbook* (*Vol. 2, Provider Handbooks*) for information about CRCP (CCP) services.

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2.6 Clinician-Directed Care Coordination Services (CCP)

2.6.1 Services, Benefits, and Limitations

Clinician-directed (physician, NP, CNS, and PA) care coordination services are a benefit of CCP for eligible clients who are birth through 20 years of age and have special health needs. These services are payable only to the clinician (primary care, specialist, or sub-specialist) who provides the medical home for the client.

To provide a medical home for the client, the primary care clinician directs care coordination together with the client and family. Care coordination consists of managing services and resources for clients with special health needs and their families to maximize the clients' potential and provide them with optimal health care.

Clinician-directed care coordination services (face-to-face and non-face-to-face) must include the following components:

- A written care plan (either a formal document or documentation contained in the client's progress notes) developed and revised by the medical home clinician, in partnership with the client, family, and other agreed-upon contributors. This plan is shared with other providers, agencies, and organizations involved with the care of the client, including educational and other community organizations with permission of the client or family. The care plan must be maintained by the medical home clinician and reviewed every six months or more frequently as necessary for the client's needs.
- Care among multiple providers that are coordinated through the clinician.
- A central record or database maintained by the medical home clinician containing all pertinent medical information, including hospitalizations and specialty care.
- Assistance for the client or family in communicating clinical issues when a client is referred for a consultation or additional care, such as evaluation, interpretation, implementation, and management of the consultant recommendations for the client or family in partnership and collaboration with other providers, the client, or family.

Clinician-directed care coordination services must also include the supervision of the development and revision of the client's emergency medical plan in partnership with the client, the family, and other providers for use by emergency medical services (EMS) personnel, utility service companies, schools, other community agencies, and caregivers.

Face-to-face care coordination services are encompassed within the various levels of evaluation and management (E/M) encounters and prolonged services.

Non-face-to-face clinician-directed care coordination services include:

- Prolonged services (procedure codes 99358 and 99359).
- Medical team conference (procedure code 99367).
- Care plan oversight and supervision, including telephone consultations with a specialist or subspecialist (procedure codes 99374, 99375, 99377, 99378, 99379, and 99380).
- Specialist or subspecialist telephone consultations (procedure code 99499 with modifier U9).

Non-face-to-face clinician-directed care coordination services are not considered case management by Texas Medicaid.

Specifically, non-face-to-face medical home clinician oversight and supervision of the development or revision of a client's care plan may include the following activities, which do not have to be contiguous:

- Review of charts, reports, treatment plans, and lab or study results, except for the initial interpretation or review of lab or study results ordered during, or associated with, a face-to-face encounter.

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- Telephone calls with other Medicaid-enrolled health-care professionals (not employed in the same practice) involved in the care of the client.
- Telephone or face-to-face discussions with a pharmacist about pharmacological therapies (not just ordering a prescription).
- Medical decision-making.
- Activities to coordinate services, if the coordination activities require the skill of a clinician.
- Documenting the services provided, which includes writing a note in the client's chart describing the services provided, decision-making performed, and the amount of time spent performing the countable services, including the start and stop times and time spent by the physician working on the care plan after the nurse has conveyed pertinent information from agencies and facilities to the physician.

The following activities are not covered as non-face-to-face clinician supervision of the development or revision of the client's care plan (care plan oversight services):

- Time that the staff spends getting or filing charts, calling home health agencies or clients, and similar administrative actions.
- Clinician telephone calls to client or family, except when necessary to discuss changes in client's care plan.
- Clinician time spent telephoning prescriptions to a pharmacist (does not require clinician work and does not require a clinician to perform).
- Clinician time getting or filing the chart, dialing the telephone, or time on hold (does not require clinician work and does not meaningfully contribute to the treatment of the illness or injury).
- Travel time.
- Time spent preparing claims and for claims processing.
- Initial interpretation or review of lab or study results that were ordered during, or associated with, a face-to-face encounter.
- Services included as part of other E/M services.
- Consultations with health professionals not involved in the client's case.

2.6.1.1 Non-Face-to-Face Services

2.6.1.1.1 Non-Face-to-Face Medical Conferences

Procedure code 99367 must be used when billing for medical team conferences.

2.6.1.1.2 Non-Face-to-Face Clinician Supervision of a Home Health Client

Procedure code 99374 or 99375 must be used when billing for services requiring interaction with a home health agency.

2.6.1.1.3 Non-Face-to-Face Clinician Supervision of a Hospice Client

Procedure code 99377 or 99378 must be used when billing for services requiring interaction with a hospice.

2.6.1.1.4 Non-Face-to-Face Clinician Supervision of a Nursing Facility Client

Procedure code 99379 or 99380 must be used when billing for services requiring interaction with a nursing facility.

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2.6.1.1.5 Non-Face-to-Face Prolonged Services

Procedure code 99358 or 99359 must be used when billing for prolonged services without face-to-face contact. This service is to be reported in addition to other clinician services, including E/M services at any level, or health-care professionals outside of a home health agency, hospice, or nursing facility.

Non-face-to-face prolonged services are limited to a maximum of 90 minutes once per client by the same provider unless one of the following significant changes in the client's clinical condition occurs:

- The client will soon be, or has recently been, discharged from a prolonged and complicated hospitalization that required coordination of complex care with multiple providers in order for the client to be adequately cared for in the home.
- The client has experienced recent trauma resulting in new medical complications that require complex interdisciplinary care.
- The client has a new diagnosis of a medically complex condition requiring additional interdisciplinary care with additional specialists.

Procedure code 99359 must be billed on the same date of service as procedure code 99358. Additional prolonged non-face-to-face services may be authorized if the provider submits supporting documentation for authorization.

Procedure code 99358 must be used to report non-face-to-face prolonged services of at least 30 minutes total duration. Prolonged services of less than 30 minutes are considered part of the physician's E/M service being provided.

Procedure codes 99358 and 99359 will be denied if billed on the same date of service as any of the following procedure codes:

Procedure Codes									
99202	99203	99204	99205	99212	99213	99214	99215	99221	99222
99223	99231	99232	99233	99234	99235	99236	99242	99243	99244
99245	99252	99253	99254	99255	99281	99282	99283	99284	99285
99304	99305	99306	99307	99308	99309	99310	99341	99342	99344
99345	99347	99348	99349	99350	99417	99418			

Procedure code 99359 is used to report an additional 15 to 30 minutes of prolonged non-face-to-face services beyond the first hour. Prolonged services of less than 15 minutes beyond the first hour are considered part of the first hour.

Non-face-to-face prolonged services procedure codes 99358 and 99359 may be used when billing for completion of paperwork required by a judge to determine guardianship of a client. Required paperwork may include a certified medical examination form for clients who are birth through 20 years of age that are eligible for the Texas Health Steps program on the date of service.

2.6.1.1.6 Non-Face-to-Face Specialist or Subspecialist Telephone Consultation

Telephone consultations are limited to two every six months to the same provider and will not be reimbursed to the clinician providing the medical home.

The clinician providing the medical home must have an authorization on file for one of the following procedure codes before the specialist or subspecialist can be reimbursed:

Procedure Codes									
99358	99374	99375	99377	99378	99379	99380			

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Because the specialist or sub-specialists cannot be reimbursed without the medical home clinician's current prior authorization information, the clinician providing the medical home should provide their information to the specialist or subspecialist.

The specialist or subspecialist will not be separately reimbursed for the telephone consultation if he or she is the medical home clinician because care plan oversight by the medical home provider includes telephone consultations. The referring provider's NPI and prior authorization number must be submitted on the claim.

2.6.1.1.7 General Requirements for Non-Face-to-Face Clinician-Directed Care Coordination Services

These services may be reimbursed for the medical home clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to, or performed by others, do not count towards care coordination reimbursement. Care coordination provided during post-surgical care is a benefit if the care is unrelated to the surgery.

2.6.1.1.8 Non-Face-to-Face Care Plan Oversight

The medical home clinician who bills for the care plan oversight must be the clinician who signed the plan of care (POC) in the home health agency (procedure codes 99374 and 99375), hospice (procedure codes 99377 and 99378), or nursing facility (procedure codes 99379 and 99380).

Procedure code 99374 is denied when billed on the same date of service by the same provider as procedure code 99375.

Procedure code 99377 is denied when billed on the same date of service by the same provider as procedure code 99378.

Procedure code 99379 is denied when billed on the same date of service by the same provider as procedure code 99380.

Care plan oversight services may be reimbursed for the clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

Reimbursement for procedure codes 99374 or 99375, 99377 or 99378, and 99379 or 99380 are limited to one per client, per calendar month for any provider. Providers should bill the code that most appropriately reflects the total time spent in a calendar month performing care plan oversight.

The medical home clinician may not have a significant financial or contractual relationship with the home health agency as defined in 42 Code of Federal Regulations (CFR) §424.

The medical home clinician may not be the medical director or employee of the hospice and may not furnish services under arrangements with the hospice, including volunteering.

2.6.1.1.9 Medical Team Conference

One medical team conference (procedure code 99367) may be reimbursed once every six months when the medical home coordinating clinician attests that they are providing the medical home for the client. The coordinating clinician may be the client's primary care provider or a specialist.

Additional medical team conferences may be considered with documentation of a change in the client's medical home.

The medical team conference time must be documented in the client's record.

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2.6.1.2 Face-to-Face Services

2.6.1.2.1 General Requirements for Face-to-Face Clinician-Directed Care Coordination Services

Providers must use the most appropriate face-to-face E/M procedure codes to bill for care coordination services.

- When counseling or care coordination requires more than 50 percent of the client or family encounter (face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital), then time may be considered the key or controlling factor to qualifying for a particular level of E/M service.
- Counseling is a discussion with the client or family concerning diagnostic studies or results, prognosis, risks and benefits, management options, importance of adhering to the treatment regimen, and client and family education.

Modifiers must be used as appropriate for billing.

Any face-to-face inpatient or outpatient E/M procedure code that is a benefit of Texas Medicaid may be billed on the same day as the following non-face-to-face clinician-directed care coordination procedure codes when the procedure requires significant, separately-identifiable E/M services by the same physician on the same day.

Procedure Codes									
99367	99374	99375	99377	99378	99379	99380			

2.6.2 Prior Authorization and Documentation Requirements

Non-face-to-face clinician-directed care coordination services provided by the medical home require prior authorization. Providers must submit a request for prior authorization within seven business days of the date of service. Prior authorization is limited to a maximum of six months. Prior authorization is required to recertify the client for additional six-month periods and requires submission of a new request with documentation supporting medical necessity for ongoing services.

Prior authorization for initial non-face-to-face clinician-directed care coordination requires documentation of at least one covered face-to-face inpatient or outpatient E/M visit by the medical home clinician directing the care coordination during the six months preceding the provision of the first non-face-to-face care coordination service.

Prior authorization for subsequent non-face-to-face clinician-directed care coordination services requires at least one covered face-to-face inpatient or outpatient E/M visit by the medical home clinician directing the care coordination during the previous 12 months or more frequently as indicated by the client's condition.

Prior authorization of CCP services may be requested in writing by completing a CCP Prior Authorization Request Form, attaching the necessary supportive documentation as detailed below, and mailing or faxing it to the TMHP-CCP department:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program
PO Box 200735
Austin, TX 78720-0735
Fax: 1-512-514-4212

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For prior authorization to be considered, clients must require complex and multidisciplinary care modalities involving regular clinician development or revision of care plans, review of subsequent reports of client status, and review of related laboratory and other studies:

- *Medically complex*. The health care needed by a Medicaid client achieves the designation of medically complex when the approved POC necessitates a clinical professional practicing within the scope of his or her license and in the context of a medical home to coordinate ongoing treatment to ensure its safe and effective delivery. The diagnosis must be covered under Texas Medicaid and be characterized by one of the following:
  - Significant and interrelated disease processes that involve more than one organ system (including behavioral health diagnoses) and require the services of two or more licensed clinical professionals, specialists, or subspecialists.
  - Significant physical or functional limitations that require the services of two or more therapeutic or ancillary disciplines, including, but not limited to, nursing, nutrition, OT, PT, ST, orthotics, and prosthetics.
  - Significant physical, developmental, or behavioral impairment that requires the integration of two or more medical or community-based providers, including, but not limited to, educational, social, and developmental professionals, that impact the care of the client.
- *Multidisciplinary Care*. Care is multidisciplinary when the medically necessary covered services of an approved POC include the need to coordinate the assessment, treatment, or services of a Medicaid-enrolled clinical provider with two or more additional medical, educational, social, developmental, or other professionals impacting the health care of the client.

Prior authorization is effective for care coordination services provided over a period of six months. Medical home clinicians must submit a revised care plan for subsequent periods of prior authorization.

Documentation of the following components must be submitted with the prior authorization form to obtain an initial authorization or renewal:

- A current medical summary, encompassing all disciplines and all aspects of the client's care, and containing key information about the client's health, including conditions, complexity, medications, allergies, past surgical procedures, and so on.
- A current list of the main concerns, issues, and problems as well as key strengths and assets and the related current clinical information including a list of all diagnosis codes.
- Planned action steps and interventions to address the concerns and to sustain and build strengths, with the expected outcomes.
- Disciplines involved with the client's care and how the multiple disciplines will work or are working together to meet the client's need. Providers must explain how the multidisciplinary approach will or do benefit the client's needs.
- Short-term and long-term goals with timeframes.

The supporting documentation can be any of the following:

- A formal written care plan
- Progress note detailing the care coordination planning
- A letter of medical necessity detailing the care plan oversight and care coordination

Clinician-directed care coordination services must be documented in the client's medical record. Documentation must support the services being billed and must include a record of the medical home clinician's time spent performing specific care coordination activities, including start and stop times.

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The documentation must also include a formal care plan and an emergency services plan. The supporting documentation maintained in the client's medical records must be dated and include the following components and requirements:

- Problem list
- Interventions
- Short-term and long-term goals
- Responsible parties

Client medical records are subject to retrospective review.

Documentation for care coordination provided during post-surgical care must clearly indicate the care coordination is unrelated to the surgery.

2.6.2.1 Documentation Requirements for the Medical Home Clinician for a Telephone Consult with a Specialist

The clinician providing the medical home must maintain the following documentation in the client's medical record:

- Start and stop times showing that the consultation was at least 15 minutes
- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment or laboratory services
- The name of the specialist or subspecialist

2.6.2.2 Documentation Requirements for the Specialist or Subspecialist for a Telephone Consult with the Medical Home Clinician

Specialists or subspecialists must complete and retain the Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician Directed Care Coordination Services-CCP. These records are subject to retrospective review. The supporting documentation must include, but is not limited to the following:

- The client's name, date of birth, and Medicaid identification number
- Start and stop times indicating the consultation lasted at least15 minutes
- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment or laboratory services
- The name and telephone number of the clinician providing the medical home
- NPI for the specialist or subspecialist and the clinician providing the medical home

2.6.3 Claims Information

Claims for clinician-care coordination services must be submitted to TMHP in an approved electronic claims format or on a 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.

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Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

2.6.4 Reimbursement

Clinician-directed care coordination services are reimbursed in accordance with 1 TAC §355.8441.

2.7 Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about CCP therapy services.

2.8 Durable Medical Equipment (DME) Supplier (CCP)

2.8.1 Enrollment

To be eligible to participate in CCP, providers of DME (including customized or non-basic medical equipment) and expendable medical supplies must be enrolled in Medicare.

Home health agencies that provide DME and supplies should refer to subsection 2.1, "Enrollment" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*).

2.8.1.1 Pharmacies (CCP)

Pharmacy providers are eligible to participate in CCP. To be enrolled in CCP, the pharmacy must also be enrolled in VDP.

This enrollment allows pharmacy providers to bill for those medications and supplies payable by Medicaid for clients who are birth through 20 years of age but *not* covered by VDP (e.g., some over-the-counter drugs, some nutritional products, diapers, and disposable or expendable medical supplies). Pharmacy providers must continue to bill HHSC for drugs covered under VDP.

To locate a pharmacy CCP provider, use the Online Provider Lookup (OPL) at opl.tmhp.com.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

Section 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

Section 2, "Texas Medicaid (Title XIX) Home Health Services" for details about coverage through Texas Medicaid (Title XIX) Home Health Services.

2.8.2 Services, Benefits, and Limitations

DME is defined as medical equipment that is manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate the client's disability, condition, or illness.

Because there is no single authority (such as a federal agency) that confers the official status of "DME" on any device or product, HHSC retains the right to make such determinations with regard to DME covered by Texas Medicaid. DME covered by Texas Medicaid must either have a well-established history of efficacy or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment serves a medical purpose, can withstand repeated use, and is appropriate and safe for use in the home.

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Requested DME may be a benefit of Texas Medicaid when it meets the Medicaid definition of DME.

The majority of DME and expendable medical supplies are covered through Texas Medicaid (Title XIX) Home Health Services.

If a service cannot be provided through Texas Medicaid (Title XIX) Home Health Services, the service may be covered through CCP if it is determined to be medically necessary for the client and if FFP is available.

If a DME provider is unable to deliver a piece of equipment, the provider must allow the client the option of obtaining the DME or expendable medical supplies from another provider.

Periodic rental payments are made only for the lesser of the following:

- The period of time the equipment is medically necessary
- The total monthly rental payments equal the reasonable purchase cost for the DME

DME will be purchased when a purchase is determined to be medically necessary and more cost effective than leasing the device with supplies. Only new, unused equipment will be purchased. When a provider is replacing a piece of rental DME with purchased DME, the provider must supply a new piece of DME to the client.

Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.

DME repair will be considered based on the age of the item and cost to repair it. A request for repair of DME must include an itemized estimated cost list from the vendor or DME provider who will make the repairs.

Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.

All adjustments and modifications to a wheeled mobility system that are made within the first six months after delivery are considered part of the purchase price. However, DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase unless there had been a significant change in the client's condition, as documented by the physician familiar with the client.

Rental reimbursement to the same provider cannot exceed the purchase price, except as addressed in specific policies.

All DME purchased for a client becomes the Medicaid client's property upon receipt of the item. Delivered equipment will become the Medicaid client's property in the following instances even though it will not be prior authorized or reimbursed:

- Equipment delivered to the client before the physician signature date on the CCP Prior Authorization Request Form or prescription.
- Equipment delivered more than three business days before obtaining prior authorization from TMHP that meets the criteria for purchase.

As long as the client is eligible for CCP services on the date the custom equipment is ordered from the manufacturer, the provider must use the order date as the date of service since custom equipment is client specific and cannot be used for another client.

To establish medical necessity of the equipment for the client, the provider must have on file in the client's records current documentation that is signed by a physician (e.g., a signed and dated prescription) showing the following:

- A diagnosis relative to each item requested.

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- The specific type of supply needed.
- The length of time needed.

2.8.2.1 Purchase Versus Equipment Rental

When providing equipment not prior authorized under Texas Medicaid (Title XIX) Home Health Services for CCP clients with long-term or chronic conditions, it is more cost-effective, in many cases, to purchase the equipment rather than rent it. The client's condition and length of time the equipment will be used must be carefully assessed before prior authorization for rental or purchase is requested. CCP nurses determine whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, the duration of use, and the age of the equipment.

CCP does not pay for the purchase of certain types of equipment; consequently, long-term rental may be considered. Most other equipment is rented for only four months initially. During this time, the provider must assess whether the equipment should be purchased before the rental lapses. Rentals and purchases must be prior authorized.

After prior authorization is obtained for purchase, new equipment must be provided and the rental discontinued. CCP does not purchase used equipment.

Providers of customized or nonbasic medical equipment also must be enrolled as Medicare DME providers.

2.8.3 Prior Authorization and Documentation Requirements

Providers can request prior authorization for most DME through the TMHP website. Providers that make written requests for prior authorization must complete the CCP Prior Authorization Request Form on the TMHP website at www.tmhp.com, and they must attach the documentation necessary to support the request. The documentation must include a current prescription that has been signed and dated by a physician (M.D. or D.O.), and it must be mailed or faxed to TMHP with the prior authorization request. For specific policy information not contained in this manual related to the purchase of DME, providers can call TMHP-CCP Customer Service at 1-800-846-7470.

A completed CCP Prior Authorization Request Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client before requesting prior authorization. The completed CCP Prior Authorization Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.

To complete the prior authorization process by paper, the DME provider must fax or mail the completed CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client's medical record at the provider's place of business.

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

To avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of the medical necessity for the equipment and services requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies.

A determination as to whether the equipment will be rented, purchased, repaired, or modified will be made by HHSC or its designee based on the client's needs, duration of use, and age of the equipment.

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Equipment that has been purchased may be considered for replacement when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or expendable medical supply. Physician prescriptions must be specific to the item requested. For example, if the provider is requesting a customized wheelchair, the prescription must request a customized wheelchair, not just a wheelchair. Providers must submit a CCP Prior Authorization Request Form and documentation to support medical necessity to the CCP department *before* providing services. Providers must obtain prior authorization within three business days of the requested date of service.

Refer to: Section 2.2.30, "Procedure Codes That Do Not Require Prior Authorization" for details about specific procedure codes that do not require prior authorization through Texas Medicaid (Title XIX) Home Health Services.

2.8.3.1 Equipment Accessories

CCP may consider prior authorization of equipment accessories, such as ventilator and oxygen trays and positioning inserts, when supporting documentation takes into account all the client's needs, capabilities, and physical or mental status.

2.8.3.2 Equipment Modifications

A modification is the replacement of a component due to changes in the client's condition, not the replacement of a component that is no longer functioning.

DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase. All modifications to a wheeled mobility system that are made within the first six months after delivery are considered part of the purchase price.

However, CCP may consider prior authorization of modifications to custom equipment if a change occurs in the client's needs, capabilities, or physical or mental status that cannot be anticipated. Documentation must include:

- All projected changes in the client's needs.
- The age of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

2.8.3.3 Equipment Adjustments

Adjustments do not require supplies.

Labor for adjustments within the first six months after delivery are not prior authorized because these are considered part of the purchase price.

Up to one hour of labor for adjustments may be considered for reimbursement with prior authorization through CCP as needed after the first six months. Providers must use procedure code K0739 for adjustments.

2.8.3.4 Repair to Client-Owned Equipment

Repairs to a wheeled mobility system within the first six months after delivery are considered part of the purchase price. Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair.

HHSC or its designee reserves the right to request additional documentation about the need for repairs when there is evidence of abuse or neglect to equipment by the client, client's family, or caregiver. When there is documented proof of abuse or neglect, requests for repairs will not be prior authorized.

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Providers are responsible for maintaining documentation in the client's medical record that specifies the repairs and supporting medical necessity.

Documentation must include all of the following:

- The date of purchase
- The serial number of the current equipment (as applicable)
- The cause of the damage or need for repairs
- What steps the client or caregiver will take to prevent further damage if repairs are due to an accident
- When requested, the cost of purchasing new equipment as opposed to repairing current equipment

Temporary replacement of client-owned respiratory equipment during the repair may be considered for prior authorization for one month using procedure code K0462.

Labor for repair of client-owned respiratory equipment may be considered for prior authorization using procedure code K0739 up to a maximum of two hours per day (maximum quantity of eight units).

Routine maintenance of rental equipment is the provider's responsibility.

2.8.3.5 DME Certification and Receipt Form

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver.

The DME provider must maintain the signed and dated form in the client's medical record.

DME claims and appeals that meet or exceed a billed amount of $2,500 for the same date of service will suspend for verification of client receipt of the DME item(s). The DME Certification and Receipt Form must be faxed to 1-512-506-6615. If the claim is submitted without the form or if receipt of the DME item(s) cannot be verified, the DME item(s) on the claim will be denied. TMHP may contact the client that received the product for verification of services rendered.

Refer to: DME Certification and Receipt Form on the TMHP website at www.tmhp.com.

2.8.3.6 Documentation of Supply Delivery

Providers must retain individual delivery slips or corresponding invoices for each date of service to document the date of delivery for all supplies provided to a client. Providers must disclose this documentation to HHSC or its designee upon request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until all audit questions, appeals, hearings, investigations, or court cases are resolved. The DOS is the date on which supplies are delivered to the client or shipped by a carrier to the client as evidenced by the dated tracking document attached to the corresponding invoice for that date.

Documentation of delivery must include one of the following:

- Delivery slip or invoice signed and dated by the client or caregiver.
- A dated carrier tracking document with the shipping date and delivery date as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or corresponding invoice, or
- If using a third-party distributor, the delivery confirmation from the third-party distributor and corresponding tracking number from the third-party distributor's carrier must be attached.

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The dated delivery slip or invoice must include the client's full name and address to where supplies were delivered, and an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client, and the corresponding tracking number from the carrier. This document could also include prices, shipping weights, shipping charges, and any other description.

All claims submitted for DME supplies must include the same quantities or units that are documented on the delivery slip or corresponding invoice and on the CCP Prior Authorization Request form. They must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 300 diapers is delivered, the delivery slip or invoice and the claim must reflect that 300 diapers were delivered and not that one package was delivered. Diaper wipes are measured as boxes or packages. If one box of 200 wipes is delivered, the delivery slip or invoice and the claim must reflect that one box was delivered and not that 200 individual wipes were delivered. There must be one dated delivery slip or invoice for each claim submitted for each patient. All claims submitted for DME supplies must reflect either one business day before or one business day after the date of service as documented on the delivery slip or corresponding invoice and the same timeframe covered by the CCP Prior Authorization Request form. The DME Certification and Receipt Form is still required for all equipment delivered.

2.8.3.7 Specific CCP Policies

Most DME and expendable medical supplies are available under Texas Medicaid (Title XIX) Home Health Services. If the service is not available under Texas Medicaid (Title XIX) Home Health Services, CCP may cover the requested service, if the client is CCP-eligible and the service is medically necessary, requested by a physician, and for which FFP is available.

Refer to: DME Certification and Receipt Form on the TMHP website at www.tmhp.com.

The *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for DME services.

2.9 Early Childhood Intervention (ECI) Services

The Texas Health and Human Services (HHS) ECI program is available statewide to all children who have been determined to be eligible for ECI services by ECI contractors. To be eligible for ECI services, children must be 35 months of age and younger (i.e., before their third birthday) and have disabilities or developmental delays as defined by ECI criteria. Texas Medicaid covers the ECI claims for children who are Medicaid clients.

All health-care professionals are required by federal and state regulations to refer children who are 35 months of age and younger (i.e., before their third birthday) to the Texas HHS ECI program as soon as possible, but no longer than 7 days after identifying a disability or suspected delay in development. Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

To refer families for services, providers can call their local ECI program, or they can call the HHS Inquiry Line at 1-877-787-8999. For additional ECI information, providers can visit the Early Childhood Intervention Services page of the HHS website at www.hhs.texas.gov. Persons who are deaf or hard of hearing may use the relay option of their choice or dial 7-1-1 to connect with Relay Texas.

2.9.1 Enrollment

The Texas HHS ECI program contracts with local non-profit entities to take referrals, determine clients' eligibility, and provide services to ECI-eligible children and their families. The non-profit entities must contract with the Texas HHS ECI program and must comply with all of the applicable federal and state laws and regulations that govern the Texas HHS ECI program.

ECI contractors are eligible to enroll as Texas Medicaid ECI providers to render services to eligible Medicaid clients. After providers meet the criteria of the Texas HHS ECI program, they must complete a Medicaid application.

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To participate in Texas Medicaid, an ECI contractor must submit a copy of the current contract award from the Texas HHS ECI program.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about the procedures for enrolling as a Medicaid provider.

2.9.2 Services, Benefits, and Limitations

Prior authorization is not required for evaluations, re-evaluations, seating assessments, therapy services, specialized skills training (SST), and targeted case management (TCM). The IFSP Services Pages identify the amount, duration, and scope for the provision of specialized rehabilitative services (SRS) treatment services and serves as the prior authorization for ECI services. The IFSP is retained in the client's record and is subject to retrospective review.

ECI services include TCM and SRS, which includes occupational therapy (OT), physical therapy (PT), speech therapy (ST), and SST.

ECI SRS services may be provided in the following places of service (POS): office/facility (POS 1), home (POS 2), outpatient (POS 5 applicable only to ECI services rendered in a Prescribed Pediatric Extended Care Center [PPECC]), and other locations (POS 9). In addition to these places of service, TCM may be provided in inpatient hospital (POS 3) and outpatient hospital (POS 5).

ECI services of OT, PT, ST, SST, and TCM are provided to Medicaid-eligible clients who are birth through 35 months of age and have a documented developmental delay or a medically diagnosed condition as established by the Texas Health and Human Services Commission (HHSC) (26 TAC, Part 1, Chapter 350), or an auditory or visual impairment as defined by the Texas Education Agency (19 TAC §89.1040).

To the maximum extent appropriate, ECI services are delivered in the client's natural environment, as defined in 26 TAC, Part 1, Chapter 350, and are family-centered.

The interdisciplinary team must document ECI eligibility decisions in accordance with 26 TAC, Part 1, Chapter 350. The eligibility statement must be in the child's record and updated when eligibility changes or is re-determined.

All documentation of ECI services, including the plan of care specified in the Individualized Family Service Plan (IFSP), must be retained in the client's record and available upon request. The IFSP is a written plan of care for providing ECI services and other medical, health, and social services to an eligible child and the child's family when necessary to enhance the child's development.

ECI service providers are employees and subcontractors of non-profit entities that have contracts with the State of Texas for the provision of Individuals with Disabilities Education Act (IDEA) Part C Early Childhood Intervention services.

Medically necessary services may be provided by other Medicaid-enrolled providers in addition to the services provided by the ECI contractor. For example, the family may choose to receive speech therapy from the ECI contractor and physical therapy from a home health provider. Or, outpatient clinic personnel may have expertise that will enhance the services of the ECI provider resulting in ECI providers and other Medicaid-enrolled providers providing services within the same discipline.

Only the services provided to ECI enrolled children by ECI contracted entities must comply with the Medicaid medical guidelines for ECI services.

Services provided by other Medicaid-enrolled providers, including other providers of physical, occupational, and speech therapy, must comply with Medicaid medical guidelines that apply to those provider types (e.g., outpatient rehabilitation facility, home health agency).

ECI services use techniques by which the ECI service provider engages the family or caregiver in activities to meet the developmental needs of the child.

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ECI services are performed in accordance with 26 TAC, Part 1, Chapter 350.

To the maximum extent possible, ECI services are provided in the client's natural environment, as defined in 34 Code of Federal Regulations (CFR) Part 303, unless the IFSP team determines the identified outcomes cannot be achieved in a natural environment. Natural environments are defined as settings that are natural or typical for the same-aged infant or toddler without a disability, and may include the home and community settings such as daycare, playgrounds, stores, and restaurants.

Justification for providing services in other settings (e.g., office, clinic, PPECC) must be documented in the client's record.

2.9.2.1 Physical, Occupational, and Speech Therapies and Specialized Skills Training (PT, OT, ST, and SST)

PT, OT, ST, and SST are benefits for clients with an acute or a chronic condition when documented on the IFSP. Documentation on the IFSP is evidence that services are developed and recommended by the child's interdisciplinary team, including the parents and a licensed practitioner of the healing arts (as defined in 26 TAC, Part 1, Chapter 350).

PT, OT, ST, and SST must be performed and delivered as identified in the IFSP.

Missed visits may be rescheduled within the authorization period as long as the total number of visits or units provided does not exceed the amount authorized in the client's IFSP. The ECI contractor must document the reason for visits outside of the weekly or monthly frequency in the client's record.

A single identified need and treatment goal (outcome on the IFSP) may be addressed by more than one discipline.

More than one discipline can evaluate a child at the same time to facilitate compliance with the federal requirement for multidisciplinary evaluation (34 CFR, Part 303).

A client may receive a combination of PT, OT, ST, or SST with any other IFSP service when the IFSP indicates necessity for co-visits or co-treatment (i.e., two or more services to be provided at the same time).

PT, OT, ST, and SST may be delivered to a client individually or in a group setting according to 26 TAC, Part 1, Chapter 350 and when documented in the IFSP.

Documentation of each PT, OT, ST, and SST contact must be entered into the child's record in accordance with 26 TAC, Part 1, Chapter 350.

2.9.2.2 Physical, Occupational, and Speech Therapy (PT, OT, and ST)

Physical and occupational therapy treatment services require orders from a referring provider once a year.

Speech therapy treatment services do not require an order from a referring provider.

Therapy goals for acute or chronic conditions include, but are not limited to the following:

- Improving function
- Maintaining function
- Slowing the deterioration of function

2.9.2.2.1 Physical Therapy (PT)

PT includes services that address the promotion of sensory and motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation.

All services must be performed in accordance with 42 CFR 440.110.

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A PT evaluation, re-evaluation, or seating assessment may be performed without an order from a referring provider as allowed by 22 TAC Part 16, Chapter 322, §322.1(a)(2)(A).

PT services must be provided by one of the following:

- A licensed physical therapist who meets the requirements of 42 CFR 440.110(a)
- A licensed physical therapy assistant (PTA) when the assistant is acting under the direction of a licensed physical therapist in accordance with 42 CFR 440.110 and all other applicable state and federal law

2.9.2.2.2 Occupational Therapy (OT)

OT includes services that address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the client's functional ability to perform tasks in the home and community settings.

All services must be performed in accordance with 42 CFR 440.110.

An OT evaluation, re-evaluation, or seating assessment may be performed without an order from a referring provider as allowed by §454.213 of the Texas Occupations Code.

OT services must be provided by one of the following:

- A licensed occupational therapist who meets the requirements of 42 CFR 440.110(b)
- A licensed or licensed and certified occupational therapist assistant (OTA) when the assistant is acting under the direction of a licensed occupational therapist in accordance with 42 CFR 440.110 and all other applicable state and federal law

2.9.2.2.3 Speech Therapy (ST)

Speech and language therapy includes services designed to promote rehabilitation and remediation of delays or disabilities in language-related symbolic behaviors, communication, language, speech, emergent literacy, or feeding and swallowing behavior.

All services must be delivered in accordance with 42 CFR 440.110 and §401.001(6) of the Texas Occupations Code.

A ST evaluation, re-evaluation, and treatment service may be performed without a physician order as allowed by Chapter 401 of the Texas Occupations Code.

ST services must be provided by one of the following:

- A licensed speech-language pathologist (SLP) who meets the requirements of 42 CFR 440.110(c) and all other applicable state and federal law
- A licensed assistant in SLP when the assistant is acting under the direction of a licensed SLP in accordance with 42 CFR 440.110
- A licensed intern when the intern is acting under the direction of a licensed SLP in accordance with 42 CFR 440.110 and all other applicable state and federal law

2.9.2.3 Physical Therapy, Occupational Therapy, and Speech Therapy Procedure Codes

Clients who are eligible for ongoing PT, OT, and ST through the ECI program may request additional therapy under the Early & Periodic Screening, Diagnosis, & Treatment (EPSDT) benefit of Medicaid (also known as Texas Health Steps) when medically necessary.

Refer to: Section 5, "Children's Therapy Services Clients birth through 20 years of age" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about physical, occupational, and speech therapy procedure codes outside of the ECI benefit that are not defined in this section.

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2.9.2.3.1 Evaluation and Re-evaluation Procedure Codes

The following encounter-based evaluation and re-evaluation procedure codes for PT, OT, and ST are benefits of Texas Medicaid:

Procedure Codes	Description
97165, 97166, or 97167	OT Evaluation
97168	OT Re-evaluation
97161, 97162, or 97163	PT Evaluation
97164	PT Re-Evaluation
92521, 92522, 92523, or 92524	ST Evaluation
S9152	ST Re-Evaluation
92610	ST Evaluation swallowing function

2.9.2.3.2 Time-Based Procedure Codes

The following time-based PT and OT treatment procedure codes may be a benefit of Texas Medicaid and must be billed in 15-minute increments (units).

Procedure Codes									
97032	97033	97034	97035	97036	97110	97112	97113	97116	97124
97140	97530	97535	97542	97750	97760	97761	97763		

2.9.2.3.3 Untimed PT and OT Procedure Codes

The following untimed PT and OT treatment procedure codes representing supervised modalities are limited to one encounter each, per date of service per discipline, must be delivered on the same day as one or more time-based codes listed above, and are subject to the CMS NCCI relationships.

Procedure Codes							
97012	97014	97016	97018	97022	97024	97026	97028

PT and OT group therapy procedure code 97150 may be reimbursed as an untimed procedure code, payable per encounter, and reimbursed once per date of service per discipline.

2.9.2.3.4 Encounter-Based Speech Therapy Procedure Codes

Speech therapy individual treatment codes must be billed per encounter and are limited to once per day per provider. Only one ST treatment procedure code 92507 or 92526 may be reimbursed per date of service.

ST group treatment procedure code 92508 may be reimbursed as an untimed procedure code, payable per encounter, and reimbursed once per date of service.

2.9.2.3.5 Modifier Requirements for PT, OT, or ST Services

The following modifiers must be submitted for PT, OT, and ST treatment services. Services delivered using synchronous audiovisual technology must also be billed with modifier 95 to indicate remote delivery:

Modifier	Description
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care
GN	Services delivered under an outpatient speech therapy plan of care

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Modifier	Description
UB	Services delivered by a therapy assistant under supervision of a licensed therapist
UC	Assessment performed by an OT or PT
U5	Services delivered by a licensed therapist or a physician

Modifier UB or U5 is required on all claims for therapy treatment procedure codes to designate whether treatment was provided by a licensed therapist or a licensed assistant.

Modifier U3 is not used by an ECI contractor for co-visits or co-treatments.

2.9.2.3.6 Seating Assessments

Seating assessments are reimbursed in 15-minute increments (units) and must be billed with procedure code 97542.

The PT completing the assessment must submit procedure code 97542 with modifiers GP and UC in order to bill for the seating assessment.

The OT completing the assessment must submit procedure code 97542 with modifiers GO and UC in order to bill for the seating assessment.

2.9.2.3.7 Specialized Skills Training (SST) Services

SST services are rehabilitative services to promote age-appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

Services must include all the following:

- Be designed to create learning environments and activities that promote the client's acquisition of skills in one or more of the following developmental areas: physical or motor, communication, adaptive, cognitive, and social or emotional.
- Skills training and anticipatory guidance for family members, or other significant caregivers, to ensure effective treatment and to enhance the client's development.

SST services do not require an order from a referring provider. The ECI contractor ensures that SST services are provided by a certified early intervention specialist. SST services must be provided by an early intervention specialist who meets the criteria established in 26 TAC Part 1, Chapter 350.

SST services must be submitted with procedure code T1027, and must be billed in 15-minute increments. SST services may be performed individually or in a group. SST services performed for an individual must be billed using modifier U1.

SST services delivered using synchronous audiovisual technology must also be billed using modifier 95 to indicate remote delivery.

2.9.2.3.8 Reimbursement Guidelines for PT, OT, ST, and SST

Claims may be submitted to Medicaid when the interaction is directly with the client and the client's parent(s) as defined in 20 U.S.C. §1401, or the client and the routine caregiver(s) as defined in 26 TAC, Part 1, Chapter 350.

ECI services must be billed under the ECI contractor's NPI and benefit code of EC1 as the insured's policy group when submitting claims.

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about benefit codes.

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Physical therapy, occupational therapy, and speech-language pathology evaluations are performed for the purposes of initial determination of need for rehabilitative services and annually to verify the child's ongoing need for rehabilitative services. To ensure there are no gaps in rehabilitative services, the annual evaluation should occur prior to the child's annual IFSP meeting.

Physical, occupational, and speech therapy evaluation and re-evaluation services are benefits through the ECI Medicaid benefit and do not require an order from a referring provider.

Physical therapy, occupational therapy, and speech-language pathology re-evaluations may be performed periodically during the child's annual enrollment in ECI services, and without a physician's order, to determine if changes to the IFSP are necessary.

Evaluations, re-evaluations, and seating assessments are not required to be listed on the IFSP Service Pages. A physical or occupational therapist may provide a seating assessment that is required to order a wheeled mobility system. A seating assessment does not require an order from a referring provider.

Refer to: Subsection 2.2.17, "Mobility Aids" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for information about mobility aids.

Reimbursement is available to two or more of the ECI contractor's service providers when the client receives a combination of any Medicaid-covered service identified on the IFSP and the IFSP indicates necessity for co-visits or co-treatments (i.e., two or more services to be provided at the same time). For example, the child may receive both PT and ST at the same time. Another example, the child may receive counseling and SST at the same time.

Reimbursement is available to two or more of the ECI contractor's service providers when they are conducting an evaluation at the same time.

When an evaluation and treatment service within the same discipline occur on the same day, only the evaluation will pay.

When a re-evaluation and treatment service within the same discipline occur the same day, only the treatment will pay.

PT, OT, and ST equipment and supplies used during therapy visits are not reimbursed separately.

Reimbursement under Medicaid benefit guidelines applies to only the services provided to ECI enrolled children by ECI contracted entities.

Reimbursement for services provided to ECI enrolled children by other Medicaid-enrolled providers (e.g., home health, CORF) is available under the Medicaid medical policies that apply to those provider types.

2.9.2.4 Telehealth Synchronous Audiovisual Services

Telehealth services may be provided using synchronous audiovisual technologies if clinically appropriate and safe, as determined by the provider, and agreed to by the client receiving services.

Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telehealth services.

Providers must defer to the needs of the client receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the client in service's choice and not provider convenience.

Services delivered by synchronous audiovisual technology will require participation of a parent or caregiver to assist with the treatment.

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Therapy assistants may deliver services and receive supervision using synchronous audiovisual technology in accordance with each discipline's rules. Providers should refer to state practice rules and national guidelines regarding supervision requirements for each discipline.

Note: *Telehealth services must adhere to documentation, privacy, informed consent, and security requirements as outlined in the Telecommunication Services Handbook (Vol. 2, provider handbooks).*

The following services may be provided through telehealth delivery using synchronous audiovisual technology:

Services	Procedure Codes
Specialized skills training (SST)	T1027
Targeted case management (TCM)	T1017
Physical therapy (PT) evaluations and reevaluations	97161, 97162, 97163, 97164
Occupational therapy (OT) evaluations and reevaluations	97165, 97166, 97167, 97168
PT and OT treatments	97110, 97112, 97150, 97530, 97535
Speech therapy (ST) evaluations and reevaluations	92521, 92522, 92523, 92524, 92610, S9152
ST treatments	92507, 92508, 92526

Providers must use modifier 95 to indicate remote delivery. Providers are reminded to use the required modifiers GP, GO, and GN on all claims except evaluation and re-evaluation procedures for physical, occupational, or speech therapy treatment.

2.9.2.4.1 Telehealth Exclusions

The following procedure codes are in-person only and will not be reimbursed if provided through telehealth delivery:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97113	97124	97140	97542	97760	97761	97763

Any PT, OT, ST, and SST services delivered through synchronous telephone (audio-only) technology is not a benefit.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

2.9.2.5 Targeted Case Management (TCM)

TCM services are provided to assist an eligible client and his or her family in gaining access to the rights and procedural safeguards under Part C of IDEA, and to needed medical, social, educational, developmental, and other appropriate services.

TCM services are performed in accordance with the ECI Medicaid benefit guidelines and 26 TAC, Part 1, Chapter 350.

TCM services do not require an order from a referring provider, but must be delivered by a qualified ECI contractor. The ECI contractor ensures that TCM services are provided by the assigned Service Coordinator who meets the criteria established in 26 TAC Part 1, Chapter 350.

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TCM is provided in the natural environment (including office, home, daycare, and other community locations), outpatient, PPECC, and inpatient hospital setting.

The documentation for each TCM contact must be in accordance with 26 TAC, Part 1, Chapter 350.

The place of service is the location of the service coordinator at the time of service delivery.

TCM services provided face-to-face must be billed using modifier U1.

TCM services must be submitted with procedure code T1017, and must be billed in 15-minute increments.

TCM services may be delivered face-to-face or by telephone.

TCM services (procedure code T1017) may also be delivered using a synchronous telephone (audio-only) platform. TCM services delivered using a synchronous telephone (audio-only) platform are subject to the restrictions outlined in the *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)*.

TCM services delivered using synchronous audiovisual technology must also be billed using modifier 95 to indicate remote delivery.

TCM services delivered using synchronous audio-only (including telephone) technology must also be billed with modifier 93.

2.9.2.5.1 Guidelines for TCM Services

Claims may be submitted to Texas Medicaid when the interaction is directly with the client or the client's parent(s) as defined in 20 United States Code (U.S.C.) §1401), or other routine caregiver(s) as defined in 26 TAC, Part 1, Chapter 350.

Contacts may be made with other individuals when directly related to identifying the eligible client's needs, helping the eligible client access services, identifying needs and support to assist the eligible client in obtaining services, providing the service coordinator with useful feedback, and alerting the service coordinator to changes in the eligible client's needs. These contacts must be documented in the client's record, but are not submitted as claims to Medicaid if they took place outside of the presence of the client or the client's parent or routine caregivers.

2.9.2.6 Guidelines for ECI Services Performed in a Prescribed Pediatric Extended Care Center (PPECC)

When ECI services are rendered in a PPECC, the place of service will be outpatient hospital (used for a PPECC). The PPECC's NPI must appear on the claim, in addition to the ECI contractor's NPI. The ECI contractor and PPECC must have a written agreement for the provision of ECI services at the PPECC. The written agreement must address responsibilities of both parties, and how the parties will coordinate related to the client's IFSP or plan of care, which includes documentation of coordination with the PPECC. The written agreement must be maintained in the client's record.

2.9.3 Claims Filing and Reimbursement

2.9.3.1 Claims Information

Claims for SST and TCM services that have been rendered by an ECI contractor must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Contractors may purchase CMS-1500 paper claim forms from the vendor of their choice; TMHP does not supply the forms. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills or itemized statements are not accepted as claim supplements.

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Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) to find the instructions for completing paper claims.

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

2.9.3.1.1 Billing Units Based on 15 Minutes

All claims for reimbursement are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded to the nearest quarter hour.

The following table shows the time intervals for 1 through 8 units:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

2.9.3.1.2 Managed Care Clients

If the child is enrolled in a Medicaid managed care organization (MCO), claims for PT, OT, and ST are submitted to the MCO.

TCM services are carved-out of Medicaid managed care and must be billed to TMHP for payment consideration.

SST services are carved-out of Medicaid managed care and claims must be billed to TMHP for payment consideration.

2.9.3.2 Reimbursement

ECI therapy, SST, and TCM services are reimbursed according to a maximum allowable fee established by HHSC. See the applicable fee schedule on the TMHP website at www.tmhp.com.

- ECI therapy services are reimbursed in accordance with 1 TAC §355.8441.
- SST services are reimbursed in accordance with 1 TAC §355.8422.
- TCM services are reimbursed in accordance with 1 TAC §355.8421.

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2.10 Health and Behavior Assessment and Intervention

2.10.1 Services, Benefits, and Limitations

Health and Behavior Assessment and Intervention (HBAI) services are a benefit of Texas Medicaid for persons who are 20 years of age and younger when the services are provided by a licensed practitioner of the healing arts (LPHA) who is co-located in the same office or building complex as the physician, PA, NP, or CNS who is treating the person receiving services. Co-location is defined as the provision of services in the same office or building complex in which the client's physician, PA, or APRN has their practice.

In many cases, the treating physician, PA, NP, or CNS will be the person's primary care provider; however, a specialist seeing a person regularly may function in a similar role to a primary care provider and may also make HBAI referrals to a co-located LPHA.

HBAI services are designed to identify the psychological, behavioral, emotional, cognitive and social factors important to prevention, treatment or management of physical health symptoms.

HBAI services are a benefit when the person receiving services meets the following criteria:

- The person has an underlying physical illness or injury.
- There are indications that biopsychosocial factors may be significantly affecting the treatment or medical management of an illness or an injury.
- The person is alert, oriented, and, depending on the person's age, has the capacity to understand and to respond meaningfully during the evaluation.
- The person has a documented need for psychological evaluation or intervention to successfully manage his or her physical illness, and activities of daily living.
- The assessment is not duplicative of other provider assessments.

HBAI services that include the family of the person receiving services are a benefit when the family member directly participates in the overall care of the person receiving services.

Family is defined as a responsible adult. This adult individual has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the person receiving services. Responsible adults include, but are not limited to, biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

HBAI services may be reimbursed when billed with the following procedure codes:

Procedure Codes						
96156	96158	96159	96164	96165	96167	96168

These services may be rendered by physician, nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA), licensed professional counselor (LPC), licensed clinical social worker (LCSW), licensed marriage family therapist (LMFT), Comprehensive Care Program (CCP) LCSW, or psychologist provider in the office or outpatient setting.

LMFTs must bill with state defined modifier U8 to identify services billed.

For services that are rendered by physician, NP, CNS, or PA providers, claims must be submitted with the appropriate evaluation and management (E/M) procedure codes (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, or 99215). The physician, NP, CNS, or PA may bill the HBAI procedure codes for an LPHA that is in the medical practice.

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Refer to: Section 9.2.60, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks)* for more information about delegated psychological services and the appropriate use of modifiers by psychologists and LMFTs.

HBAI services are limited to a total of three units per day, by any provider, as follows:

- The initial 30 minutes of health behavior intervention (procedure codes 96158, 96164, and 96167) is limited to one unit per day.
- Each additional 15 minutes of health behavior intervention (procedure codes 96159, 96165, and 96168) is limited to two units per day.

Procedure codes 96167 and 96168 which include the family of the person receiving services, are a benefit when the family member directly participates in the overall care of the person receiving services.

An in-person evaluation is defined as a patient evaluation conducted by a provider who is at the same physical location as the person receiving services. These services are considered acute per rolling 180 days from the initiation of services and are limited as shown in the following table:

Procedure Codes	Limitations
96156	Limited to a maximum of 2 per client, per rolling 180 days, any provider
96158, 96164, 96167	Limited to a maximum of 8 per client, per rolling 180 days, any provider
96159, 96165, 96168	Limited to a maximum of 14 per client, per rolling 180 days, any provider

Rural Health Clinics and Federally Qualified Health Centers may be reimbursed for in-person evaluation visits based on encounter rates.

Documentation must be maintained in the person's medical record that details the change in the mental or medical status warranting reassessment of the person's capacity to understand and cooperate with the medical interventions that are necessary to the client's health and well-being.

Persons receiving services must be referred for psychiatric evaluation or psychotherapy as soon as the need is identified. Providers cannot use all 16 units if the need for psychiatric or psychological intervention is identified earlier.

After the initial HBAI assessment, if the person is receiving behavioral health services from another health-care provider, the HBAI provider should coordinate with the external behavioral health provider and establish the most appropriate course of treatment for the person.

Refer to: Section 4, "Outpatient Mental Health Services" for more information about behavioral health services beyond the acute care limitations outlined in this section.

Subsection 3.4, "Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

The initial clinical interview, reassessment, psychophysiological monitoring, observation, and intervention do not include the following:

- Conversations about educating the family or caregivers outside of the in-person evaluation sessions
- Psychotherapy

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After the initial 180 days of HBAI services, the person receiving services may receive another episode of HBAI services with the same medical diagnosis if there is a newly identified behavioral health issue. The person may have two episodes of HBAI services per rolling year.

HBAI services are adjunct to other services and are to be used as a non-intensive means to identify specific needs. As appropriate, the person receiving services should be referred for those additional services that would meet the person's biopsychosocial needs.

2.10.2 Telemedicine and Telehealth

Providers must defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

Providers must provide HBAI services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, HBAI services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Synchronous Audiovisual Technology

HBAI services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. HBAI services provided by synchronous audiovisual technology must be billed using modifier 95.

The following HBAI services may be provided by synchronous audiovisual technology:

Procedure Codes						
96156	96158	96159	96164	96165	96167	96168

Synchronous Telephone (Audio-Only) Technology

HBAI services may be provided by synchronous telephone (audio-only) technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. HBAI services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

The following HBAI services may be provided by synchronous telephone (audio-only) technology:

Procedure Codes						
96156	96158	96159	96164	96165	96167	96168

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth to include informed consent, and privacy and security requirements.

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2.10.3 Documentation Requirements for Telemedicine and Telehealth

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

2.10.4 Prior Authorization and Documentation Requirements

Prior authorization is not required for HBAI services.

Documentation is required for HBAI services to support the medical necessity of the initial assessment, reassessment, and intervention.

For the initial assessment, documentation must support the medical necessity of the assessment and must include the following information:

- The date of initial diagnosis of physical illness
- A clear rationale for assessment
- Outcome of assessment, which includes mental status and the client's or caregiver's ability to understand and respond meaningfully
- Goals and expected duration of specifically recommended psychological intervention(s)

For reassessment, documentation must support the reassessment is necessary and include the following information:

- The date of change in mental or physical status
- Rationale for re-assessment with a clear indication of precipitating events.

For the intervention, documentation must support the necessity of the intervention and include the following information:

- Evidence that the person receiving services or caregiver has the capacity to understand and respond meaningfully,
- Clear outline of planned psychological intervention
- Goals of the psychological intervention identifying expected improvement in compliance with the medical treatment plan
- The client's response to the intervention
- Rationale for frequency and duration of acute care services

All documentation must include the amount of time spent in the assessment or intervention and must be documented in the client's medical record.

All services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

2.10.5 Claims Information

Claims for HBAI services must be submitted to TMHP in an approved electronic claims format or on a 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.

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Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

2.10.6 Reimbursement

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.11 Medical Nutrition Counseling Services (CCP)

2.11.1 Enrollment

Independently practicing licensed dietitians may enroll in Texas Medicaid to provide services to CCP-eligible clients. Dieticians who provide nutrition assessments and counseling must be currently licensed by the Texas Department of Licensing and Regulation (TDLR) in accordance with the Licensed Dietitians Act, Chapter 701, Texas Occupations Code.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.11.2 Services, Benefits, and Limitations

Medical nutrition therapy (assessment, re-assessment, and intervention) and medical nutrition counseling may be beneficial for treating, preventing, or minimizing the effects of illness, injuries, or other impairments. A case manager, school counselor, or school nurse may refer a client for medical nutrition counseling services.

Medical nutrition counseling services are a benefit when all of the following criteria are met:

- The client is 20 years of age or younger
- The client is eligible for CCP
- The services are prescribed by a physician
- The services are performed by a Medicaid-enrolled licensed dietitian
- Clinical documentation supports medical necessity and medical appropriateness
- FFP is available

Medical nutrition therapy and nutrition counseling may be considered beneficial for disease states for which dietary adjustment has a therapeutic role. Such disease states include, but are not limited to, the following conditions:

- Abnormal weight gain
- Cardiovascular disease
- Diabetes or alterations in blood glucose
- Eating disorders
- Gastrointestinal disorders
- Gastrostomy or other artificial opening of gastrointestinal tract
- Hypertension
- Inherited metabolic disorders

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- Kidney disease
- Lack of normal weight gain
- Multiple food allergies
- Nutritional deficiencies

Nutrition intervention for the following conditions is considered experimental and investigational and is not a benefit:

- Attention-deficit hyperactivity disorder
- Chemical sensitivities
- Chronic fatigue syndrome
- Idiopathic environmental intolerance

Medical nutrition counseling services for the diagnosis of obesity without a comorbid condition is not a benefit.

Medical nutrition therapy (procedure code 97802) is a more comprehensive service than medical nutrition counseling and is provided to individual clients for assessment and intervention. Procedure code 97802 is limited to one session per day and four units per rolling year.

Medical nutrition therapy (procedure code 97803) is provided to individual clients for a reassessment and intervention, after the initial assessment and intervention. Procedure code 97803 may be used for direct therapy sessions with clients. These sessions are limited to 1 session per day and 12 units per rolling year.

Nutrition assessments and re-assessments are in-depth evaluations of both objective and subjective data related to an individual's food and nutrient intake, lifestyle, and medical history. Nutrition assessments and re-assessments are performed as part of medical nutrition therapy. Nutrition assessments and re-assessments may be required as a result of a medical diagnosis and may be performed in conjunction with other therapies for treatment or as a goal to help clients make and maintain dietary changes. Documentation must include the following:

- Objective and subjective data obtained
- Height, weight, body mass index (BMI), and correlating percentiles on the growth curves
- Estimated caloric needs
- Nutritional diagnosis
- Intervention and plan
- Evaluation

Medical nutrition counseling (procedure code S9470) is provided to individual clients after an initial assessment and is less comprehensive than medical nutrition therapy. Nutritional counseling may be used to discuss the plan of care or intervention and to determine whether modifications are needed. Procedure code S9470 is limited to one visit per day and four visits per rolling year.

Medical nutrition group therapy (procedure code 97804) is not a benefit in the home setting, and does not include an individual nutrition assessment. Medical nutrition group therapy is limited to eight units per rolling year.

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Medical nutrition group therapy may be provided to a group of clients with the same condition. While medical nutrition group therapy must be led by a Medicaid-enrolled dietitian licensed by the TDLR, other health-care providers may participate in the group sessions. The focus of the therapy is on nutrition and health for chronic conditions such as the following:

- Acquired acanthosis nigricans
- Diabetes
- Dysmetabolic syndrome X
- Eating disorder
- Hyperlipidemia
- Other specified hypoglycemia
- Pure hypercholesterolemia
- Pure hyperglyceridemia

Medical nutrition group therapy sessions must last at least 30 minutes, have a minimum of two clients and a maximum of ten clients, and must include the following:

- An age-appropriate presentation on nutrition issues related to the chronic condition. (The presentation may include information about prevention of disease exacerbation or complications and living with chronic illness. The presentation may also offer suggestions for making healthy food choices or changing ideas about food.)
- A question-and-answer period.

Client participation in medical nutrition group therapy is optional. Providers must obtain an informed consent from a client's parent or guardian before rendering services. The medical documentation maintained in a client's medical record must include the following:

- Physician prescription
- Referral, if applicable
- Location where the services were provided
- Services that were provided during medical nutrition group therapy
- Goals or objectives for the group therapy
- Client participation
- Beginning and ending time of the group therapy session

In the following table, the procedure codes in Column A will be denied as part of another service if they are submitted by any provider for the same date of service as the corresponding procedure codes in Column B:

Column A: Procedure Codes Denied When Submitted With…	Column B: Procedure Codes
S9470	97802, 97803, or 97804

Claims for medical nutrition therapy and counseling services should be submitted as follows:

Procedure Code	Time Unit	Limitation
97802 Initial assessment	15 minutes	4 units per rolling year

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Procedure Code	Time Unit	Limitation
97803 Reassessment	15 minutes	12 units per rolling year
97804 Group	30 minutes	8 units per rolling year
S9470 Dietitian visit	Per visit	1 visit per day/ 4 visits per rolling year

2.11.3 Prior Authorization and Documentation Requirements

Prior authorization is required for services that exceed the limitations for medical nutrition therapy (assessment, re-assessment, and intervention), medical nutrition group therapy, and nutrition counseling visits.

Prior authorization is also required for consideration of other health conditions that are not addressed.

The following documentation must be submitted to the CCP Prior Authorization Unit for prior authorization:

- Completed CCP Prior Authorization Request Form
- Treatment plan
- Diagnosis of a condition for which there is medical necessity for the service
- Obstacles for not meeting goals
- Interventions planned to meet goals

The prescribing physician and provider must maintain documentation of medical necessity, including the completed CCP Prior Authorization Request Form, in a client's medical record. The physician must maintain the original signed copy of the CCP Prior Authorization Request Form. The completed CCP Prior Authorization Request Form is valid for a period of up to six months from the date of the physician's signature.

2.11.4 Telehealth Services

Certain telehealth services may be provided for medical nutrition therapy and nutrition counseling services clients if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interactions, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telehealth services. Therefore, providers must document in the person's medical record the reason(s) that services were delivered by synchronous telephone (audio-only) technology.

The following medical nutrition therapy services are authorized for telehealth delivery using synchronous audiovisual and synchronous telephone (audio-only) technologies, when noted:

Procedure Codes						
97802	97803	97804				

The procedure codes in the table above may be delivered by synchronous telephone (audio-only) technology only during certain PHE or natural disasters.

Medical nutrition counseling services (procedure code S9470) are authorized for telehealth delivery using synchronous audiovisual and synchronous telephone (audio-only) technologies, when noted.

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Medical nutrition counseling services (procedure code S9470) may be delivered by synchronous telephone (audio-only) technology only during certain PHE or natural disasters.

Services provided by synchronous audio-visual technology must be billed using modifier 95.

Services delivered using audio-only technologies must be billed using modifier 93.

Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided.

During a Declaration of State of Disaster, the Texas Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for information on restrictions for services delivered by synchronous telephone (audio-only) technologies.

2.11.5 Claims Information

Providers must submit services provided by licensed dietitians in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply the forms.

Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 paper claim form or its equivalent.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

Medical Nutrition Counseling (CCP Only) on the TMHP website at www.tmhp.com for a claim form example.

2.11.6 Reimbursement

Dietitian services are reimbursed in accordance with 1 TAC §355.8441.

2.12 Personal Care Services (PCS) (CCP)

2.12.1 Enrollment

CCP providers that want to participate in the delivery of PCS to Medicaid clients must be enrolled with TMHP and have the appropriate HHSC licensure or certification. All PCS providers must have an NPI.

Providers that are currently contracted with HHSC to administer consumer-directed services (CDS) or provide PCS through the service responsibility option (SRO), including providers currently enrolled in Texas Medicaid, are required to enroll or re-enroll separately as a CDS or SRO provider. Texas Medicaid enrolls only new providers that are currently contracted with HHSC to provide PCS through CDS and SRO.

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Providers (other than those discussed above) that want to provide PCS to Medicaid clients must enroll through TMHP. Texas Medicaid enrollment rules for PCS participation require providers to have one of the following categories of HHSC licensure prior to enrollment:

- Personal Assistance Services (PAS)
- Licensed Home Health Services (LHHS)
- Licensed and Certified Home Health Services (LCHHS)

LCHH and LHH agencies that are currently enrolled through TMHP do not need to enroll as CCP-PCS providers to provide PCS. Providers must have an NPI in one of the following enrollment categories: LHHS agency, LCHHS agency, or PCS provider.

Providers that are enrolled as any entity other than an LHHS agency or LCHHS agency are required to meet the provider enrollment rules in order to participate in the delivery of PCS through Texas Medicaid.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.12.2 Services, Benefits, and Limitations

PCS is a benefit of CCP for Texas Medicaid clients who are birth through 20 years of age. PCS may not be authorized in hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual or developmental disabilities (ICF-IID). PCS will be denied when billed on the same date of service as an inpatient stay service. The provider may appeal the denied claim with documentation supporting that PCS was performed while the client was not in a hospital setting. PCS are support services provided to clients who meet the definition of medical necessity and require assistance with the performance of ADLs, instrumental activities of daily living (IADLs), and health maintenance activities (HMAs) due to a physical, cognitive, or behavioral limitation related to a client's disability or chronic health condition. PCS are provided by someone other than the responsible adult of the client who is a minor child or the legal spouse of the client.

A responsible adult is an individual, 18 years of age or older, who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to, biological parents, adoptive parents, step parents, foster parents, legal guardians, court-appointed managing conservators, and the primary adult who is acting in the role of parent.

PCS are those services that assist eligible clients in performing ADLs, IADLs, and HMAs. The scope of ADLs, IADLs, and HMAs includes a range of activities that healthy, nondisabled adults can perform for themselves. Typically, developing children gradually and sequentially acquire the ability to perform these ADLs, IADLs, and HMAs for themselves. If a typically developing child of the same chronological age could not safely and independently perform an ADL, IADL, or HMAs without adult supervision, then the client's responsible adult ensures that the client's needs for the ADLs, IADLs, and HMAs are met.

PCS include direct intervention (assisting the client in performing a task) or indirect intervention (cueing or redirecting the client to perform a task). ADLs, IADLs, and HMAs include, but are not limited to, the following:

ADLs	IADLs
Bathing	Escort or Assistance with Transportation Services
Dressing	Grocery or Household Shopping
*** Escort or Assistance with Transportation Services includes the coordination of transportation to medical appointments and accompaniment to appointments to assist with needed ADLs. PCS does not include the payment for transportation or transportation vehicles since these services are available through MTP.**	

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ADLs	IADLs
Eating	Laundry
Locomotion or Mobility	Light housework
Personal Hygiene	Meal preparation
Positioning	Medication Assistance
Toileting	Money management
Transferring	Telephone Use or Other Communication
*** Escort or Assistance with Transportation Services includes the coordination of transportation to medical appointments and accompaniment to appointments to assist with needed ADLs. PCS does not include the payment for transportation or transportation vehicles since these services are available through MTP.**	

Note: *Health maintenance activities (HMAs) and nurse-delegated tasks that fall within the scope of the task listed above are allowable in PCS.*

Note: *Exercise and range of motion are not available through PCS, but are services that could be provided through PT, PDN, or home health SN.*

PCS does not include the following:

- ADLs, IADLs, or HMAs that a typically developing child of the same chronological age could not safely and independently perform without adult supervision
- Services that provide direct intervention when the client has the physical, behavioral, and cognitive abilities to perform an ADL, IADL, or health-related function without adult supervision
- Services used for or intended to provide respite care, child care, or restraint of a client
- Stand-by supervision related to safety
- Potty training
- Grocery shopping for members of the client's family or household
- Cleaning for members of the client's family or household (exception: light housework is approved if the client shares a room with a person)
- Cleaning the entire house (exception: a need for clean environment is approved if related to the client's diagnosis or condition [e.g., asthma, allergies, or autoimmune deficiencies])

  Note: *Cleaning an area or equipment that is used to complete a task may be included in the light housework IADL, as appropriate.*
- Laundry services for members of the client's family or household (exception: laundry is approved when related to the client's diagnosis or condition that results in soiled bedding or clothing for the client beyond the norm [e.g., incontinence, feeding tube, trachea, an ostomy, diapers, or skin condition])
- Waiting time for the laundry machine to complete a cycle in the home setting (exception: the time an attendant is at a laundromat completing the laundry task for the client is covered for PCS)
- Meal preparation for members of the client's family or household
- Time of a PCS attendant while acting as the responsible adult for the receipt of medical care or providing medical transportation

An escort is approved if it is related to the client's diagnosis or condition, such as using the toilet at the appointment or assistance carrying equipment (e.g., feeding pump, oxygen tank).

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An escort is approved if it is related to the client's diagnosis or condition and the responsible adult is occupied during the transport. For example, a child's condition might include behaviors that create an unsafe situation for the child during transport, such as removing a seatbelt, attempting to open the car door while the car is in motion, or elopement.

PCS does cover the entire time that an attendant is away from the home performing this task.

PCS is considered for reimbursement when providers use procedure code T1019 in conjunction with the appropriate modifier listed in the following table. PCS provided by a home health agency or PCS-only provider, including PCS being provided under the SRO defined in 40 TAC Part 1, Chapter 41, must be billed in 15-minute increments. PCS provided by a financial management services agency (FMSA) under the CDS option defined in 40 TAC Part 1, Chapter 41, must submit the attendant fee in 15-minute increments. FMSAs must bill the administration fee once per calendar month per client for any month in which the client receives PCS under the CDS option and regardless of the number of PCS units of service the client receives under the CDS option during the month. PCS claims are considered for reimbursement only when TMHP has issued a valid PAN to a PCS provider.

PCS Procedure Codes	
All PCS Providers* (except FMSA)	
Procedure Code	T1019
Modifier	U6 (PCS each 15 minutes)
	UA (Behavioral health condition, each 15 minutes)
FMSA Under CDS Option*	
Procedure Code	T1019
Modifier	U7 (Attendant fee each 15 minutes)
	U8 (Administration fee once a month)
	UB (Behavior health condition, each 15 minutes)
*** 40 TAC Part 1, Chapter 41**	

Home health agencies and Personal Care Services (PCS) providers that provide PCS and Community First Choice (CFC) Services in the home setting may be reimbursed for nurse evaluation and supervision using procedure code G0162.

The following limitations apply for procedure code G0162:

- For a registered nurse (RN) assessment, procedure code G0162 (without modifier) is limited to three hours per day (12 to 15 minute increments) and two occurrences per rolling year for any provider.
- For training and supervision of the attendant, procedure code G0162 must be billed with modifier U1 and is limited to three hours (12 to 15 minute increments) per 30 days for any provider.

Note: *Training and supervision and an RN assessment may be billed on the same day.*

Prior authorization is not required for procedure code G0162.

2.12.2.1 Place of Service

PCS may be provided in the following settings if medically necessary:

- The client's home
- The client's school
- The client's daycare facility

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- Other community setting in which the client is located

Note: *For claims filing purposes, the PCS provider must bill POS 2 (home) when submitting claims to TMHP.*

Texas Medicaid does not reimburse providers for PCS that duplicate services that are the legal responsibility of school districts. The school district, through the School Health and Related Services (SHARS) program, is required to meet the client's personal care needs while the client is at school. If those needs cannot be met by SHARS or the school district, the school district must submit documentation to the Texas Department of State Health Services (DSHS) case manager indicating the school district is unable to provide all medically necessary services. When clients are receiving both PCS and PDN services from an individual person over the same span of time, the combined total number of hours for PCS and PDN are reimbursed according to the maximum allowable rate.

2.12.2.2 Client Eligibility

The PCS benefit is available to Texas Medicaid clients who:

- Are birth through 20 years of age.
- Are enrolled with Texas Medicaid.
- Are eligible for CCP.
- Have physical, cognitive, or behavioral limitations related to a disability or chronic health condition that inhibits the client's ability to accomplish ADLs, IADLs, or HMAs.

Whether the client has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition that inhibits the client's ability to accomplish ADLs, IADLs, or HMAs, the following needs and conditions of the responsible adult will be considered:

- The responsible adult's need to sleep, work, attend school, and meet their own medical obligations
- The responsible adult's legal obligation to care for, support, and meet the medical, educational, and psychosocial needs of other dependents
- Whether requiring the responsible adult to perform the PCS will put the client's health or safety in jeopardy
- The time periods during which the PCS tasks are required by the client, as they occur over the course of a 24-hour day and a seven-day week.
- Whether or not the need to help the family perform PCS on behalf of the client is related to a medical, cognitive, or behavioral condition that results in a level of functional ability that is below that expected of a typically developing child of the same chronological age
- Whether services are needed based on:
  - The Practitioner Statement of Need (PSON)
  - The client's personal care assessment form (PCAF)

Clients who are enrolled in a HHSC waiver program may also receive PCS if they are eligible for it, as long as the services that are provided through the waiver program and PCS are not duplicated. Clients who are enrolled in the following HHSC waiver programs may access the PCS benefits if they meet the PCS eligibility requirements:

- Community Living Assistance and Support Services (CLASS)
- Deaf/Blind Multiple Disabilities (DBMD)
- Community-Based Alternatives (CBA)
- Consolidated Waiver Program (CWP)

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- Medically Dependent Children Program (MDCP)
- Texas Home Living Waiver (TxHmL)
- Home and Community Services (HCS)

Note: *Clients who receive HCS Residential Support Services, Supervised Living Services, or Foster/ Companion Care Services are not eligible to receive attendant care services through PCS.*

Clients must choose the program through which they receive attendant care, if they meet the eligibility requirements of both programs. Clients will be given the following options for the delivery of attendant care services:

- A client can receive all attendant care services through PCS.
- A client can decline PCS and receive all attendant care service through a waiver program, if the waiver program offers attendant care.

Clients who participate in the CDS option for PCS and for a waiver program are required to choose one FMSA to provide services through both programs. FMSAs will only be permitted to file the financial management services (FMS) fee, also known as the monthly administrative fee, through one program. The FMSA must file the FMS claim through the program that provides the highest reimbursement rate.

2.12.2.2.1 Accessing the PCS Benefit

Clients must be referred to DSHS before receiving the PCS benefit. A referral can be made by any person who recognizes a client may have a need for PCS, including, but not limited to, the following:

- The client, a parent, a guardian, or a responsible adult
- A primary practitioner, primary care provider, or medical home
- A licensed health professional who has a therapeutic relationship with the client and ongoing clinical knowledge of the client
- A family member
- Home health, personal assistance, or FMSA providers

Referrals to DSHS can be made to the appropriate DSHS Health Service Region, based on the client's place of residence in the state. Clients, parents, or guardians may also call the TMHP PCS Client Line at 1-888-276-0702 for more information on PCS. PCS providers must provide contact information for the client or responsible adult to DSHS or the TMHP PCS Client Contact Line when making a referral.

Upon receiving a referral, DSHS assigns the client a case manager, who then conducts an assessment in the client's home with the input and assistance of the client or responsible adult. Based on the assessment, the case manager identifies whether the client has a need for PCS. If the case manager identifies a need for PCS, the client or responsible adult is asked to select a Medicaid-enrolled PCS provider in their area.

Once a provider is selected, the DSHS case manager prior authorizes a quantity of PCS based on the assessment and requests TMHP to issue a PAN to the selected PCS provider. The PCS provider uses the PAN to submit claims to TMHP for the services provided.

2.12.2.2.2 The Primary Practitioner's Role in the PCS Benefit

A client who is assessed for the PCS benefit must have a primary practitioner (a licensed physician, APRN, or PA) or a primary care provider who has personally examined the client within the last 12 months and reviewed all of the appropriate medical records. The primary practitioner or primary care provider must have established a diagnosis for the client and must provide continuing care and medical supervision of the client. Prior to authorizing PCS, HHSC requires the completion of an HHSC-

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approved Practitioner Statement of Need (PSON) by a primary practitioner. The PSON must be on file with HHSC prior to the initiation of PCS and will only accept the PSON from an individual who is a physician, APRN, or PA.

The PSON certifies that the client is 20 years of age or younger and has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition. The primary practitioner or primary care provider must mail or fax the completed PSON to the appropriate DSHS Health Services Region. DSHS keeps the signed and dated PSON and the client's PCAF in the client's case management record for the duration of the client's participation in the benefit.

When a behavioral health condition exists, the primary practitioner may be a behavioral health provider.

If the client's medical record does not include the primary practitioner's documentation and a PSON that certifies that the client has a physical, cognitive or behavioral health condition that impacts the client's ability to perform an ADL or IADL, then PCS payments may be recouped.

Note: *If a client is entering or is already in the conservatorship of the state, PCS may be provisionally initiated for up to 60 days once eligibility has been established through the assessment.*

HHSC requires the reassessment of the client's need for PCS every 12 months or when requested due to a change in the client's health or living condition. A new PSON will be required at each annual reassessment and when there is a change in the client's medical condition that may increase the need for services.

2.12.2.3 PCS Provided in Group Settings

PCS may be provided in a provider to client ratio other than one-to-one. Settings in which providers can provide PCS in a provider to client ratio other than one-to-one include homes with more than one client needing PCS, foster homes, and independent living arrangements.

A PCS provider may provide PCS to more than one client over the span of the day as long as:

- Each client's care is based on an individualized service plan.
- Each client's needs and service plan do not overlap with another client's needs and service plan.

  Example: *If the prior authorized PCS hours for Client A is four hours, Client B is six hours, and the actual time spent with both clients is eight hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client's prior authorized hours or total hours worked. It would be acceptable to bill four hours for Client A and four hours for Client B, or three hours for Client A and five hours for Client B. It would not be acceptable to bill five hours for Client A and three hours for Client B. It would be acceptable to bill ten hours if the individual person actually spent ten hours onsite providing prior authorized PCS split as four hours for Client A and six hours for Client B. A total of ten hours cannot be billed if the individual person worked only eight hours.*

- PCS may be delivered in a client-to-provider ratio other than one-on-one as long as each client's care is based on an individualized POC and each client's needs are being met. Only the time spent on authorized PCS tasks for each client is eligible for reimbursement. Total PCS billed for all clients cannot exceed an individual attendant's total number of hours at the place of service.

When there is more than one client within the same household receiving PCS, the DSHS case manager will synchronize authorizations within the households for all eligible clients. The DSHS case manager will assess all eligible clients in the home and submit authorizations for all eligible clients in the household for the same authorization period. DSHS case managers will communicate with the provider the actions that are being taken using the existing Communication Tool.

Note: *There should be no lapse in services to the client.*

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2.12.3 Prior Authorization and Documentation Requirements

Prior authorization is required before services are provided. All PCS must be prior authorized by a DSHS case manager based upon client need, as determined by the client assessment. DSHS prior authorizes PCS for eligible clients. The DSHS case manager notifies TMHP of the authorized quantity of PCS. TMHP sends a notification letter with the PAN to the client or responsible adult and the selected PCS provider if PCS is approved or modified. Only the client or responsible adult receives a notification letter with an explanation of denied services. PCS is prior authorized for periods of up to twelve months. PCS providers must provide services from the start of care date agreed to by the client or responsible adult, the case manager, and the PCS provider.

PCS may be authorized in the same day as PPECC, if medically necessary. However, they must be rendered in a home setting, before or after PPECC services.

A PCS provider may obtain prior authorization to provide enhanced PCS to clients with a behavioral health condition when the following criteria are met:

- The DSHS case manager completes the Personal Care Assessment Form (PCAF) and identifies the behavioral health condition.
- The PCAF indicates that the identified behavioral health condition impacts the client's ability to perform an ADL or IADL.
- The PCAF indicates which ADL(s) or IADL(s) cannot be performed by the client without assistance.
- The DSHS case manager submits the appropriate modifier on the authorization request.

When a client experiences a change in condition, the client or responsible adult must notify the DSHS Health Service Office in the client's region. A new assessment is required when a client's physician orders services in a PPECC. A DSHS case manager must perform a new assessment and prior authorize any revisions in the quantity of PCS based on the new assessment. TMHP issues a revised authorization and notifications are sent to the client or responsible adult and the selected PCS provider. If the change is made during a current prior authorization period, the new prior authorization will maintain the same end date as the original prior authorization period. The revised authorization period will begin on the SOC date stated in the new assessment.

For continuing and ongoing PCS needs beyond the initial prior authorization period of up to twelve months, a DSHS case manager must conduct a new assessment and submit a new authorization request to TMHP. TMHP sends a notification letter updating the prior authorization to the client, responsible adults, and the selected PCS provider.

HHSC or its designee may suspend an authorization for PCS when either:

- The client or the client's family creates an unsafe environment for the attendant's health and safety.
- The provider requests suspension for the reasons outlined in 40 TAC Part 1, Chapter 41.

Providers can call a toll-free PCS Provider Inquiry Line at 1-888-648-1517 for assistance with inquiries about the status of a PCS prior authorization. Providers should direct inquiries about other Medicaid services to the TMHP Contact Center at 1-800-925-9126. PCS providers should encourage the client or responsible adult to contact the appropriate DSHS Health Service Region with inquiries or concerns about the PCS assessment.

> ***Note:*** *Any organization that employs attendants who provide PCS, and any organization serving as an FMSA, must comply with all documentation requirements as specified by the PCS program.*

2.12.3.1 PCS Provider Responsibilities

PCS providers must comply with all applicable federal, state, and local laws and regulations.

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All PCS providers must maintain written policies and procedures for obtaining consent for medical treatment in the absence of the responsible adult. The procedure and policy must meet the standards of the Texas Family Code, Chapter 32.

Providers must accept clients only when there is a reasonable expectation and evidence that the client's needs can be adequately met in the POS. The POS must be able to support the client's health and safety needs and adequately support the use, maintenance, and cleaning of all required medical devices, equipment, and supplies. Necessary primary and backup utility, communication, and fire safety systems must be available in the POS.

The PCS provider is responsible for the supervision of the PCS attendant as required by the PCS provider's licensure requirements.

2.12.3.2 Documentation of Services Provided and Retrospective Review

Documentation elements are routinely assessed for compliance in retrospective review of client records, including the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- All attendants' arrival and departure times are documented with signature and time.
- Documentation of services correlates with, and reflects medical necessity for, the services provided on any given day.
- Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

2.12.4 Coordination with PPECC Provider

When a DSHS case manager is notified by the client, client's responsible adult, or client's physician that PPECC services have been initiated, revised, or recertified, the DSHS case manager must conduct a PCS reassessment, and submit all documentation required for a revision, modification, or denial of the original PCS authorization request, including a Physician's Statement of Need if there is a change in client condition. The new authorization request must be submitted within ten (10) business days of notification.

DSHS case managers must provide documentation to support medical necessity if PCS service hours do not decrease when PPECC services are initiated.

DSHS case managers must also document coordination with the PPECC provider, maintaining documentation that the client or the client's responsible adult has participated in the development of the plan of care.

When a client receives both PCS and PPECC in a single day, and decides to receive fewer hours of service in a PPECC (i.e., shifts more services to the home setting), or terminates PPECC services, the PCS case manager must conduct a reassessment, and submit all documentation required for a revision, modification, or denial of the original PCS authorization request, including a Physician's Statement of Need if there is a change in condition within ten (10) business days of notification by the client, client's responsible adult, or client's physician.

Similarly, if the client decides to receive fewer hours of PCS services in the home, and increase PPECC hours, the DSHS case manager must conduct a reassessment, and submit all documentation required for an modification of the authorization request, within ten (10) business days of notification by the client, client's responsible adult, or client's physician.

Note: *Coordination requirements may be different in a Medicaid managed care environment.*

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PCS services rendered in a client's home may be billed before or after PPECC services on the same day, but not at the same time as PPECC services. PCS services required while a client is in a PPECC are considered part of the PPECC billable rate.

2.12.5 Claims Information

TMHP processes PCS claims. PCS providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. PCS providers, other than home health agencies, that are enrolled as PAS-only providers, FMSAs, or SRO providers must file PCS claims using a CMS-1500 paper claim form. Home health agencies, including those enrolled as an FMSA, or an SRO provider, must file PCS claims using the UB-04 CMS-1450 paper claim form. TMHP does not supply the forms.

Home health agencies and consumer-directed agencies that bill for PCS using procedure code T1019 must include the prior authorization number on claims submitted for reimbursement. Additionally, providers utilizing paper, TexMedConnect, or billing through EDI must include the prior authorization number with all claims submissions.

2.12.5.1 Managed Care Clients

PCS services are carved-out of the Medicaid Managed Care Program for State of Texas Access Reform (STAR) clients and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's MCO. Claims for STAR Health, STAR Kids, and STAR+PLUS are not carved out and must be submitted to the client's MCO for payment consideration.

2.12.5.2 PCS for STAR Health Clients

PCS for eligible STAR Health clients are authorized and processed by Superior HealthPlan.

Medicaid providers that want to provide PCS services to clients in the STAR Health program should contact Superior HealthPlan for information regarding the contracting and credentialing process at:

Superior HealthPlan - Network Development
Telephone: 1-866-615-9399 Ext. 22534
Email: shp-networkdevelopment@centene.com

2.12.6 Reimbursement

Providers of PCS are reimbursed in accordance with 1 TAC §355.8441.

2.13 Community First Choice (CFC) Services

2.13.1 Enrollment

CFC providers, including providers offering the Service Responsibility Option (SRO), must be licensed and enrolled in Texas Medicaid and comply with all applicable federal, state, and local laws and regulations. When CFC is provided through the Consumer Directed Services (CDS) option by a Financial Management Services Agency (FMSA), the FMSA must be certified and enrolled in Texas Medicaid as a FMSA and must comply with all applicable federal, state, and local laws and regulations.

Note: *CDS, FMSA, and SRO are defined in the Title 40 Texas Administrative Code (TAC), Part 1, Chapter 41. Licensure requirements for FMSA and SRO providers are defined in the Title 40 TAC, Part 1, Chapter 49.*

Note: *Any organization that employs attendants who provide CFC, and any organization serving as an FMSA, must comply with all documentation requirements as specified in CFC program policy.*

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All CFC providers must maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of a responsible adult that meet the standards of the Texas Family Code, Chapter 32.

Providers must only accept clients when there is a reasonable expectation and evidence that the client's CFC needs can be adequately met in the place of service.

The CFC provider is responsible for supervising the CFC attendant in accordance with the provider's licensure requirements.

Note: *For CFC services delivered through a HHSC 1915(c) waiver or through a managed care organization (MCO), providers must refer to HHSC or the MCO for information about benefits, limitations, prior authorization, reimbursement, and specific claim processing procedures.*

2.13.2 Services, Benefits, and Limitations

CFC services may be rendered by a Home Health Agency, PCS-only provider, Financial Management Services Agency (FMSA) under the CDS option, or by a Service Responsibility Option (SRO) Provider.

CFC is a benefit for Texas Medicaid fee-for-service clients who are birth through 20 years of age and who are:

- Eligible for medical assistance under the state plan
- Need help with activities of daily living; and
- Need an institutional level of care (to include hospital, nursing facility, intermediate care facility for clients with intellectual disabilities or institution of mental disease)

Services included are CFC personal assistance services, CFC habilitation, and CFC support management. CFC personal assistance services is the assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/or cueing. CFC habilitation services are the acquisition, maintenance, and enhancement of skills necessary for the client to accomplish ADLs, IADLs, and health maintenance activities (HMAs). CFC support management is voluntary training on how to select, manage, and dismiss attendants.

CFC includes assistance with ADLs, IADLs and HMAs through hands-on assistance, supervision, or cueing. CFC also includes training on the acquisition, maintenance, and enhancement of skills necessary for the client to accomplish ADLs, IADLs, and HMAs.

ADLs are activities that include:

- Bathing—Assisting the client with any or all parts of bathing; selecting appropriate water temperature and flow speed, turning water on and off; laying out and putting away supplies; transferring in and out of bathtub or shower; washing and drying hair and body; clean up after task is completed.
- Dressing—Assisting the client with any or all parts of getting dressed; putting on, fastening, and taking off all items of clothing; donning and removing shoes or prostheses; choosing and laying out weather-appropriate clothing.
- Eating—Assisting the client with some or all parts of eating and drinking; feeding the client; assistance with utensils or special or adaptive eating devices; clean up after task is completed.
- Personal hygiene: Assisting the client with some or all parts of personal hygiene; routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, perineum; basic nail care; applying deodorant; routine skin care; clean up after task is completed.

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- Toileting—Assisting the client with some or all parts of toileting; using commode, bedpan, urinal, toilet chair; transferring on and off; cleansing; changing diapers, pad, incontinence supplies; adjusting clothing; clean up after task is completed.
- Locomotion or mobility—Assisting the client with moving between locations; assisting the client with walking or using wheelchair, walker, or other mobility equipment.
- Positioning—Assisting the client with positioning their body while in a chair, bed, or other piece of furniture or equipment; changing and adjusting positions; moving to or from a sitting position; turning side-to-side; assisting the client to sit upright.
- Transferring—Assisting the client with moving from one surface to another with or without a sliding board; moving from bed, chair, wheelchair, or vehicle to a new surface; moving to or from a standing or sitting position; moving the client with lift devices.

IADLs are activities that include:

- Telephone use or other communication—Assisting the client in making or receiving telephone calls; managing and setting up communication devices; making and receiving the call for the client.
- Grocery or household shopping—Shopping for or assisting clients in shopping for grocery and household items; preparing a shopping list; putting food and household items away; picking up medication and supplies.
- Light housework—Performing or assisting the client in performing light housework such as: Cleaning and putting away dishes; wiping countertops; dusting; sweeping, vacuuming or mopping; changing linens and making bed; cleaning bathroom; taking out trash.
- Laundry—Assisting the client with doing laundry; gathering, sorting, washing, drying, folding, and putting away personal laundry, bedding, and towels; removing bedding to be washed and remaking the bed; using a laundry facility.
- Meal preparation—Assisting clients in preparing meals and snacks; cooking; assembling ingredients; cutting, chopping, grinding, or pureeing food; setting out food and utensils; serving food; preparing and pouring a predetermined amount of liquid nutrition; cleaning the feeding tube; cleaning area after meal; washing dishes.
- Money management—Assisting the client with managing their day-to-day finances; paying bills; balancing checkbook; making deposits or withdrawals; assisting in preparing and adhering to a budget.
- Medication assistance or administration—Assisting the client with oral medications that are normally self-administered, including administration through a permanently placed feeding tube with irrigation.
- Escort or assistance with transportation services—Assisting the client in making transportation arrangements for medical and other appointments; accompanying the client to a health care appointment to assist with needed ADLs.

HMAs include tasks that may be exempt from delegation based on the Registered Nurse (RN) assessment that enables the client to remain in an independent living environment and go beyond ADLs because of the higher skill level in which they are required to perform. HMAs will be limited to those within the scope of CFC that include:

- Administering oral medications that are normally self-administered, including administration through a permanently placed feeding tube with irrigation.
- Topically applied medications.
- Insulin or other injectable medications prescribed in the treatment of diabetes mellitus administered subcutaneously, nasally, or via an insulin pump.

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- Unit dose medication administration by way of metered dose inhaler (MDIs) including medications administered as nebulizer treatments for prophylaxis or maintenance.
- Routine administration of a prescribed dose of oxygen.
- Noninvasive ventilation (NIV) such as continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP) therapy.
- The administering of a bowel and bladder program, including suppositories, enemas, manual evacuation, intermittent catheterization, digital stimulation associated with a bowel program, tasks related to external stoma care including but not limited to pouch changes, measuring intake and output, and skin care surrounding the stoma area.
- Routine preventive skin care and care of Stage 1 pressure ulcers.
- Feeding and irrigation through a permanently placed feeding tube inserted in a surgically created orifice or stoma.
- Those tasks that an RN may reasonably conclude as safe to exempt from delegation based on an assessment consistent with 22 Texas Administrative Code (TAC) §225.6 of this title (relating to the RN Assessment of the client).
- Reporting as to the client's condition, including changes to the client's condition or needs and completing appropriate record.
- Skin care: Maintenance of the hygienic state of the client's skin under optimal conditions of cleanliness and comfort.
- Use of durable medical equipment (DME).
- Such other tasks as the Board of Nursing may designate.

Whether the client has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition that inhibits the client's ability to accomplish ADLs, IADLs, or HMAs, the following needs and conditions of the responsible adult will be considered in the determination of hours for CFC personal assistance services:

- The responsible adult's need to sleep, work, attend school, and meet their own medical obligations
- The responsible adult's legal obligation to care for, support, and meet the medical, educational, and psychosocial needs of other dependents
- Whether requiring the responsible adult to perform the CFC personal assistance services will put the client's health or safety in jeopardy
- The time periods during which the CFC personal assistance services tasks are required by the client, as they occur over the course of a 24-hour day and a seven-day week.
- Whether or not the need to help the family perform CFC personal assistance services on behalf of the client is related to a medical, cognitive, or behavioral condition that results in a level of functional ability that is below that expected of a typically developing child of the same chronological age

CFC also includes training on the acquisition, maintenance, and enhancement of the following additional habilitation needs:

- Community integration—Client may need assistance finding, participating in and accessing community activities or community services such as free meal programs, churches, parks or self-advocacy training or events.
- Use of adaptive equipment—Client may need assistance operating, learning to use, or accessing adaptive equipment.

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- Personal decision-making—Client may need assistance making decisions for him or herself, including assistance in assessing what is important to that client, pros and cons, as well as consequences.
- Reduce challenging behaviors to allow clients to accomplish ADLs, IADLs, and HMAs—Client may need assistance in increasing positive social encounters and engagement in preferred activities. Client may have challenging behaviors that can be reduced through behavior support plans, prompting, rewards, or redirection among others.
- Socialization/relationship development—Client may need assistance with development and maintenance of relationships or appropriate social behaviors.
- Accessing leisure and recreational activities—Client may need assistance identifying, finding, or accessing activities they would like to participate in during leisure time.

CFC does not include the following:

- Direct intervention to perform a task the client has the physical, behavioral, and cognitive abilities to perform;
- Skilled nursing services, or the supervision of delegated nursing tasks as described in the Texas Nurse Practice Act, the Act's implementing regulations, the Texas Medicaid Provider Procedures Manual sections for Private Duty Nursing (PDN) Services - THSteps - Comprehensive Care Program (CCP) and Home Health Skilled Nursing and Home Health Aide Services;
- Costs associated with purchasing products for ADLs or IADLs;
- Services used for or intended to provide respite care, child care, or restraint of a client;
- Duplication of services provided by another program;
- Tasks that a typically developing child of the same chronological age could not safely and independently perform without adult supervision;
- Services provided in an institutional setting including hospitals, nursing facilities, psychiatric hospitals, or intermediate care facilities for clients with intellectual or developmental disabilities.

CFC is considered for reimbursement when billed with procedure code T1019 in conjunction with the appropriate modifier listed in the following table. CFC provided by a home health agency or PCS-only provider, including CFC being provided under the SRO defined in 40 TAC Part 1, Chapter 41, must be billed in 15-minute increments. CFC provided by a FMSA under the CDS option defined in 40 TAC Part 1, Chapter 41, must submit the attendant fee in 15-minute increments.

CFC Procedure Codes	
All CFC Providers (except FMSA)	
Procedure Code	T1019
Modifier	UD (CFC —client needs attendant care only, each 15 minutes)
	U9 (CFC—client needs habilitation only, or attendant and habilitation, each 15 minutes)
Procedure Code	T1019

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CFC Procedure Codes	
Modifier	U3 (CFC attendant care for PCS - CDS Option, each 15 minutes) ***Note:*** *This modifier will be used for individuals receiving attendant care only.*
	U4 (CFC Habilitation for PCS - CDS Option, each 15 minutes) ***Note:*** *This modifier will be used for individuals receiving attendant care and habilitation.*
	U5 (CFC CDS, per month) ***Note:*** *This modifier is used for the administrative fee for CFC provider under the CDS option.*

FMSAs must bill the administration fee once per calendar month per client for any month in which the client receives CFC under the CDS option and regardless of the number of CFC units of service the client receives under the CDS option during the month. CFC claims are considered for reimbursement only when TMHP has issued a valid PAN to a CFC provider.

Home health agencies and Personal Care Services (PCS) providers that provide PCS and Community First Choice (CFC) Services in the home setting may be reimbursed for nurse evaluation and supervision using procedure code G0162.

The following limitations apply for procedure code G0162:

- For a registered nurse (RN) assessment, procedure code G0162 (without modifier) is limited to three hours per day (12 to 15 minute increments) and two occurrences per rolling year for any provider.
- For training and supervision of the attendant, procedure code G0162 must be billed with modifier U1 and is limited to three hours (12 to 15 minute increments) per 30 days for any provider.

Note: *Training and supervision and an RN assessment may be billed on the same day.*

Prior authorization is not required for procedure code G0162.

2.13.2.1 Place of Service

CFC may be provided in the following settings:

- Client's home;
- Client's school;
- Client's daycare facility; or
- Other community setting in which the client is located.

Note: *For claims filing purposes, the CFC provider must bill POS 2 (home) when submitting claims to TMHP.*

Texas Medicaid does not reimburse providers for CFC services that duplicate services that are the legal responsibility of school districts. The school district, through the School Health and Related Services (SHARS) program, is required to meet the client's personal care needs while the client is at school. If those needs cannot be met by SHARS or the school district, the school district must submit documentation to the DSHS case manager indicating the school district is unable to provide all medically necessary services.

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2.13.3 CFC Attendant and Habilitation Services in Group Settings

CFC may be provided in a provider to client ratio other than one-to-one. Settings in which providers can provide CFC in a provider to client ratio other than one-to-one include homes with more than one client needing CFC, foster homes, and independent living arrangements. A CFC provider may provide CFC to more than one client over the span of the day as long as:

- Each client's care is based on an individualized service plan.
- Each client's needs and service plan do not overlap with another client's needs and service plan.
- Only the time spent on authorized CFC tasks for each client is eligible for reimbursement. Total CFC billed for all clients cannot exceed an individual attendant's total number of hours at the place of service.

When there is more than one client within the same household receiving CFC, the Department of State Health Services (DSHS) case manager will synchronize authorizations within the households for all eligible clients. The DSHS case manager will assess all eligible clients in the home and submit authorizations for all eligible clients in the household for the same authorization period. DSHS case managers will communicate with the provider the actions that are being taken using the existing Communication Tool.

2.13.4 Prior Authorization

Prior authorization is required before services are provided. All CFC must be prior authorized by a DSHS case manager based upon client need, as determined by the client assessment. DSHS prior authorizes CFC for eligible clients. The DSHS case manager notifies TMHP of the authorized quantity of CFC. TMHP sends a notification letter with the prior authorization number (PAN) to the client or responsible adult and the selected CFC provider if CFC is approved or modified. Only the client or responsible adult receives a notification letter with an explanation of denied services. CFC is prior authorized for periods of up to twelve months. CFC providers must provide services from the start of care date agreed to by the client or responsible adult, the case manager, and the CFC provider.

When DSHS has approved CFC services, DSHS will send the client's selected CFC provider: A CFC Communication tool, specifying the approved hours and CFC tasks and a copy of the Personal Care Assessment Form (PCAF) CFC Addendum, which documents that client's goals and preferences for the delivery of CFC services. The CFC provider may receive a Practitioner's Statement of Need (PSON) for the client, but this form is not required documentation for CFC and is intended merely for informational purposes.

When a client experiences a change in condition, the client or responsible adult must notify the DSHS Health Service Office in the client's region. A DSHS case manager must perform a new assessment and prior authorize any revisions in the quantity of CFC based on the new assessment. TMHP issues a revised authorization and notifications are sent to the client or responsible adult and the selected CFC provider. If the change is made during a current prior authorization period, the new prior authorization will maintain the same end date as the original prior authorization period. The revised authorization period will begin on the start of care date stated in the new assessment.

For ongoing CFC needs beyond the initial prior authorization period of up to twelve months, a DSHS case manager must conduct a new assessment and submit a new authorization request to TMHP. A new in-home assessment must be conducted every twelve months with the client. TMHP will send a notification letter updating the prior authorization to the client, responsible adults, and the selected CFC provider. HHSC or its designee may suspend an authorization for CFC when either:

- The client or the client's family creates an unsafe environment for the attendant's health and safety; or
- The provider requests suspension for the reasons outlined in 40 TAC Part 1, Chapter 41.

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Providers can call a toll-free Provider Inquiry Line at 1-888-648-1517 for assistance with inquiries about the status of a CFC prior authorization. Providers should direct inquiries about other Medicaid services to the TMHP Contact Center at 1-800-925-9126. CFC providers should encourage the client or responsible adult to contact the appropriate DSHS Health Service Region with inquiries or concerns about the CFC assessment.

2.13.4.1 CFC Provider Responsibilities

CFC providers must comply with all applicable federal, state, and local laws and regulations. All CFC providers must maintain written policies and procedures for obtaining consent for medical treatment in the absence of the responsible adult. The procedure and policy must meet the standards of the Texas Family Code, Chapter 32. Providers must accept clients only when there is a reasonable expectation and evidence that the client's needs may be adequately met in the place of service (POS). The POS must be able to support the client's health and safety needs and adequately support the use, maintenance, and cleaning of all required medical devices, equipment, and supplies. Necessary primary and backup utility, communication, and fire safety systems must be available in the POS. The CFC provider is responsible for the supervision of the CFC attendant as required by the CFC provider's licensure requirements.

2.13.4.2 Documentation Requirements

Documentation elements are routinely assessed for compliance in retrospective review of client records, including the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- All attendants' arrival and departure times are documented with signature and time.
- Documentation of services correlates with, and reflects medical necessity for, the services provided on any given day.
- Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

2.13.5 Claims Information

TMHP processes CFC claims. CFC providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. CFC providers, other than home health agencies, that are enrolled as PAS-only providers, FMSAs, or SRO providers must file CFC claims using a CMS-1500 paper claim form. Home health agencies, including those enrolled as an FMSA, or an SRO provider, must file PCS claims using the UB-04 CMS-1450 paper claim form.

TMHP does not supply the forms. Home health agencies and consumer-directed agencies that bill for CFC using procedure code T1019 must include the prior authorization number on claims submitted for reimbursement. Additionally, providers utilizing paper, TexMedConnect, or billing through EDI must include the prior authorization number with all claims submissions.

2.13.5.1 Managed Care Clients

CFC services are carved-out of the Medicaid Managed Care Program for State of Texas Access Reform (STAR) clients and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's MCO. Claims for STAR Health and STAR+PLUS are not carved out and must be submitted to the client's MCO for payment consideration.

2.14 Private Duty Nursing (PDN)(CCP)

Refer to: The *Home Health Nursing and Private Duty Nursing Services Handbook* (*Vol. 2, Provider Handbooks*) for information about private duty nursing (PDN) (CCP) services.

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2.15 Prescribed Pediatric Extended Care Centers (PPECC) (CCP)

PPECC services may be a benefit of the Texas Health Steps (THSteps) Comprehensive Care Program (CCP) for Medicaid clients who are:

- 20 years of age and younger;
- THSteps - CCP eligible;
- Medically or technologically dependent;

  Note: *The term "medically dependent or technologically dependent client" does not include a minor or occasional medical condition that does not require continuous nursing care, including asthma or diabetes, or a condition that requires an epinephrine injection.*

- Have an acute or chronic condition;
- Require ongoing skilled nursing care beyond the level of skilled nursing visits normally authorized under Texas Medicaid Home Health Skilled Nursing (HHSN) and Home Health Aide (HHA) services;
- Meet the medical necessity criteria for admission to a PPECC detailed in the "Prior Authorization and Documentation Requirements" section, and have a physician's order prescribing PPECC services; and
- Have chosen to receive PPECC services.

A PPECC does not provide emergency services. PPECCs must follow the safety provisions in state PPECC licensure requirements, including the adoption and enforcement of policies and procedures for a client's medical emergency. PPECCs must call for emergency transport to the nearest hospital when emergency services are needed by a PPECC client.

2.15.1 Services, Benefits, and Limitations

PPECC services are provided in a non-residential facility licensed by HHSC. PPECCs serve four or more medically dependent or technologically dependent clients who are 20 years of age or younger and who require ongoing skilled nursing prescribed by the client's physician to avert death or further disability or require the routine use of a medical device to compensate for a deficit in life-sustaining body function.

Services must be included in a PPECC plan of care (POC) and are limited to no more than 12 hours in a 24-hour period. PPECC services may not be provided overnight. PPECC services are intended as an alternative to private duty nursing (PDN). Clients who are eligible to receive PDN services may also receive PPECC services. A client may choose to receive all authorized PPECC and PDN service hours through PPECC services only, PDN services only, or a combination of both PPECC and PDN services. If a client chooses to receive both PPECC and PDN services, the client must not receive service hours in addition to what was initially authorized for PPECC and PDN unless additional hours are medically necessary.

PPECCs must comply with:

- Medicaid program rules, as well as PPECC licensing statute and rules;
- Mandatory reporting of suspected abuse and neglect of children;
- Texas Medicaid provider participation requirements; and
- The requirements of the TMPPM.

Clients who receive PPECC services through THSteps-CCP require ongoing medical supervision by the ordering physician who has a therapeutic relationship with and ongoing clinical knowledge of the client. An in-person evaluation must be performed each year by the ordering physician for each client. A physician order is required for each authorization period including initial, revisions, and recertification.

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A physician in a relationship with a PPECC (employed by or contracted with a PPECC) cannot provide the physician's order, unless the physician is the client's treating physician and has examined the client outside of the PPECC setting.

The following services may be rendered at a PPECC, but are not considered part of the PPECC services covered by Texas Medicaid, and must be billed separately by Medicaid-enrolled service providers:

- Speech, physical, and occupational therapies
- Certified respiratory care practitioner services
- Early intervention services provided through the Early Childhood Intervention (ECI) program, which are subject to ECI policies.

When the client's POC indicates that therapy services are required while the client is at the PPECC, clients must be provided a choice in speech, occupational, and physical therapy providers, as well as certified respiratory care providers. PPECC providers must coordinate care with the therapy providers to ensure the client receives therapy services as required in the PPECC setting.

Clients from birth through 36 months of age must be given the option of receiving ECI services in addition to their PPECC services. The PPECC providers must coordinate care with the client's ECI service coordinator.

ECI services rendered in a PPECC are provided by entities that are contracted with the state to provide early intervention services.

When therapy services (occupational, speech, and/or physical therapy), or certified respiratory care services are rendered in a PPECC, they may be provided by:

- Medicaid-enrolled providers contracted with or employed by the PPECC or Medicaid-enrolled providers not employed by or contracted with the PPECC.
- Independent therapists
- Home health therapists
- Certified respiratory care providers

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about CCP therapy services.

The *Certified Respiratory Care Practitioner (CRCP) Services Handbook* (*Vol. 2, Provider Handbooks*) for information about CRCP (CCP) services.

An admission authorized under this section is not intended to supplant the right of a client to access PDN, personal care services (PCS), HHSN, HHA, and therapies (physical, occupational, and speech), as well as certified respiratory care practitioner services and ECI services rendered in the client's residence when medically necessary.

PPECC providers must collaborate and coordinate care with the client's existing service providers, including physicians, therapists, certified respiratory care practitioners, and home health agencies rendering services such as PDN and/or HHSN, HHA services, PCS, hospice, and other providers who render medically necessary services. The PPECC must ensure the provision of the following basic services:

- The development, implementation, and monitoring of a comprehensive POC in collaboration with the client or the client's responsible adult that addresses the client's medical, nursing, psychosocial, therapeutic, and developmental services, including the following prescribed services:
  - Skilled nursing
  - PCS to assist with activities of daily living or instrumental activities of daily living while in the PPECC

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- Functional developmental services
- Nutritional and dietary services, including nutritional counseling

Note: *Nutritional services must comply with standards in HHSC licensure rules related to nutritional counseling and dietary services.*

- Occupational, physical and speech therapy
- Respiratory care
- Psychosocial services
- Physician's oversight of services

- The POC must also include the following, as applicable:
  - Training for the client's responsible adult associated with caring for a medically or technologically dependent client.
  - Specification whether the client is stable to receive transportation services provided by the PPECC as determined by the client's ordering physician.
  - If the client's ordering physician determines the client is stable, the client's ordering physician, in collaboration with the PPECC, must specify the type of provider—registered nurse (RN), licensed vocational nurse (LVN) or direct care staff—who must be on board the PPECC transport vehicle to assist the client during transportation to and from the PPECC.
    - Transportation must be provided by a PPECC when the client's ordering physician has determined that the client is stable, and the client or the client's responsible adult wants the client to receive transportation services to and from the PPECC.
    - When a PPECC provides transportation to a PPECC client, an RN, LVN, or direct care staff employed by the PPECC must be on board the transport vehicle as determined by the client's ordering physician, in collaboration with the PPECC.
    - The client does not need to be accompanied by the client's responsible adult when a PPECC provides transportation.
    - When a client's ordering physician has determined a client is stable to receive PPECC transportation and the client or the client's responsible adult wants the client to receive transportation services, the client must be able to utilize transportation services offered by the PPECC with the assistance of a PPECC nurse or direct care staff to and from the PPECC, rather than a non-emergency ambulance.
    - A non-emergency ambulance may not be utilized for transport to and from a PPECC.

Note: *A client or a client's responsible adult may decline a PPECC's transportation services entirely, on a specific date or for part of a day, and choose to be transported by other means, including their responsible adult. A client or a client's responsible adult's decision to utilize or not utilize PPECC transportation services does not preclude a PPECC from being eligible for reimbursement of non-transportation services.*

- Direct care staff, defined in licensure regulations, works under the supervision of an RN and provides direct care to a client
- PPECC services must be:
  - Individualized, specific, and consistent with symptoms or confirmed diagnosis of the condition, illness or injury under treatment, not in excess of the client's needs;
  - Consistent with generally accepted professional medical standards as determined by the Medicaid program and may not be experimental or investigational;

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- Reflective of the level of service that can be safely and effectively furnished;
- Furnished in a manner not primarily intended for the convenience of the client, the client's responsible adult, or the provider.

Note: *The fact that a client's ordering physician has prescribed, recommended, or approved medical care, goods or services does not, in itself, make such care or services medically necessary or a covered service.*

2.15.1.1 Prior Authorization and Documentation Requirements

Prior authorization is required for PPECC services, excluding PPECC transportation. All requests for PPECC services must be based on the client's current medical needs. Texas Medicaid defines medically necessary THSteps services as health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability, physical or mental illness, or chronic conditions.

Documentation of medical necessity is required for PPECC services. PPECC services are considered medically necessary when a client meets all of the following admission criteria:

- Eligible for THSteps-CCP;
- 20 years of age or younger;
- Requires ongoing skilled nursing care and supervision beyond the level of skilled nursing visits normally authorized under Texas Medicaid HHSN and HHA services, skillful observations, judgments, and therapeutic interventions all or part of the day to correct or ameliorate health status;
- Considered to be a medically dependent or technologically dependent client in accordance with Texas Health and Safety Code chapter 248A;
- Stable for outpatient medical services, and does not present significant risk to other clients or personnel at the PPECC;
- Requires ongoing and frequent skilled interventions to maintain or ameliorate health status, and delayed skilled intervention is expected to result in:
  - Deterioration of a chronic condition;
  - Loss of function;
  - Imminent risk to health status due to medical fragility; or
  - Risk of death.
- Has a physician's order prescribing PPECC services signed and dated by an ordering physician who has personally examined the client in person within 30 calendar days prior to admission and reviewed all appropriate medical records;
- The physician may waive the examination when:
  - A diagnosis has already been established by the physician;
  - The client is under the continuing care and medical supervision of the physician; and
  - The physician has stated in writing that an examination of the client 30 calendar days prior to admission is not medically necessary.
- If a physician waives an examination, the physician must examine the client in person within 365 calendar days after the date of the client's last examination and the physician and PPECC must maintain documentation of the waived examination in the client's medical record
- Has consent for the client's admission to the PPECC signed and dated by the client or the client's responsible adult. Admission must be voluntary and based on the preference for PPECC services in place of PDN by the client or client's responsible adult in both managed care and non-managed care service delivery systems.

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- Resides with the responsible adult and does not reside in any 24-hour inpatient facility, including the following:
  - General acute hospital
  - Skilled nursing facility
  - Intermediate care facility
  - Special care facility, including sub-acute units or facilities for the treatment of AIDS.

The PPECC will hold interdisciplinary conferences when PPECC services are initiated, recertified, or revised, and at least every 90 calendar days. Interdisciplinary conferences should include the client's responsible adult and the following, as applicable:

- The client's Department of Family and Protective Services case worker
- The client's therapy provider(s)
- Hospice provider

Note: *For clients who receive their PPECC services through a Medicaid managed care organization (MCO), the MCO service coordinator and/or service manager should be included in interdisciplinary conferences.*

When the sole purpose of PPECC services is to train and educate the client's responsible adult or the client (e.g., how to administer total parenteral nutrition (TPN) or how to manage a chronic condition), PPECC services will not be approved.

Training in a home setting for certain services such as how to administer TPN may be considered through intermittent HHSN visits.

Refer to: The *Home Health Nursing and Private Duty Nursing Services Handbook* (*Vol. 2, Provider Handbooks*) for more details on training and education for the client or the client's responsible adult on TPN administration in a home setting.

2.15.1.1.1 Initial Authorization Requests

Initial requests may be prior authorized for a maximum of 90 calendar days. Requests for the prior authorization, including all required documentation, must be submitted to the claims administrator by electronic portal, fax, or mail no later than 3 business days following the start of care (SOC). Requests received after the 3 business day period allowed will be denied for dates of service (DOS) that occurred before the date the request is received.

When PPECC services are authorized, the authorized period begins on the day of the week that prior authorization starts. For example, if service hours are authorized on a weekly basis, the period would begin from the day of the week the prior authorization period begins and continue for 7 calendar days. PPECC services may be authorized based on the client's individual needs. Services may be authorized as hours per day, hours per week or days per week.

Consistent with PPECC licensure requirements, an initial comprehensive nursing assessment must be completed, signed, and dated by the PPECC RN no earlier than 3 business days before the SOC at the PPECC and no later than the day the client is admitted to the center. The initial comprehensive nursing assessment must be performed by a PPECC RN and cannot be delegated. The initial comprehensive nursing assessment is used to establish the POC and must support medical necessity for the client to receive ongoing skilled nursing care. The comprehensive nursing assessment must include the elements outlined in the "Documentation Requirements" section.

Note: *The PPECC provider may be asked to submit additional documentation to support medical necessity as defined in this section.*

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A written order prescribing PPECC services signed and dated by the client's ordering physician must be in place by the SOC. The physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.

Initial prior authorization requests for PPECC services must include all the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the ordering physician.
- A completed Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form signed and dated by the ordering physician, and the PPECC RN completing the POC. A PPECC may also submit the POC on their own form, but the POC must contain all required elements listed in the "Documentation Requirements" section. A written or verbal physician approval of the POC from the ordering physician must be in place by the SOC. If the PPECC has a verbal approval of the POC at the time the prior authorization request is submitted, the dated documentation of this POC verbal approval must be submitted with the POC, followed by the physician-signed and dated POC within 14 calendar days from the receipt of the authorization request by the claims administrator.

  Note: *For authorization purposes only, a physician signature on the PPECC POC serves as the physician order. However, the physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.*

- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form, as detailed in the "Documentation Requirements" section, signed, and dated by the ordering physician, RN completing the comprehensive nursing assessment, and client or client's responsible adult.
- Signed and dated consent of the client or client's responsible adult documenting their choice for PPECC services. The signed consent must include an acknowledgment by the client or the client's responsible adult that they have been informed that their PDN service hours might be reduced as a result of accepting PPECC services. Signed and dated consent to share the client's personal health information with the client's other providers to ensure coordination of care must also be obtained.

  Note: *A client or client's responsible adult signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form meets the client consent requirements.*

The ordering physician, PPECC RN, and client or client responsible adult signatures on the initial prior authorization request forms must be current. Current is defined as signed and dated within the 30 calendar day period before the SOC. Prior authorization request forms received with signatures dated after the SOC will be denied for DOS prior to the latest signed and dated documentation.

Note: *The client or client's responsible adult signature is not required on the CCP Prior Authorization Request form or the PPECC Plan of Care form.*

When initial prior authorization requests are submitted with a verbal approval of the POC, to be current, the ordering physician's dated signature on the POC must be within the fourteen (14) calendar day period following the receipt of the authorization request by the claims administrator. If the POC is not received with a dated physician signature within fourteen (14) calendar days of the receipt of the authorization request by the claims administrator, the prior authorization will be considered incomplete and will be denied.

When initial prior authorization requests are submitted with a verbal approval of the POC, all other required documentation forms must still be signed and dated within the 30 calendar day period before the SOC. If the other required documentation forms are received with dated signatures after the SOC, DOS prior to the latest signed and dated documentation will be denied.

Requests for authorizations of PPECC services should always be commensurate with the client's medical needs.

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The length of the authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and client or client's responsible adult. PPECC services will not be authorized for more than 90 calendar days from the SOC for an initial authorization.

Note: *Clients enrolled in a Medicaid managed care health plan may receive services from a PPECC. Authorization must be received from the health plan.*

2.15.1.1.2 Recertification

A recertification is a new authorization period that may be approved for up to a maximum of 180 calendar days when the client meets medical necessity criteria. Recertification requests may be submitted by electronic portal, fax, or mail. The client or the client's responsible adult, physician, and PPECC provider must agree in writing that the recertification is appropriate each certification period.

An updated comprehensive nursing assessment as outlined in the "Documentation Requirements" section must be performed by the PPECC RN no more than 30 calendar days before the current authorization period expires. If there is no change in the client's condition, the POC must document medical necessity to support continued PPECC services.

A recertification request must be submitted to the claims administrator no more than 30 calendar days before a current authorization period will expire. Requests received after the current authorization period expires will be denied for DOS that occurred before the date the request is received.

A written order prescribing PPECC services signed and dated by the client's ordering physician must be in place by the recertification SOC. The physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.

Recertification prior authorization requests for PPECC services must include all the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the ordering physician within 30 calendar days prior to the recertification SOC date.
- A completed Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form signed and dated by the ordering physician and the PPECC RN who completed the POC within 30 calendar days prior to the recertification SOC date. A PPECC may also submit the POC on their own form, but the POC must contain all required elements listed in the "Documentation Requirements" section.
    - The PPECC provider is responsible for ensuring that the ordering physician reviews and signs the POC within 30 calendar days prior to the expiration of the authorization period and this documentation must be maintained in the client's record.

    Note: *For authorization purposes only, a physician signature on the PPECC POC serves as the physician order. However, the physician order as detailed in the "Documentation Requirements" section must be maintained in the client's record.*
- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form, as detailed in the "Documentation Requirements" section, signed and dated by the ordering physician, RN who completed the comprehensive nursing assessment, and client or client's responsible adult within 30 calendar days prior to the recertification SOC date.

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- Signed and dated consent of the client or client's responsible adult documenting their choice for PPECC services. The signed consent must include an acknowledgment by the client or the client's responsible adult that they have been informed that their PDN service hours might be reduced as a result of accepting PPECC services. Signed and dated consent to share the client's personal health information with the client's other providers to ensure coordination of care must also be obtained.

  Note: *A client or client's responsible adult signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form meets the client consent requirements.*

The PPECC provider may request a revision of a recertification at any time during the recertification period. Revisions must follow the instructions outlined in "Revisions to the Plan of Care" in this section. The PPECC provider must notify the claims administrator and the client's ordering physician at any time during a recertification period if the client's condition changes, the authorized services are not commensurate with the client's medical needs, and the client requires additional hours of ongoing skilled nursing services. The submission of a revision authorization request with physician signatures on required documentation meets the notification requirement.

2.15.1.1.3 Revisions to the Plan of Care

The PPECC provider may request a revision to the POC at any time during an authorization period. Requests for changes in the service hours during a current authorization period should be submitted if there is a change in the client's condition, or the authorized services are not commensurate with the client's medical needs and additional authorized hours are medically necessary.

Revisions during a current authorization period must fall within that authorization period. If the revision is requested beyond the existing authorization period, the provider must request a recertification authorization and submit all required documentation for a recertification.

Note: *Schedule changes that do not affect overall authorized ongoing skilled nursing hours do not require a revision authorization request, but must be documented in the client's medical record.*

Requests for revisions must be submitted to the claims administrator as soon as the PPECC identifies the need for a revision. Revision requests may be submitted by electronic portal, fax, or mail.

Requests for revisions must be submitted within 3 business days of the revised SOC date. Requests received after the 3 business days will be denied for DOS that occurred before the request is received.

When a client's condition changes during the course of the authorization period that impacts the amount or duration of services, an updated comprehensive nursing assessment, as outlined in the "Documentation Requirements" section, performed by a PPECC RN is required. An updated comprehensive nursing assessment is not necessary if there is not a change in the client's condition.

The PPECC provider must notify the claims administrator and the client's ordering physician at any time during an authorization period if the client's condition changes, the authorized services are not commensurate with the client's medical needs, and the client requires additional hours of ongoing skilled nursing services. Submission of a revision authorization request, with physician signatures on required documentation, meets the notification requirement.

A written or verbal order prescribing PPECC services from the ordering physician must be in place by the revised SOC. If the PPECC obtains a verbal order from the ordering physician, the PPECC must maintain dated documentation of this verbal order in the client's medical record, and the PPECC must obtain a written, signed, and dated order within the fourteen (14) calendar day period following the receipt of the verbal order. The physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.

Revision prior authorization requests for PPECC services must include all the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the ordering physician.

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- An updated Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form signed and dated by the ordering physician and the PPECC RN who completed the POC. A PPECC may also submit the POC on their own form, but the POC must contain all required elements listed in the "Documentation Requirements" section. A written or verbal physician approval of the POC from the ordering physician must be in place by the revised SOC. If the PPECC has a verbal approval of the POC at the time the prior authorization request is submitted, the dated documentation of this POC verbal approval must be submitted with the POC, followed by the physician signed and dated POC within 14 calendar days from the receipt of the authorization request by the claims administrator.

  Note: *For authorization purposes only, a physician signature on the PPECC POC serves as the physician order. However, the physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.*

- An updated Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form, as detailed in the "Documentation Requirements" section, signed and dated by the ordering physician, RN who completed the comprehensive nursing assessment, and client or client's responsible adult.
- Signed and dated consent of the client or client's responsible adult documenting their choice for PPECC services. The signed consent must include an acknowledgment by the client or the client's responsible adult that they have been informed that their PDN service hours might be reduced as a result of accepting PPECC services. Signed and dated consent to share the client's personal health information with the client's other providers to ensure coordination of care must also be obtained.

  Note: *A client or client's responsible adult signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form meets the client consent requirements.*

- The ordering physician, PPECC RN, and client or client responsible adult signatures on the revision prior authorization request forms must be current. Current is defined as signed and dated within the 30 calendar day period before the revised SOC. Revision prior authorization request forms received with signatures dated after the revised SOC will be denied for DOS prior to the latest signed and dated documentation.
- When revision prior authorization requests are submitted with a verbal approval of the POC, to be current, the ordering physician's dated signature on the POC must be within the fourteen (14) calendar day period following the receipt of the authorization request by the claims administrator. If the POC is not received with a dated physician signature within fourteen (14) calendar days of the receipt of the authorization request by the claims administrator, the prior authorization will be considered incomplete and will be denied.
- When revision prior authorization requests are submitted with a verbal approval of the POC, all other required documentation forms must still be signed and dated within the 30 calendar day period before the revised SOC. If the other required documentation forms are received with dated signatures after the revised SOC, DOS prior to the latest signed and dated documentation will be denied.

2.15.1.1.4 Coordination with Private Duty Nursing (PDN)

When a client or client's physician notifies the PPECC that the client also receives PDN from a Medicaid-enrolled PDN provider, the PPECC must coordinate services with the PDN provider. Both PDN and PPECC services are considered ongoing skilled nursing. A client has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing where PPECC services are available. Skilled nursing services are authorized for a set number of hours based on the client's medical necessity at the time of the prior authorization request. Skilled nursing hours are not expected to

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increase when the client utilizes a combination of both PPECC and PDN services, unless there is a documented change in medical condition, or the authorized hours are not commensurate to the client's medical needs and additional hours are medically necessary.

PPECC and PDN providers must collaborate in developing their respective 24-hour flow charts found in the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers each time a client's authorization for ongoing skilled nursing is initiated, recertified, and revised.

Both providers must maintain documentation that the client or the client's responsible adult has participated in the development of the POC (e.g., the completed PPECC POC and Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers, with the client's or client's responsible adult's signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers.)

Both providers must discuss with the client or the client's responsible adult how care will be coordinated between the two providers.

When a new service is initiated for ongoing skilled nursing services, and the client wants to receive both PDN and PPECC services, the claims administrator will compare the Nursing Addendum's 24-hour daily care flow sheets and medical necessity documentation (e.g., authorization requests). Upon subsequent approval of PDN or PPECC services, the provider who submitted the initial prior authorization request that established the number of authorized skilled nursing hours will have their authorized hours reduced to prevent duplication. (E.g., if the client currently has PDN, and then adds PPECC services, the PDN hours will be reduced.)

When hours are reduced, the PDN or PPECC provider affected by the reduction will be notified by the claims administrator when the reduction is effective, and the revised amount of authorized hours. A revision request from the provider affected by the reduction, with documentation of medical necessity is required only if there is a change in the client's medical condition or the client's medical needs are not commensurate with authorized hours and additional ongoing skilled nursing hours are medically necessary. No action is required from the provider affected by the reduction if additional hours are not medically necessary.

2.15.1.1.5 Client Receives both PPECC and PDN Services and Shifts Services from One to the Other

A client receiving both PPECC and PDN services may choose to shift approved hours from one ongoing skilled nursing provider to another.

The receiving provider (PPECC or PDN provider who will gain hours in the shift) must submit all required documentation for a revision.

The sending provider (PPECC or PDN provider who will lose hours in the shift) will receive a notice from the claims administrator with revised (decreased) hours and the effective date of the reduction. The sending provider does not need to take any action unless there is a change in the client's medical condition, or the authorized hours are not commensurate with the client's medical needs, and additional ongoing skilled nursing hours are medically necessary. If there is a medical need for additional ongoing skilled nursing hours, the sending provider may submit a revision request.

The total combined hours between PPECC and PDN services are not expected to increase without client medical necessity for additional hours (e.g., change in client condition or authorized hours are not commensurate with the client's medical needs).

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2.15.1.1.6 PPECC Provider Change During an Existing Authorization Period

If a provider or client discontinues PPECC services during an existing prior authorized period and the client requests services through a new PPECC provider, the new PPECC provider must follow all of the processes and submit documentation required for an initial request, as well as the following:

A change of provider letter signed and dated by the client or the client's responsible adult documenting the date the client ended PPECC services (effective date of the change) with the previous provider, the names of the previous and new providers, and an explanation of why providers were changed.

When the new provider submits an authorization request, including all required documentation for an initial request, it will be authorized for no more than 90 calendar days regardless of the number of provider changes a client chooses to make.

2.15.1.1.7 Termination of Authorizations

Authorization for PPECC services will be terminated when:

- The client is no longer eligible for THSteps-CCP.
- The client no longer meets the medical necessity criteria for PPECC services.
- The place of service cannot ensure the health and safety of the client.
- The client or the client's responsible adult refuses to comply with the service plan and compliance is necessary to assure the health and safety of the client.
- The client changes providers, and the change of notification is submitted to the claims administrator in writing with a prior authorization request from the new provider.
- After receiving PPECC services, the client opts to decline PPECC services and receive their services at home. The home health agency or independent provider offering ongoing skilled nursing (e.g., PDN) must submit or update all required authorization documentation to the claims administrator.

2.15.1.1.8 Appeal of Authorization Decisions

Providers may appeal denials or modifications of requested PPECC services with documentation to support the medical necessity of the requested PPECC services.

Appeals must be submitted to the claims administrator's CCP department with complete documentation and any additional information within two weeks of the date on the decision letter. If changes are made to the authorization based on this documentation, CCP claims administrators will go back no more than three (3) business days for initial, or revision requests; and no more than 7 calendar days for recertification requests.

The client or the client's responsible adult will be notified of any denial or modification of requested services and will be given information about how to appeal the claims administrator's decision or request a fair hearing.

PPECC services may be denied when:

- The client does not meet medical necessity criteria for admission.
- The client does not have an ordering physician.
- The client is 21 years of age or older.
- The client's needs are not beyond the scope of services available through Texas Medicaid HHSN and/or HHA services because the needs can be met on a part-time or intermittent basis through a visiting nurse.
- The services are primarily intended to provide respite care or child care.
- The services are provided for the sole purpose of responsible adult training.

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- The prior authorization request is submitted with documentation of a verbal physician approval of the POC, and the physician signed and dated POC is not received by the claims administrator within 14 calendar days of the receipt of the authorization request by the claims administrator.
- The prior authorization request is submitted late.
- The request is incomplete.
- The information in the request is inconsistent.
- The requested services are not ongoing skilled nursing services.
- There is a duplication of services.

Appeals to prior authorization requests must be submitted for processing to the Claims Administrator Prior Authorization Department (fee-for-service clients).

Note: *Clients enrolled in a Medicaid managed care health plan may receive services from a PPECC. Prior authorization requests for these clients must be submitted solely to the client's MCO.*

2.15.1.1.9 Documentation Requirements

In addition to the requirements outlined in the "Prior Authorization and Documentation Requirements" section, the following documentation requirements apply. Services not supported by documentation are subject to recoupment.

All services and documentation outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

PPECCs must maintain documentation in the client's medical record, including but not limited to the following:

- Written orders from the ordering physician that prescribe PPECC services. If the PPECC obtains a verbal order for a revision request from the ordering physician, dated documentation of this verbal order must also be maintained in the client's medical record. The physician's order must include the following:
  - Client's name, date of birth, gender, and Medicaid number
  - Provider name, NPI, address, and phone number
  - Date the client was last seen by the physician
  - Description of current medical diagnosis or condition
  - Nursing services
  - Medication administration, if applicable
  - Dietary needs, if applicable
  - Permitted activities, if applicable
  - Therapies, if applicable
  - Determination of whether the client is stable enough to receive PPECC transportation services and, if the client is determined to be stable, the provider type that must be on board: RN, LVN, or direct care staff, if applicable.
  - Other services, if applicable
  - Approval of the client's admission to the PPECC
- A completed CCP Prior Authorization Request form signed and dated by the ordering physician.

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- A completed PPECC Plan of Care form must be signed and dated by the ordering physician and the PPECC RN completing the POC. If the PPECC obtains verbal approval of the POC from the ordering physician, the PPECC must maintain dated documentation of this verbal approval of the POC in the client's medical record. The POC using either the PPECC POC form or a PPECC-developed form, must include the following components:
  - The client's name, date of birth, and Medicaid number
  - The PPECC's name, National Provider Identifier (NPI), taxonomy, address, hours of operation, phone number, and fax number
  - The ordering physician's name, NPI and phone number
  - The PDN provider's name, NPI, address, phone number and fax number, if applicable
  - Date the client was last seen by the ordering physician
  - Date the PPECC comprehensive nursing assessment was completed and the name, title, and credentials of the RN who completed the comprehensive nursing assessment
  - The requested SOC date and requested end date for PPECC services
  - The client's scheduled days and hours of attendance for PPECC services
  - List of services the client receives in the home and school settings. [e.g., ECI, therapies, School Health and Related Services (SHARS), PCS, PDN, therapies, HHSN, HHA, case management services, hospice, and Medicaid waiver programs such as Medically Dependent Children's Program (MDCP), Home and Community-Based Services (HCS), Deaf-Blind Multiples Disabilities (DBMD), Texas Home Living (TxHL), and Community Living Assistance and Support Services (CLASS)]

    Note: *Services provided under these programs will not prevent a client from obtaining medically necessary services.*
  - All pertinent diagnoses and known allergies
  - Nursing services to be provided, including amount, duration, and frequency
  - The client's prognosis
  - The client's mental status
  - Rehabilitation potential
  - The equipment and/or supplies required
  - Therapies (occupational, physical, speech, and respiratory care), including how those therapies are accessed, amount, duration, and frequency. Therapies provided in the PPECC, as well as outside the PPECC (e.g., school based), must be documented.
  - Nutritional requirements, including type, method of administration, and frequency
  - Medications, including the dose, route, and frequency and any medication-related allergies if known
  - Treatments, including amount and frequency
  - Wound care orders and measurements
  - Safety measures to protect against injury
  - Prior and current functional or medical limitations
  - Permitted activities

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- Functional developmental services and psychosocial services, including amount, duration, and frequency
- Other prescribed services, including amount, duration, and frequency
- The determination from the client's ordering physician whether the client is stable to receive PPECC transportation. The description of the type of provider-RN, LVN, or direct care staff-who must be present on board the PPECC vehicle to assist the client if the client is determined stable.
- Responsible adult training needs
- Name and phone number of the responsible adult when the client is a minor
- Client's emergency contact name and phone number
- Confirmation that a signed contingency plan is in place in circumstances when PPECC services are not available (e.g., fire, flood, windstorm, or electrical malfunctions) and for emergencies that occur while the client is in the care of the PPECC
- Confirmation of a discharge plan, including instructions for timely discharge or referral
- RN who completed the POC signature and date of signature
- Ordering physician signature and date of signature

- The PPECC comprehensive nursing assessment. The comprehensive nursing assessment must be performed by a PPECC RN and cannot be delegated. The comprehensive nursing assessment must include:
  - Complexity and intensity of the client's care
  - Stability and predictability of the client's condition
  - Frequency of the client's need for skilled nursing services
  - Identified medical, nursing, psychosocial, therapeutic, nutritional, dietary, functional, educational, and developmental needs and goals, and any training needs for the client or the client's responsible adult
  - Description of wounds, if present
  - The client's equipment needs and whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client
  - The comprehension level of the client's responsible adult; and
  - Receptivity to training and ability level of the responsible adult
- The completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the ordering physician, RN who completed the comprehensive nursing assessment, and the client or client's responsible adult. The Nursing Addendum form must include the following components:
  - The client's name and Medicaid number
  - The requested SOC date and requested end date for PPECC services
  - A nursing care plan summary, including a current problem list
  - A current summary and rationale page
  - A 24-hour daily care flow sheet

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- An acknowledgments page that includes the signed and dated signature of the client or the client's responsible adult, the RN who completed the POC, and the ordering physician

Note: *For further details on completing PPECC prior authorization forms, refer to the Instructions for Completing Prescribed Pediatric Extended Care Center Prior Authorization Forms.*

- The signed and dated consent of the client or the client's responsible adult documenting:
  - The client or client's responsible adult choice for PPECC services.
  - Acknowledgment that the client or client's responsible adult have been informed that their PDN service hours might be reduced as a result of accepting PPECC services.
  - Consent to share the client's personal health information with the client's other providers to ensure coordination of care.
  - The client or the client's responsible adult has been informed about how care will be coordinated between the client's providers.
  - The client or the client's responsible adult has been involved in the development of the POC.

Note: *A client or client's responsible adult signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers meets the client consent requirements.*

- Confirmation of PDN provider notification, including the date the notification was provided when a client is receiving PDN services.
- Notes from interdisciplinary team meetings.
- Documentation of all discrepancies between the weekly service hours scheduled and the service hours provided. Examples include but are not limited to, doctor's appointments; the PPECC was closed one day for unforeseen reasons; the client was hospitalized; or the client's responsible adult was ill and could not provide services that they would normally provide.
- For each day that PPECC services are provided, the PPECC must maintain the following documentation:
  - A daily attendance log that includes:
    - The date of attendance.
    - The name of the client.
    - The signature of the responsible adult and the time when the PPECC assumes responsibility for the care of the client, which is the time the client boards the PPECC transport vehicle or the time the client is brought to the PPECC by a responsible adult.
    - The signature of the responsible adult and the time when the responsible adult assumes responsibility for the care of the client, which is the time the client is taken off the PPECC transport vehicle at their return destination or the time the client is picked up from the PPECC by a responsible adult.
    - The name of the PPECC staff member riding in the PPECC transport vehicle when PPECC transportation services are used and whether the staff member is an RN, LVN, or direct care staff.
    - The name of the specific person or persons (e.g., nursing, direct care staff, therapist) providing services,
    - Date of service,
    - Type of services performed, and
    - The start and end times of services performed.

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- When a PPECC provides transportation for a PPECC client, an RN, LVN, or direct care staff, as determined by the client's ordering physician in collaboration with the PPECC, must be on board the PPECC transport vehicle to assist the client during transportation. The PPECC must ensure that the driver and the RN, LVN, or direct care staff member on board the PPECC transport vehicle maintain a daily transportation log that must include:
  - The driver's name.
  - The name of the PPECC staff member and whether the staff member is an RN, LVN, or direct care staff member.
  - The date of service.
  - The name of the client.
  - The time that the client is put on the transport vehicle to deliver the client to the PPECC.
  - The time that the client arrives at the PPECC.
  - The time that the client is put on the transport vehicle to return to their responsible adult or authorized adult.
  - The time that the client arrives at their return destination and the name of the person to whom the client was released.
  - The reason that the transport time was longer than one hour for a client who is in transport longer than one hour traveling to the PPECC or longer than one hour traveling to their return destination.

To complete a prior authorization process by paper, the provider must complete and submit the prior authorization documentation through fax or mail and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the PPECC's place of business.

To complete a prior authorization process electronically, the provider must complete and submit the prior authorization documentation through any approved electronic method, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the PPECC's place of business.

The PPECC provider may use any reliable method to record times, dates, and signatures provided that it is accurate and allows for an auditable review of the records, including electronic census, time-stamp, scanning, and signature records.

The PPECC provider must keep these records in case of an audit or monitoring.

The PPECC must coordinate the following with the client or the client's responsible adult:

- The client's transportation schedule
- The pick-up and drop-off locations (such as home or school)
- The authorized persons to whom the client may be released

A responsible adult must be provided daily a written, one-page summary of services provided to the client for each day that the client is in the PPECC's care.

The PPECC must maintain documentation in the client's medical record of the notification provided to the client or the client's responsible adult of an intent to transfer or discharge the client as follows:

- A copy of the written notification provided
- Personal contact with the client or the client's responsible adult
- Notification to the provider of the date of transfer or discharge.

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PPECC service providers must provide written notice to clients of their intent to voluntarily terminate PPECC services at least fifteen (15) calendar days prior to terminating services, except in situations of a potential threat to the provider's personal safety.

The PPECC and the therapy provider must have a written agreement regarding the provision of therapy services when therapy services (occupational, speech, physical, and respiratory care) are provided at the PPECC. The written agreement must address the responsibilities of both parties and how the parties will coordinate related to the client's POC.

The PPECC and hospice provider must have a written agreement for each client regarding the provision of hospice services when hospice is provided at the PPECC. The written agreement must address the responsibilities of both parties and how the parties will coordinate related to the client's POC. The written agreement must be kept in the client's medical record.

The ordering physician must also maintain a copy of the signed and dated physician order and signed and dated POC in the client's medical record.

2.15.1.1.10 Exclusions

The services that are not covered by the PPECC benefit include the following:

- Baby food or formula.
- PPECC services to clients related to the PPECC owner by blood, marriage or adoption.
- Services that are intended to provide mainly respite care or child care and do not directly relate to the client's medical needs or disability.
- PPECC services rendered to a client who does not meet the definition of a medically or technologically dependent minor.
- Services covered separately by Texas Medicaid, such as:
- Speech, occupational, physical, respiratory therapy services, and ECI services.
- Durable medical equipment (DME), medical supplies, nutritional products provided to the client by Medicaid's DME and medical supply service providers.
- PDN, HHSN, and HHA services provided in the home setting when medically needed in addition to the PPECC services authorized.
- Services that are the legal responsibility of a local school district.
- Individualized comprehensive case management beyond required service coordination.

2.15.1.1.11 Claims Filing and Reimbursement

PPECC services may be reimbursed when billed with procedure codes T1025, T1026, or T2002.

Services begin when the PPECC assumes responsibility for the care of the client (i.e., the point the client boards the PPECC transportation, or when the client is brought to the PPECC by a responsible adult) and ends when the care is relinquished to the client's responsible adult.

Providers must use appropriate procedure codes for the PPECC services performed. Procedure codes T1025 and T2002 are limited to once per day.

The PPECC per diem procedure code (T1025) and hourly procedure code (T1026) may not be billed on the same day.

Procedure code T1026 is allowed on an hourly basis, up to four hours. Services beyond four hours must be billed using procedure code T1025. At a minimum, four hours and fifteen minutes of services must be provided before procedure code T1025 may be billed.

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For procedure code T1026, a minimum of 15 minutes of service is required to round up to a full hour after the first hour.

Procedure code T2002 is not allowed without a PPECC service on the same day, same provider.

PPECC per diem procedure code T1025 and hourly procedure code T1026 may be billed without nonemergency transportation procedure code T2002 on the same date of service.

Therapy services are billed separately by Medicaid-enrolled licensed therapists, including ECI providers, and are subject to prior authorization and policies governing Physical, Occupational, and Speech Therapy - Children (Acute and Chronic), or ECI services, as applicable.

If hospice services are rendered in a PPECC setting, they must be billed separately by Medicaid-enrolled hospice providers, and are subject to prior authorization and policies governing hospice reimbursement.

The following services may be billed on the same day as PPECC services, but they may not be billed simultaneously with PPECC services. These services may be billed before or after PPECC services:

- Private Duty Nursing
- Home Health Skilled Nursing
- Home Health Aide services
- Personal Care Services

PCS services provided in a PPECC are considered part of the PPECC billable rate.

PPECC services may be reimbursed only to a licensed PPECC.

Note: *Texas Medicaid will not reimburse PPECC services that duplicate services that are the legal responsibility of the school districts. The school district, through the SHARS program, is required to meet the client's skilled nursing needs while the client is at school. However, if those needs cannot be met by SHARS or the school district, documentation supporting medical necessity may be submitted to the claims administrator.*

Parental accompaniment is not required for PPECC reimbursement.

Non-emergency ambulance service providers will not be reimbursed for transportation to and from a PPECC.

PPECC services are subject to retrospective review and possible recoupment when the medical record does not document the provision of PPECC services is medically necessary based on the client's medical needs at the time PPECC services were rendered. The PPECC provider must explain all discrepancies between the service hours approved and the service hours provided. For example: The parents withdrew their client from a PPECC and released the provider from all responsibility for the service hours; the PPECC was closed one day for unforeseen reasons; the client was hospitalized; or the responsible adult was ill and could not provide services that he or she would normally provide.

Payment will not be rendered for services that are not prior authorized.

2.16 Therapy Services (CCP)

Refer to: Section 5, "Children's Therapy Services Clients birth through 20 years of age" for information about CCP therapy services.

2.17 Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP)

Inpatient psychiatric treatment in a nationally accredited freestanding psychiatric facility or a nationally accredited state psychiatric hospital is a benefit of Texas Medicaid for clients who are birth through 20 years of age at the time of the service request and service delivery, if the client meets certain conditions.

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Refer to: Subsection 3.4, "Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

2.18 Inpatient Rehabilitation Facility (Freestanding) (CCP)

2.18.1 Enrollment

Note: *Rehabilitation provided at an acute care facility is covered through Texas Medicaid fee-for-service.*

To be eligible to participate in CCP, a freestanding inpatient rehabilitation facility must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Texas Medicaid enrolls and reimburses freestanding inpatient rehabilitation facilities for CCP services and Medicare deductibles or coinsurance according to current payment guidelines. The information in this section is applicable to CCP services only.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.18.1.1 Continuity of Hospital Eligibility Through Change of Ownership

Under procedures set forth by the CMS and HHSC, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

- The provider must obtain recertification as a Title XVIII (Medicare) hospital.
- The hospital under new ownership must submit a new signed and dated HHSC Medicaid Provider Agreement between the hospital and HHSC.

Providers can access the HHSC Medicaid Provider Agreement through the Provider Enrollment and Management System (PEMS).

2.18.2 Services, Benefits, and Limitations

Inpatient rehabilitation services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Inpatient rehabilitation services will be considered for an acute problem or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services. A condition is considered to be acute or an acute exacerbation of a chronic condition only during the six months from the onset date of the acute condition or the acute exacerbation of the chronic condition.

When a client is admitted to an inpatient facility for acute care physical, occupational, or speech therapy services, the therapy services are reimbursed as part of the inpatient hospital reimbursement methodology (Diagnosis- Related Group [DRG] or Tax Equity and Fiscal Responsibility Act [TEFRA]) and not reimbursed separately to the individual therapist. The hospital must include the physician's written treatment plan that supports the medical necessity of the hospitalization and services.

2.18.2.1 Comprehensive Treatment

The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.

Comprehensive rehabilitation treatment must be under the leadership of a physician. Comprehensive rehabilitation treatment must be an active interdisciplinary team, defined as at least two types of therapies.

Comprehensive treatment must consist of at least two appropriate physical modalities designed to resolve or improve the client's condition (OT, PT, and ST), and must be provided for a minimum of three hours per day for five days per week.

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2.18.3 Prior Authorization and Documentation Requirements

All inpatient rehabilitation services provided to clients who are birth through 20 years of age in a freestanding inpatient rehabilitation facility require prior authorization.

Prior authorization will be considered when the client has met all of the following criteria:

- The client has an acute problem or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services.
- The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.
- The client requires and will receive multidisciplinary team care defined as at least two therapies (OT, PT, or ST).
- This therapy will be provided for a minimum of three hours per day, five days per week.

The physician and the provider must maintain all documentation in the client's medical record.

Inpatient rehabilitation may be prior authorized for up to two months when the attending physician submits documentation of medical necessity. The treatment plan must indicate that the client is expected to improve within a 60-day period and be restored to a more functional lifestyle for an acute condition or the previous level of function for an acute exacerbation of a chronic condition.

Requests for subsequent services for increments up to 60 days may be prior authorized based on medical necessity. Requests for prior authorization of subsequent services must be received before the end-date of the preceding prior authorization.

A prior authorization request for an additional 60 days of therapy will be considered with documentation supporting medical necessity.

Supporting documentation for an initial request must include the following:

- The request for inpatient rehabilitation and the treatment plan must be signed and dated by the physician. The physician's signature is valid for no more than 60 days prior to the requested start of care date.
- A CCP Prior Authorization Request Form signed and dated by the physician.
- A current therapy evaluation with the documented age of the client at the time of evaluation.
- Therapy goals related to the client's individual needs; goals may include improving or maintaining function, or slowing of deterioration of function.
- An updated written comprehensive treatment plan established by the attending physician or by the therapist to be followed during the inpatient rehabilitation admission that:
    - Is under the leadership of a physician and includes a description of the specific therapy being prescribed, diagnosis, treatment goals related to the client's individual needs, and duration and frequency of therapy.
    - Includes the date of onset of the illness or injury requiring the freestanding inpatient rehabilitation facility admission.
    - Includes the requested dates of service.
    - Incorporates an active interdisciplinary team.
    - Consists of at least two appropriate physical modalities (OT, PT, and ST) designed to resolve or improve the client's condition.
    - Includes a minimum of three hours of team interaction with the client every day, five days per week.

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- In addition to the documentation for an initial request, supporting documentation for a request for subsequent services must include the following:
  - A brief synopsis of the outcomes of the previous treatment relative to the debilitating condition.
  - The expected results to be achieved by an extension of the active treatment plan, and the time interval at which this extension outcome should be achieved.
  - Discussion why the initial two months of inpatient rehabilitation has not met the client's needs and why the client cannot be treated in an outpatient setting.

After receiving the documentation establishing the medical necessity and plan of medical care by the treating physician, prior authorization is considered by CCP for the initial service and an extension of service as applicable. A request for prior authorization must include documentation from the provider to support the medical necessity of the service.

2.18.4 Claims Information

Providers must submit inpatient rehabilitation services to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form. Providers must purchase the UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

For OT, PT, and ST services, freestanding inpatient rehabilitation facilities and acute care hospitals can use revenue codes 128, 420, 424, 430, 434, 440, and 444.

TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims. Claims for services that have been prior authorized must reflect the PAN in Block 63 of the UB-04 CMS-1450 paper claim form or its electronic equivalent.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions.

Inpatient Rehabilitation Facility (Freestanding) (CCP Only) on the TMHP website at www.tmhp.com for a claim form example.

2.18.5 Reimbursement

Reimbursement for care provided in the freestanding inpatient rehabilitation facility is made under the Texas Diagnosis-Related Group (DRG) Payment System.

Refer to: Subsection 3.7.4.4.1, "Day Outliers" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for reimbursement information.

2.18.5.1 Client Transfers

When more than one hospital provides care for the same case, the hospital furnishing the most significant amount of care receives consideration for a full DRG payment.

The other hospital(s) is/are paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the R&S Report indicates per diem pricing related to a client transfer.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The facility must bill only one claim.

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After all hospital claims have been submitted, HHSC performs a post-payment review to determine whether the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

3 Texas Health Steps (THSteps) Dental

Medicaid dental services rules are described under Title 25 Texas Administrative Code (TAC) Part 1, Chapter 33. The online version of TAC is available at the Secretary of State's website at www.sos.state.tx.us/tac/index.shtml. All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including standards for documentation and record maintenance as stated in 22 TAC §108.7, *Minimum Standard of Care*, General, and §108.8, *Records of the Dentist*.

Dental providers must also comply with mandated record retention and patient counseling standards, as required by Texas Health and Safety Code, Section 431.024.

Note: *Exceptions to a board-eligible or board-certified orthodontist may be considered for clients in a rural or frontier area or where access to care is an issue.*

All dental providers must refer to the Current Dental Terminology (CDT) book for recording services provided and when reporting procedures on a paper or electronic claim submission form.

Note: *THSteps dental benefits are administered as Children's Medicaid Dental Services by dental managed care organizations for most Medicaid fee-for-service and managed care clients who are 20 years of age and younger.*

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) or to the HHSC website at www.hhs.texas.gov/services/health/medicaid-chip, for additional information about children's Medicaid dental Services.

Under the Early Periodic Screening Diagnostic, and Treatment (EPSDT) regulation, known in Texas as Texas Health Steps (THSteps), Section 1905(r) of the Social Security Act mandates that all Medicaid eligible beneficiaries who are birth through 20 years of age receive medically necessary services to treat, correct, and ameliorate illnesses and conditions identified if the service is covered in the state's Medicaid plan or is an optional Medicaid service. It is the responsibility of the state to determine medical necessity on a case-specific basis. No arbitrary limitations on services are allowed (e.g., one pair of eyeglasses or 10 therapy sessions per year) if determined to be medically necessary.

Services not covered under this section include:

- Experimental or investigational treatment.
- Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.
- Services for the caregiver or provider convenience.

All EPSDT requirements must be adhered to for beneficiaries who receive services under managed care arrangements.

3.1 Enrollment

To become a provider of THSteps or intermediate care facility for persons with intellectual disability (ICF-IID) dental services, a dentist must:

- Practice within the scope of the provider's professional licensure.

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- Complete the Dental Provider Enrollment Application through the Provider Enrollment and Management System (PEMS).

Dental providers are required to maintain an active license status with the TSBDE. TMHP receives a monthly automated board feed from TSBDE to update licensure information. If licensure cannot be verified with the automated board feed, it is the providers' responsibility to provide a copy of the active TSBDE license to TMHP. If TSBDE has a delay in processing license applications and renewals, the provider must request a letter from TSBDE for their individual provider information and send the letter of verification of current licensure to TMHP. The letter must contain the provider's specific identification information, license number, and licensure period.

If TMHP cannot verify a valid license at the time of enrollment, it is the providers' responsibility to provide a copy of the active TSBDE license to TMHP.

A dental provider cannot be enrolled if his or her dental license is due to expire within 30 days; a current license must be submitted. Dental licensure for owners of a dental practice is a requirement of the Occupations Code, Vernon's Texas Codes Annotated (VTCA), Subtitle D, Chapters 251-267 (the Texas Dental Practice Act).

All owners of a dental practice must maintain an active license status with the TSBDE to receive reimbursement from Texas Medicaid. Any change in ownership or licensure status for any enrolled dentist must be immediately reported in writing to TMHP Provider Enrollment and will affect reimbursement by Texas Medicaid.

The application form includes a written agreement with HHSC.

Dental providers may enroll in the THSteps Dental program and ICF-IID Dental Programs or as a Doctor of Dentistry Practicing as a Limited Physician, or both. The enrollment requirements are different with respect to the category of enrollment.

All dental providers must declare one or more of the following categories:

- General practice
- Pediatric dentist
- Periodontist
- Endodontist
- Oral and maxillofacial surgeon
- Orthodontist
- Other (prosthodontist, public health, and others)

Dentists (D.D.S., D.M.D.) who want to provide the three levels of orthodontic services must be enrolled as a dentist or orthodontist provider for THSteps and must have at least one of the following qualifications listed below for the relevant level of service.

THSteps dental providers may perform and be reimbursed for level I or level II orthodontic services if they have attested to at least one of the following requirements:

- Completion of a dental pediatric specialty residency or
- Completion of a minimum of 200 hours of continuing education in orthodontics within the last 10 years (8 hours can be online or self instruction) (Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services; however, documentation must be produced by the dentist during retrospective review.)

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Orthodontist providers may perform and be reimbursed for level I, level II, or level III orthodontic services and must be in compliance with the TSBDE rules and regulations. This designation can only be associated with dentists who are board-eligible or board-certified by an American Dental Association (ADA)-recognized orthodontic specialty board.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Dental residents may provide dental services in a teaching facility under the guidance of the attending staff/faculty member(s) as long as the facility's dental staff by-laws and standards by the Commission on Dental Accreditation (CODA) are met, and the attending dentist/faculty member has determined the resident to be competent to perform the dental services. THSteps does not require the supervising dentist to examine the client as long as these conditions are met.

In a clinic, an attending dentist/faculty member must be present in the dental clinic for consultation, supervision, and active teaching when residents are treating patients in scheduled clinic sessions. This does not preclude occasional situations where a faculty member cannot be available. A dentist must assume responsibility for the clinic's operation.

3.1.1 THSteps Dental Eligibility

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

- Began before the loss of Medicaid eligibility.
- Began before the day of the client's 21st birthday.
- Was completed within 36 months of the beginning date.

The client is not eligible for a THSteps medical checkup or THSteps dental benefits if the client's Your Texas Benefits Medicaid card or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C) states any of the following:

- Emergency
- Presumptive eligibility (PE)
- Qualified Medicare beneficiary (QMB)
- Healthy Texas Women (HTW) program

3.1.2 THSteps Dental and ICF-IID Dental Services

A provider may enroll as an individual dentist, a group practice, or both. Regardless of the category of practice designation under THSteps Dental, providers can only submit claims for THSteps and ICF-IID Dental Services.

Refer to: Subsection 3.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

3.1.3 THSteps Dental Checkup and Treatment Facilities

All THSteps dental checkup and treatment policies apply to examinations and treatment completed in a dentist's office, a health department, clinic setting, hospital operating room, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a dentist or clinic name. Mobile units can be a van or any temporary site away from the primary office and are considered extensions of that office and are not separate entities. The physical setting must be appropriate so that all elements of the checkup or treatment can be completed. The checkup must meet the requirements detailed in subsection D.5, "Parental Accompaniment" in this handbook. The provider with a mobile unit or who uses portable dental equipment must obtain a permit for the mobile unit from the TSBDE.

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3.1.4 Doctor of Dentistry Practicing as a Limited Physician

Dentists who serve clients and submit claims using medical (CPT) procedure codes, such as oral-maxillofacial surgeons, may enroll as a doctor of dentistry practicing as a limited physician. Providers may enroll as an individual dentist or as a dental group. To enroll as a doctor of dentistry practicing as a limited physician, a dentist must:

- Be currently licensed by the TSBDE or currently licensed in the state where the service was performed.
- Have a Medicare provider identification number before applying for Medicaid.
- Enroll as a limited physician.

3.1.5 Client Rights

Dental providers enrolled in Texas Medicaid enter into a written contract with HHSC to uphold the following rights of the Medicaid client:

- To receive dental services that meet or exceed the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- To receive information following a dental examination about the dental diagnosis; scope of proposed treatment, including alternatives and risks; anticipated results; and the need and risks for administration of sedation or anesthesia.
- To have full participation in the development of the treatment plan and the process of giving informed consent.
- To have freedom from physical, mental, emotional, sexual, or verbal abuse, or harm from the provider or staff.
- To have freedom from overly aggressive treatment in excess of that required to address documented medical necessity.

A provider's failure to ensure any of the client rights may result in termination of the provider agreement or contract and other civil or criminal remedies.

3.1.6 Complaints and Resolution

Complaints about dental services are typically received through the TMHP Contact Center, although a complaint is accepted from any source. A complaint is researched by TMHP and resolved or escalated as appropriate. Examples of complaints from clients about providers include:

- The provider did not consult with the client, explain what services were necessary, or obtain parent or guardian informed consent.
- The treating provider refused to make the child's record available to the new provider.
- The provider did not give the child the appropriate local anesthesia or pain medication.
- The provider did not use sterile procedures; the facility or equipment were not clean.
- The provider or his staff were verbally abusive.
- The client did not receive a service, but the provider submitted a claim to Texas Medicaid.
- The provider charged a Medicaid client for benefits covered by Medicaid.

3.2 Services, Benefits, Limitations, and Prior Authorization

3.2.1 THSteps Dental Services

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

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

THSteps' designated staff (DSHS, HHSC, or contractor), through outreach and informing, encourage eligible children to use THSteps dental checkups and services when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.

Children within Medicaid have free choice of Medicaid-enrolled providers and are given names of enrolled providers. A list of THSteps dental providers in a specific area can be obtained using the Online Provider Lookup on the TMHP website at www.tmhp.com, or by calling 1-877-847-8377.

Upon a provider's request, DSHS (or its contractor) will assist eligible children with the scheduling of free transportation to their dental appointment or clients can call the Medical Transportation Program at 1-877-633-8747.

Refer to: The *Medical Transportation Program Handbook* (*Vol. 2, Provider Handbooks*) for information about transportation arrangements.

3.2.1.1 Eligibility for THSteps Dental Services

A client is eligible for THSteps dental services from birth through 20 years of age. The eligibility period is determined by the client's age on the first of the month. If a client's birthday is not on the first of a month, the new eligibility period begins on the first day of the following month. When the client turns 21 years of age during a month, the client is eligible for THSteps dental non-CCP services through the end of that month.

A client is eligible for Comprehensive Care Program (CCP) dental services until their 21st birthday. The eligibility period ends on their 21st birthday and does not continue through the end of the month in which the birthday falls.

3.2.1.2 Parental Accompaniment

Clients who are 14 years of age and younger must be accompanied to Texas Health Steps dental checkups and visits by the client's parent, legal guardian, or another adult who is authorized by the parent or legal guardian. The authorized adult can be the client's relative. The individual accompanying the client must wait for the client while the appointment takes place. For additional information and exceptions, see "D.5 Parental Accompaniment" in this handbook.

3.2.2 Substitute Dentist

In accordance with TAC §§354.1121 and 354.1221, related to Medicaid billing for the services of substitute dentists, dentists who are temporarily absent from their practice are allowed to submit claims for reimbursement of Medicaid services rendered to their Medicaid clients by a substitute dentist.

Dentists may bill for the services of a substitute dentist pursuant to 42 CFR §447.10.

The following are conditions for reimbursement of services rendered by a substitute dentist:

- Dentists who take a leave of absence for no more than 90 days may bill for the services of a substitute dentist who renders services on an occasional basis when the primary dentist is unavailable to provide services. Services must be rendered at the practice location of the dentist who has taken the leave of absence. A locum tenens arrangement is not allowed for dentists.
- This arrangement is limited to no more than 90 consecutive days. Under this temporary basis, the primary dentist (who is the billing agent dentist) may not submit a claim for services furnished by a substitute dentist to address long-term vacancies in a dental practice. The billing agent dentist may submit claims for the services of a substitute dentist for longer than 90 consecutive days if the dentist has been called or ordered to active duty as a member of a reserve component of the Armed Forces.

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Medicaid and CSHCN accepts claims from the billing agent dentist for services provided by the substitute dentist for the duration of the billing agent dentist's active duty as a member of a reserve component of the Armed Forces.

- Providers billing for services provided by a substitute dentist must bill with modifier U5 in Block 19 of the American Dental Association (ADA) claim form.
- The billing agent dentist may recover no more than the actual administrative cost of submitting the claim on behalf of the substitute dentist. This cost is not reimbursable by Medicaid or CSHCN.
- The billing agent dentist must bill substitute dentist services on a different claim form from his or her own services. The billing agent dentist services cannot be billed on the same claim form as substitute dentist services.
- The substitute dentist must be licensed to practice in the state of Texas, must be enrolled in Texas Medicaid, and must not be on the Texas Medicaid provider exclusion list.
- The dentist who is temporarily absent from the practice must be indicated on the claim as the billing agent dentist, and his or her name, address, and NPI must appear in Blocks 53, 54, and 56 of the ADA claim form.
- The substitute dentist's NPI number must be documented in Block 35 of the ADA claim form. Electronic submissions do not require a provider signature.

Dentists must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation, as detailed above, will be subject to recoupment.

3.2.3 Texas Health Steps Dental Checkups

Texas Health Steps dental checkups include an oral evaluation, prophylaxis, topical fluoride, and appropriate radiographs.

The Texas Health Steps dental periodicity schedule for preventative and diagnostic procedures does not apply to clients living in an intermediate care facility for individuals with intellectual or developmental disabilities (ICF-IID) who are 21 years of age and older.

3.2.3.1 Exception-to-Periodicity Oral Evaluation, Dental Checkup, and Emergency or Trauma Related Services

Oral evaluations and dental checkups allow for the early diagnosis and treatment of dental problems. Oral evaluations and dental checkups might be needed at more frequent intervals than noted in the periodicity schedule.

If needed, a dental checkup or oral evaluation can still be reimbursed when the service falls outside the periodicity schedule. The rules for such exceptions are outlined below.

3.2.3.2 Exception-to-Periodicity Oral Evaluation

A Texas Health Steps exception-to-periodicity oral evaluation is limited to dental procedure code D0120.

An exception-to-periodicity oral evaluation is allowed when the service is:

- Medically necessary and based on risk factors and health needs for clients birth through 6 months of age.
- Mandated service required to meet federal or state exam requirements for Head Start, daycare, foster care or preadoption.

Providers must include all appropriate procedure codes on the dental claim submission form. Additionally, dental providers must include modifier SC or 32 to identify the reason for the exception.

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3.2.3.3 Exception-to-Periodicity Dental Checkup

A Texas Health Steps exception-to-periodicity dental checkup is allowed when the client will not be available for the next periodically due dental checkup. This includes clients whose parents are migrant or seasonal workers.

Providers must include all appropriate procedure codes on the dental claim submission form. Additionally, dental providers must include modifier SC to identify the reason for the exception.

3.2.3.4 Exception-to-Periodicity Emergency or Trauma Related Oral Evaluation

A Texas Health Steps exception-to-periodicity emergency or trauma related oral evaluation is limited to dental procedure code D0140.

A Texas Health Steps exception-to-periodicity emergency or trauma related dental service is allowed when the service is:

- Required for immediate treatment and any follow-up treatment.
- Required for therapeutic services needed to complete a case for clients who are 5 months of age and younger, when initiated as emergency services, trauma, or early childhood caries.

When submitting a claim for emergency or trauma related dental services, the provider must include:

- "Trauma" or "Emergency" in Block 30 "Description" field.
- The original date of treatment or incident in Block 35, "Remark" field.
- Completion of Block 45, "Treatment Resulting from" field, if applicable.

Providers must include all appropriate procedure codes on the dental claim submission form. Additionally, dental providers must include modifier ET to identify the reason for the exception.

Refer to: Subsection 6.7, "American Dental Association (ADA) Dental Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

3.2.3.5 Documentation

The client's dental medical record must include documentation for the exception-to-periodicity Texas Health Steps oral evaluation, dental checkup or exception-to periodicity emergency or trauma related service for medical necessity.

Dental services are subject to retrospective review and recoupment if documentation does not support the services submitted for payment.

In addition to documentation requirements outlined in the Prior Authorization section, if any, all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

3.2.3.6 Reimbursement

Providers must include the appropriate procedure code and one of the modifiers to identify the reason for the exception must be included on the ADA dental claim submission form. Procedure codes must be included in Block 29. Modifiers must be included in Block 19:

Procedure Code	Modifier to Identify Exemption	Modifier Description
D0120	32	Mandated Service
D0120	SC	Medically Necessary Service
D0140, D9110	ET	Emergency - Trauma Related Services

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3.2.3.7 Diagnostic Services

Diagnostic services should be performed for all clients, starting within the first six months of the eruption of the first primary tooth, but no later than one year of age.

Clinical Oral Evaluations

Procedure codes D0140, D0160, D0170, and D0180 are limited dental codes and may be paid in addition to a comprehensive oral exam (procedure code D0150) or periodic oral exam (procedure code D0120), when submitted within a six-month period. When submitting a claim for procedure code D0140, D0160, D0170, or D0180, the provider must indicate documentation of medical necessity on the claim. These claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.

Procedure Code	Age Restriction	Requirements
D0120	Birth through 20 years of age	
D0140	Birth through 20 years of age	Narrative required
D0145	6 months through 35 months of age	
D0150	Birth through 20 years of age	
D0160	1 year through 20 years of age	Narrative required, CCP
D0170	Birth through 20 years of age	
D0180	13 years through 20 years of age	

Procedure codes D0120, D0150, D0160, D0170, D0180, D1208, and D8660 will be denied when billed by any provider for the same date of service as procedure code D0145.

Procedure code D0120 will be denied when billed within six months of procedure code D0150 by the same provider.

Procedure code D0120 is used for periodic oral evaluations and is limited to once every six months by the same provider or dental group.

Procedure code D0140 is limited to one service per day by the same provider and twice per day for any provider.

Procedure code D0140 will be denied when submitted for the same date of service by the same provider as procedure code D0160.

Providers must be certified by the Texas Health Steps Dental Program to perform this service (procedure code D0145).

Procedure code D0145 is limited to the following:

- One service per day, any provider
- A minimum of 60 days between dates of service, any provider
- Ten services per lifetime, any provider

Procedure code D0150 is used for comprehensive oral evaluations and is limited to once every three years by the same provider.

Procedure code D0160 is used for a problem-focused, detailed, and extensive oral evaluation.

Procedure codes D0160 and D0170 are limited to once per day by the same provider.

Procedure code D0160 will be denied if submitted for the same date of service as procedure code D8070 or D8080 by the same provider.

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Procedure code D0170 will be denied when submitted for the same date of service by the same provider as procedure code D0140 or D0160.

The following procedure codes are payable to Federally Qualified Health Centers (FQHC) at the client encounter rate:

Procedure Codes									
D0120	D0140	D0145	D0150	D0160	D0170	D0180	D0330	D0340	D0350
D0470	D9994								

The provider must document medical necessity and the specific tooth or area of the mouth on the claim for procedure codes D0140, D0160, and D0170.

Documentation supporting medical necessity for procedure codes D0140, D0160, and D0170 must also be maintained by the provider in the client's medical record and must include the following:

- The client's complaint supporting medical necessity for the examination
- The specific area of the mouth that was examined or the tooth involved
- A description of what was done during the visit
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

Documentation supporting medical necessity for procedure code D0180 must be maintained by the provider in the client's medical record and must include the following:

- The client's complaint supporting medical necessity for the examination
- A description of what was done during the treatment
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

A caries risk assessment procedure code (D0601, D0602, or D0603) is required on the same claim when dental examination procedure code D0120, D0145, or D0150 are submitted for reimbursement on the same claim, for the same date of service, by the same provider.

Procedure codes D0601, D0602, and D0603 are informational only, and are not payable. Information-only procedure codes must be billed in the amount of at least $0.01 in the cost column on the claim form.

The client's dental condition(s) that justifies the risk assessment classification submitted with the claim must be maintained by the provider in the client's medical record, and it must be clearly documented using a caries risk assessment tool or in narrative charting. The client's medical record is subject to retrospective review.

Professionally developed caries risk assessment tools are available at:

- American Dental Association (ADA)
- American Academy of Pediatric Dentistry (AAPD)
- Texas Health Steps (THSteps)

Radiographs/Diagnostic Imaging (Including Interpretation)

The number of films required is dependent on the age of the client. A minimum of eight films is required to be considered a full-mouth series. Adults and children who are 12 years of age and older require 12–20 films, as is appropriate. The panoramic radiographic image (D0330) with four bitewing radiographic images (D0274) may be considered equivalent to the complete or full-mouth series of radiographic images (D0210), and the submitted amount for either combination is equivalent to the maximum fee.

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Procedure Code	Age Restriction	Requirements
D0210	2 years through 20 years of age	
D0220	1 year through 20 years of age	
D0230	1 year through 20 years of age	
D0240	Birth through 20 years of age	
D0250	1 year through 20 years of age	Narrative required, CCP
D0270	1 year through 20 years of age	
D0272	1 year through 20 years of age	
D0273	1 year through 20 years of age	
D0274	2 years through 20 years of age	
D0277	2 years through 20 years of age	
D0310	1 year through 20 years of age	Narrative required, CCP
D0320	1 year through 20 years of age	Narrative required, CCP
D0321	1 year through 20 years of age	Narrative required, CCP
D0322	1 year through 20 years of age	Narrative required, CCP
D0330	3 years through 20 years of age	
D0340	1 year through 20 years of age	Narrative required, CCP
D0350	Birth through 20 years of age	
D0367	Birth through 20 years of age	Prior authorization required

Note: *Radiograph codes do not include the exam. If an exam is also performed, providers must submit the appropriate ADA procedure code.*

Procedure code D0210 is limited to one service every three years by the same provider.

Procedure code D0210 will be denied when submitted on an emergency claim.

Procedure codes D0220, D0250, D0270, D0272, D0273, D0274, D0277, D0340, and D0350 are limited to one service per day by the same provider.

For procedure code D0230 the total cost of periapicals and other radiographs cannot exceed the payment for a complete intraoral series.

Procedure code D0240 is limited to two services per day by the same provider. Periapical films taken at an occlusal angle must be submitted as periapical radiograph (procedure code D0230). Procedure code D0240 may be submitted as an emergency service.

Procedure codes D0272, D0273, D0274, and D0277 will be denied when submitted for the same date of service as procedure code D0210 by any provider.

Procedure code D0277 will be denied when submitted for the same date of service as procedure code D0330 by the same provider.

Procedure code D0330 is limited to one service per day by any provider, and to one service every three years by the same provider.

Procedure code D0330 is not allowed on emergency claims unless third molars or a traumatic condition is involved. For clients who are 2 years of age or younger, the necessity of a panoramic film must be documented. The panoramic radiographic image (procedure code D0330) with four bitewing radio-

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graphic images (procedure code D0274) may be considered equivalent to a comprehensive intraoral series of radiographic images (procedure code D0210), and the submitted amount for either combination is equivalent to the maximum fee.

Procedure codes D0340 and D0350 are not reimbursable separately when a crossbite therapy workup is performed.

Procedure codes D0330, D0340 and D0350 are denied when submitted with procedure codes D8070 and D8080.

Procedure code D0367 is limited to a maximum of three services per year by any provider. Additional services may be considered with documentation of medical necessity.

Procedure code D0350 must be used to submit claims for photographs, and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the client's medical record when medical necessity is not evident on radiographs for dental caries or the following procedure codes. Medical necessity must be documented on the electronic or paper claim.

Procedure Codes									
D4210	D4211	D4240	D4241	D4245	D4266	D4267	D4270	D4273	D4275
D4276	D4277	D4278	D4283	D4285	D4355	D4910			

Oral Pathology Laboratory Procedure Code	**Age Restriction**	**Requirements**
D0472		By pathology laboratories only. (refer to CPT codes)
D0473		By pathology laboratories only. (refer to CPT codes)
D0474		By pathology laboratories only. (refer to CPT codes)
D0480		By pathology laboratories only. (refer to CPT codes)
D0502	1 year through 20 years of age	Narrative required, CCP
D0999	1 year through 20 years of age	Narrative required, CCP

Tests and examinations procedure codes D0415, D0460, and D0470 are restricted to clients who are 1 year through 20 years of age and are CCP eligible. A narrative is required for these services.

Procedure code D0425 is not reimbursed separately and is considered part of another dental procedure.

Procedure code D0460 is limited to one service per day by the same provider. This service is not reimbursed for primary teeth.

Procedure code D0460 will be denied when submitted for the same date of service as any endodontic procedure.

Procedure code D0470 is limited to once per lifetime, any provider.

Procedure code D0470 is not reimbursed separately when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup is performed.

Procedure code D0470 will be denied when submitted with procedure codes D8070 and D8080.

Case management procedure code D9994 is a benefit of Texas Health Steps when anticipatory guidance is provided during a first dental home visit and is restricted to clients who are 6 months through 35 months of age.

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Procedure code D9994 will be denied if not submitted with procedure code D0145 on the same day by the same provider.

3.2.3.8 * Preventive Services

Reimbursement for dental services exceeding the stated benefit limitations may be considered when medically necessary. Providers must submit documentation supporting medical necessity when submitting the claim. The documentation must also be kept in the client's medical record.

Procedure Code	[Revised] Limitations
Dental Prophylaxis	
D1110*	Limited to one prophylaxis per client, any provider, per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. Not reimbursed to orthodontist or oral maxillofacial surgeon providers. A 13–20
D1120*	Limited to one prophylaxis per client, any provider, per six-month period (includes oral health instructions). Limited to once every six months, any provider for clients who are 36 months of age or older. If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. May be performed every 60 days when provided on the same date of service as procedure code D0145 by the same provider. Not reimbursed to orthodontist or oral maxillofacial surgeon providers. A 6 months–12 years
Topical Fluoride Treatment (Office Procedure)	
D1206	Limited to once every six months, by any provider for clients who are 36 months of age or older. If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. May be performed every 60 days when provided on the same date of service as procedure code D0145 by the same provider. Not reimbursed to orthodontist or oral maxillofacial surgeon providers. A 6 months–20 years, N, CCP
D1208	Limited to once every six months, by any provider. If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. Not reimbursed to orthodontist or oral maxillofacial surgeon providers. A 6 months–20 years, N, CCP
Other Preventive Services	
D1310	Denied as part of all preventative, therapeutic, orthodontic, and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to a THSteps medical provider. The THSteps medical provider may then refer the client to a THSteps-enrolled, licensed dietitian for further nutrition counseling.
D1320	A client requiring tobacco counseling may be referred to a THSteps primary care provider. Tobacco counseling is considered inclusive of all preventive, therapeutic, orthodontic, and diagnostic dental procedures.
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	[Revised] Limitations
D1330	Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure is a benefit of the THSteps Dental Program when the services are above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the client's care. Procedure code D1330 is limited to the office setting. Denied when billed for the same DOS as dental prophylaxis (D1110 or D1120) or topical fluoride treatments (D1206 or D1208) by any provider. Limited to once per client, per year, by any provider. A 1–20, N, CCP
D1351*	Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth that is at risk for dental decay and is free of proximal caries and free of restorations on the surface to be sealed. Sealants are a benefit when applied to primary teeth (Tooth Identification (TID) A, B, I, J, K, L, S, and T) or permanent teeth (TID 1-5, 12-21, 28-32). TID and Surface Identification (SID) must be indicated on the claim form. Reimbursement will be considered on a per-tooth basis, regardless of the number of surfaces sealed. Denied when billed for the same DOS as any D4000 series periodontal procedure code. Limited to once per lifetime, per TID, any provider. If submitted on emergency claim, procedure code will be denied. Not reimbursed to orthodontist or oral maxillofacial surgeon providers. A 1–20
D1354	Application of caries arresting medicament is limited to once per lifetime per TID (A-T and 3, 14, 19, and 30) by any provider in the office setting. Denied if billed on the same date of service for the same TID as procedure code D1351 by any provider. Procedure code D1354 will be denied if billed within six months of procedure codes D9222, D9224, or 00170 with the modifier U3 by any provider. A 0–6 ***Note:*** *Silver diamine fluoride is the only material providers may use for procedure code D1354.*
D9994*	A benefit of Texas Health Steps when anticipatory guidance is provided during a first dental home visit. Denied if not submitted with procedure code D0145 on the same day by the same provider. A 6-35 months

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	[Revised] Limitations
Space Maintainers (Passive Appliances)	
Space maintainers are designed to prevent tooth movement and are a benefit of Texas Medicaid in the following situations: • After premature loss of a deciduous primary first and/or second molar(s) (TID: A, B, I, and J) for clients who are 1 through 12 years of age (procedure codes D1510 and D1516) • After premature loss of a deciduous primary first and/or second molar(s) (TID: K, L, S, and T) for clients who are 1 through 12 years of age (procedure codes D1510 and D1517) • After premature loss of a deciduous primary second molar (TID: A, J, K, and T) for clients who are 3 through 7 years of age (procedure code D1575) Removal of a fixed space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device. Procedure codes D1510, D1520, D1553, D1556, and D1575 are limited to once per lifetime, per quadrant, by any provider. Procedure codes D1551 and D1552 are limited to once per lifetime, by the same provider. Procedure codes D1516, D1517, D1526, and D1527 are limited to once per lifetime, per tooth ID, same procedure code, by any provider. Procedure code D1553 will be denied if procedure code D1510 was reimbursed within the previous rolling year, same quadrant, by the same provider. Procedure code D1551 will be denied if procedure code D1516 was reimbursed within the previous rolling year, by the same provider. Procedure code D1552 will be denied if procedure code D1517 was reimbursed within the previous rolling year, by the same provider.	
Space Maintainers (Passive Appliances) continued	
D1510*	A 1–12 (TIDs #A, B, I, J, K, L, S, T), MTID
D1516*	A 1–12 (TIDs #A, B, I, J), MTID
D1517*	A 1–12 (TIDs #K, L, S, T), MTID
D1520*	A 1–12 (TIDs #A, B, I, J, K, L, S, T), MTID A 1–12 (TIDs #3, 14, 19, 30), MTID
D1526*	A 1–12 (TIDs #A, B, I, J), MTID A 1–12 (TIDs #3, 14), MTID
D1527*	A 1–12 (TIDs #K, L, S, T), MTID A 1–12 (TIDs #19, 30), MTID
D1551	A 1–12 (TIDs #A, B, I, J,), MTID
D1552	A 1–12 (TIDs #K, L, S, T), MTID
D1553	A 1–12 (TIDs #A, B, I, J, K, L, S, T), MTID
D1556	A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), MTID
D1557	A 1-20 (TIDs #A, B, I, J,), MTID A 1-20 (TIDs #3, 14), MTID

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	[Revised] Limitations
D1558	A 1-20 (TIDs #K, L, S, T), MTID A 1-20 (TIDs #19, 30), MTID
D1575	A 3-7 (TIDs #A, J, K, T), MTID
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

3.2.3.9 Therapeutic Services

Medicaid reimbursement is contingent on compliance with the following limitations:

- Documentation requirements

Refer to: Subsection 3.3, "Documentation Requirements" in this handbook.

- More than one restoration on a single surface is considered a single restoration.
- Multiple surface restorations must show definite crossing of the plane of each surface listed for each primary and permanent tooth completed.
- A multiple surface restoration cannot be submitted as two or more separate one-surface restorations.
- Restorations and therapeutic care are provided as a Medicaid service based on medical necessity and reimbursed only for therapeutic reasons and not preventive purposes (refer to CDT).

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date the final impression was made as the DOS. If the client did not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the client's chart in lieu of a postoperative radiograph. The 95-day filing deadline is in effect from the date of the final impression. If the client returns to the office after the claim has been filed, the dentist is obligated to attempt to seat the restoration or appliance at no cost to the client or Texas Medicaid. For records retention requirements, refer to subsection 3.3, "Documentation Requirements" in this handbook.

3.2.4 Comprehensive Care Program (CCP)

The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which federal financial participation (FFP) is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as the Comprehensive Care Program (CCP).

CCP services are provided only for those clients who are birth through 20 years of age who are eligible to receive THSteps services. When the client becomes 21 years of age, all CCP benefits stop. Dental services that are a benefit through CCP are designated in the Limitations column of the tables with the notation "CCP" beginning in subsection 3.2.3.7, "Diagnostic Services" in this handbook.

3.2.5 Children's Medicaid Dental Plan Choices

Children's Medicaid dental services benefits are administered by three dental managed care organizations (i.e., dental plans) across the state of Texas.

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Medicaid Managed Care Dental Plan Provider Services	
DentaQuest	1-800-685-9971
MCNA Dental	1-855-776-6262
United Healthcare Dental	1-800-527-1764

Note: *Services provided to Medicaid managed care clients must be provided by their main dentist.*

3.2.6 Authorization Transfers for Medicaid Managed Care Dental Orthodontic Services

If a client transitions to a managed care dental plan after their orthodontic services were initially authorized by TMHP, the claims for the orthodontic services will be processed and reimbursed by the managed care dental plan. Providers should check client eligibility to identify the managed care dental plan to which the client transitions.

Claims for orthodontic services remain the responsibility of the dental managed care plan until the authorized services are completed, even if the client loses dental managed care or Medicaid eligibility.

3.2.7 ICF-IID Dental Services

ICF-IID dental services are mandated by Medicaid. Reimbursement is provided for treatment of dental problems for Medicaid-eligible residents of ICF-IID facilities who are 21 years of age and older. Residents of ICF-IID facilities who are 20 years of age and younger receive services through the regular THSteps Program. Eligibility for ICF-IID services is determined by HHSC.

Procedure codes that do not have a CCP designation in the "Limitations" column of the dental fee schedule may be submitted in a routine manner for ICF-IID clients. These procedures must be documented as medically necessary and appropriate. ICF-IID clients are not subject to periodicity for preventive care. For procedure codes that have a CCP designation, a provider may request authorization with documentation or provide documentation on the submitted claim.

Refer to: Subsection 3.2.15, "Medicaid Dental Benefits, Limitations, and Fee Schedule" in this handbook.

3.2.7.1 THSteps and ICF-IID Provision of Dental Services

All THSteps and ICF-IID dental services must be performed by the Medicaid-enrolled dental provider except for permissible work that is delegated to a licensed dental hygienist, dental assistant, or dental technician in a dental laboratory on the premises where the dentist practices, or in a commercial laboratory registered with the TSBDE. The Texas Dental Practice Act and the rules and regulations of the TSBDE (22 TAC, Part 5) define the scope of work that dental auxiliary personnel may perform. Any deviations from these practice limitations shall be reported to the TSBDE and HHSC, and could result in sanctions or other actions imposed against the provider.

THSteps and ICF-IID clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- Dental services free from abuse or harm from the provider or the provider's staff.
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

3.2.7.2 Children in Foster Care

Clients in foster care receive services from Superior HealthPlan's dental contractor. Providers may contact DentaQuest at 1-888-308-9345 for more information.

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Paper claims and requests for prior authorization must be mailed to:

DentaQuest
P.O. Box 2906
Milwaukee, WI 53201-2906
Fax: 262-834-3589

3.2.8 Written Informed Consent and Standards of Care

As outlined in 22 TAC §108.7, the dental provider must maintain written informed consent signed by the patient, or a parent or legal guardian of the patient if the patient is a minor, or a legal guardian of the patient if the patient has been adjudicated incompetent to manage the patient's personal affairs.

Additionally, as required in 26 TAC §256.6 and §256.20, THSteps providers must obtain legally effective, written informed consent before providing THSteps dental checkups and treatment services. Such consent is required for all oral evaluations; dental diagnostic, preventative, and therapeutic services; and treatment plans. The written informed consent must identify the tooth and surface IDs associated with the proposed treatment and should disclose risks or hazards that could influence a reasonable person in making a decision to give or withhold consent.

THSteps clients or their parents or legal guardians who can give written informed consent must receive information following a dental examination about the dental diagnosis, scope of proposed treatment, including alternatives and risks, anticipated results, and need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. The parent or guardian being present at the time of the dental visit facilitates the provider obtaining written informed consent. Dentists must comply with TSBDE Rule 22 TAC §108.2, "Fair Dealing."

3.2.9 First Dental Home

Based on the American Academy of Pediatric Dentistry's (AAPD) definition, Texas Medicaid defines a dental home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a client's dental home begins no later than 6 months of age and includes referrals to dental specialists when appropriate.

In providing a dental home for a client, the dental provider enhances the ability to assist clients and their parents or legal guardians in obtaining optimum oral health care. The first dental home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following:

- Oral examination
- Caries risk assessment

The following services may be reimbursed separately when provided during an FDH visit:

- Oral evaluation for a client who is 3 years of age or younger (procedure code D0145)
- Dental case management and patient education to improve oral health literacy (procedure code D9994) when providing dental anticipatory guidance
- Dental prophylaxis (procedure code D1120) if appropriate
- Topical fluoride application using fluoride varnish (procedure code D1206) if appropriate

Caries susceptibility tests are considered part of dental evaluation procedures and are not reimbursed separately.

Clients who are from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home provider.

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First Dental Home services are submitted using procedure code D0145. The dental home provider must retain supporting documentation for procedure code D0145 in the client's record. The supporting documentation must include, but is not limited to, the following:

- Oral and physical health history review
- Dental history review
- Primary caregiver's oral health
- Oral evaluation
- Caries risk assessment
- Dental prophylaxis, which may include a toothbrush prophylaxis
- Oral hygiene instruction with parent or caregiver
- Fluoride varnish application
- An appropriate preventive oral health regimen (recall schedule)
- Anticipatory guidance communicated to the client's parent, legal guardian, or primary caregiver to include the following:
  - Oral health and home care
  - Oral health of primary caregiver/other family members
  - Development of mouth and teeth
  - Oral habits
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Medications and oral health
  - Any referrals, including dental specialist's name

Procedure code D0145 is limited to individual dentists certified by the Texas Health Steps dental program to perform this service. Training for certification as a First Dental Home provider is available as a free continuing education course on the THSteps website at www.txhealthsteps.com.

Procedure codes D0120, D0150, D0160, D0170, D0180, D1208, and D8660 are denied if procedure code D0145 is submitted for the same DOS by any provider. A First Dental Home examination is limited to one service per day and ten services per client lifetime with at least 60 days between visits by any provider.

3.2.10 Teledentistry Services

Teledentistry services may be reimbursed by Texas Medicaid. When provided as a teledentistry service procedure code D0120 or D0140, must be billed with teledentistry procedure code D9995.

Teledentistry refers to the use of communication technology by a dentist to provide dental care services to a patient at a different physical location than the office setting.

Texas Health Steps dental providers that deliver teledentistry services must follow applicable Texas statutes, including the Texas Occupations Code, Title 3, and any rules and standards established by the Texas State Board of Dental Examiners (TSBDE). This includes meeting all requirements for obtaining and documenting informed consent for treatment, data collection, and data sharing, while ensuring the privacy and security of client data, in compliance with all record retention requirements.

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Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on Medicaid services provided through telecommunications.

Dental services delivered using teledentistry must meet the same standard of care as the same dental health service or procedure provided in an in-person setting.

For dental services delivered through a dental maintenance organization (DMO), providers must refer to the individual DMO benefit package for information on teledentistry services.

The service must be delivered using only synchronous real-time audiovisual technologies.

The client or parent/guardian must agree to receiving the teledentistry service.

Services provided through teledentistry outside of the frequency specified in the periodicity schedule may be reimbursed when medically necessary and criteria for procedure code D0120 or D0140 are met.

A periodic oral evaluation (procedure code D0120) may be delivered as a teledentistry service when the following criteria are met:

- The client must be 3 years through 20 years of age.
- The teledentistry platform must be operated at the patient site by a dental hygienist trained in its operation.

A limited problem-focused oral evaluation (procedure code D0140) may be delivered as a teledentistry service when the following criteria are met:

- The client must be birth through 20 years of age.
- The teledentistry platform must be operated at the patient site by a dental assistant or hygienist trained in its operation.

Synchronous Teledentistry

Real-time encounter procedure code D9995 must be included on the claim form when procedure code D0120 or D0140 is provided as a teledentistry service. Procedure code D9995 is not separately reimbursable.

When procedure code D0120 or D0140 is provided as a teledentistry service, additional documentation in the client's dental record must indicate that the service was provided using synchronous real-time audiovisual technologies. The documentation must include the following:

- The name and credentials of the dental health care professional
- The location of the dentist at the time of service

3.2.11 Dental Referrals by THSteps Primary Care Providers

Dental providers may receive referrals for clients who are 6 months of age and older from THSteps primary care providers. The primary care provider must provide information about the initiation of routine dental services with the recommendation to the client's parent or guardian that an appointment be scheduled with a dental provider in order to establish a dental home. If a THSteps dental checkup reveals a dental health condition that requires follow-up diagnosis or treatment, the provider performing the dental checkup should assist the client in planning follow-up care within their practice or in making a referral to another qualified dental provider.

Note: *For clients who are 20 years of age and younger, the client's guardian may refer the client for dental services or a client of legal age may refer themselves for dental services.*

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3.2.12 Change of Provider

A provider may refer a client to another dental provider for treatment for any of the following reasons:

- Treatment by a dental specialist such as a pediatric dentist, periodontist, oral surgeon, endodontist, or orthodontist is indicated and is in the best interests of the THSteps client.
- The services needed are outside the skills or scope of practice of the initial provider.

A provider may discontinue treatment if there is documented failure to keep appointments by the client, noncompliance with the treatment plan, or conflicts with the client or other family members. In any such action to discontinue treatment, providers must comply with 22 TAC §108.5, "Patient Abandonment."

The client also may select another provider, if desired. HHSC may refer the client to another provider as a result of adverse information obtained during a utilization review or resolution of a complaint from either provider or client.

3.2.12.1 Interrupted or Incomplete Orthodontic Treatment Plans

Authorizations for orthodontic or extensive restorative treatment plans that have been prior authorized for a provider are not transferable to another provider. If a client's treatment plan is interrupted and the services are not completed, the original or new provider must request a new prior authorization to complete the interrupted, incomplete, and prior authorized treatment plan.

To complete the treatment plan, the client must be eligible for Medicaid. It is the provider's responsibility to verify the client's eligibility through TexMedConnect, the Medicaid Client Portal for Providers, or the TMHP Contact Center.

If the client does not return for the completion of services and there is a documented failure to keep appointments by the client, the dental provider who initiated the services may submit a claim for reimbursement in compliance with the 95-day filing deadline.

Refer to: "Completion or Premature Termination of Orthodontic Services" in this handbook.

3.2.13 Periodicity for THSteps Dental Services

For clients who are 6 months through 20 years of age, dental checkups may occur at 6-month (181-day) intervals. Texas Medicaid has adopted the AAPD's "Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents" to serve as a guide and reference for dentists when scheduling and providing services to THSteps clients.

In November 2004, the ADA, in conjunction with the FDA, established "Guidelines for Prescribing Dental Radiographs." The guidelines include type of encounters relevant to the client's age and dental developmental stage. Texas Medicaid has adopted the ADA guidelines to serve as a guide and reference for dentists who treat THSteps clients.

Refer to: "Appendix G. American Academy of Pediatric Dentistry Periodicity Guidelines" in this handbook.

THSteps dental providers may provide any medically necessary dental services such as emergency, diagnostic, preventive, therapeutic, and orthodontic services that are within the Texas Medicaid guidelines and limitations specified for each area as long as the client's Medicaid eligibility is current for the date that dental services are being provided.

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3.2.13.1 Exceptions to Periodicity

If a periodic dental checkup has been conducted within the last six months, the client still may be able to receive another periodic dental checkup in the same six-month period by any provider. For THSteps clients, exceptions to the six-month periodicity schedule for dental checkup services may be approved for one of the following reasons:

- Medically necessary service, based on risk factors and health needs (includes clients who are birth through 6 months of age).
- Required to meet federal or state exam requirements for Head Start, daycare, foster care, preadoption, or to provide a checkup prior to the next periodically-due checkup if the client will not be available when due. This includes clients whose parents are migrant or seasonal workers.
- Clients' choice to request a second opinion or change service providers (not applicable to referrals).
- Subsequent therapeutic services necessary to complete a case for clients who are 5 months of age and younger when initiated as emergency services, for trauma, or early childhood caries.
- Medical checkup prior to a dental procedure requiring general anesthesia.
- A First Dental Home client can be seen up to ten times within the age of 6 through 35 months.

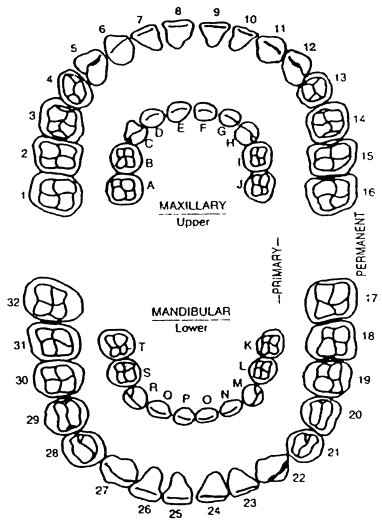
It is the provider's responsibility to verify that the client is eligible for the date that dental services are to be provided. Eligibility may be verified through TexMedConnect, the Medicaid Client Portal for Providers, or the TMHP Contact Center.

When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the client's file and on the claim submission. For claims filed electronically, check "yes" when prompted. For claims filed on paper, place comments in Block 35.

For ICF-IID clients who are 21 years of age and older, the periodicity schedule for preventive dental procedures (exams, prophylaxis, fluoride, and radiographs) does not apply.

3.2.14 Tooth Identification (TID) and Surface Identification (SID) Systems

Claims are denied if the procedure code is not compatible with TID or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. For SID designation on anterior teeth, use facial (F) and incisal (I). For SID purposes, use buccal (B) and occlusal (O) designations for posterior teeth.



SID	SID	SID	SID
Buccal	DB	DFI	DLIF
Distal	DF	DFL	DOLB
Facial	DI	DFM	MIDF
Incisal	DL	DIL	MIDL
Lingual	DO	DLB	MIDLF
Mesial	IL	DLM	MIFL
Occlusal	MB	DOB	MLBD
	MI	DOL	MLDF
	ML	ILF	MODB
	MO	MBD	MODL
	OB	MID	MODLB
	OL	MIF	MOLB
		MLB	
		MLF	
		MLI	
		MOB	
		MOD	
		MOL	
		OBL	

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3.2.14.1 Supernumerary Tooth Identification

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the Current Dental Terminology (CDT) published by the ADA.

The TID for each identified supernumerary tooth will be used for paper and electronic claims and can only be submitted for payment with the following procedure codes:

- For primary teeth only: D7111.
- For both primary and permanent teeth the following codes can be submitted: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510.

Permanent Teeth Upper Arch																
Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Super #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Permanent Teeth Lower Arch																
Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Super #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Primary Teeth Upper Arch										
Tooth #	A	B	C	D	E	F	G	H	I	J
Super #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Primary Teeth Lower Arch										
Tooth #	T	S	R	Q	P	O	N	M	L	K
Super #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

3.2.15 Medicaid Dental Benefits, Limitations, and Fee Schedule

For THSteps clients, dental procedure limitations may be waived when all the following have been met. The dental procedure is:

- Medically necessary and FFP is available for it.
- Prior authorized by the TMHP Dental Director.
- Properly documented in the client's record.

Refer to: Subsection 3.3, "Documentation Requirements" in this handbook.

For ICF-IID clients, services designated as CCP-type are available. In the "Limitations" column of the fee schedule, abbreviations indicate the age range limitations and documentation requirements. The following abbreviations also appear in a table at the bottom of each page of the fee schedule:

Acronym	Description
A	Age range limitations
CCP	Payable under CCP for clients who are 20 years of age and younger when THSteps benefits or limits are exceeded
DOS	Date of service
FMX	Intraoral radiographs—complete series
MTID	Missing tooth ID(s)

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Acronym	Description
N	Narrative of medical necessity for the procedure must be retained in the client's record
NC	Not reimbursed by Medicaid. Services may not be charged to the client.
PATH	Pathology report must accompany the claim and must be retained in the client's record
PC	Periodontal charting must be retained in the client's record
PHO	Preoperative and postoperative photographs required and must be maintained in the client's medical record
PPXR	Preoperative and postoperative radiographs are required when the procedure is performed and must be retained in the client's record; do not send with initial claims
PXR	Preoperative radiographs are required when the procedure is performed and must be retained in the client's record; do not send with initial claims

3.2.16 * Restorative Services

Procedure Code	
Amalgam Restorations—Direct (Including Polishing)	
Procedure codes D2140, D2150, D2160, and D2161 are benefits for clients who are 21 years of age or older residing in an ICF-IID facility.	
D2140*	A Birth–20, PXR
D2150*	A Birth–20, PXR
D2160*	A 1–20, PXR
D2161*	A 1–20, PXR
Resin-Based Composite Restorations—Direct	
Resin restoration includes composites or glass ionomer. Procedure codes D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394 are benefits for clients who are 21 years of age or older residing in an ICF-IID facility.	
D2330*	TID #C–H, M–R, 6–11, 22–27. A Birth–20, PXR
D2331*	TID #C–H, M–R, 6–11, 22–27. A Birth–20, PXR
D2332*	TID #C–H, M–R, 6–11, 22–27. A 1–20, PXR
D2335*	TID #C–H, M–R, 6–11, 22–27. A 1–20, PXR
D2390*	A Birth–20, PXR
D2391*	A Birth–20, PXR
D2392*	A Birth–20, PXR
D2393*	A 1–20, PXR
D2394*	A 1–20, PXR
[Revised] Inlay/Onlay Restorations (Permanent Teeth only)	
For procedure codes D2510 through D2664, inlay/onlay (permanent teeth only), porcelain is allowed on all teeth. Prior authorization is required for all onlays or permanent crowns. Procedure codes D2542, D2543, D2544, and D2662 through D2664 are payable once per client, per tooth every ten years. Additional onlays may be considered with prior authorization and documentation of medical necessity.	
D2510	A 13–20, N, PPXR, CCP
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	
D2520	A 13–20, N, PPXR, CCP
D2530	A 13–20, N, PPXR, CCP
D2542	Same as D2520. A 13–20, N, PPXR, CCP
D2543	A 13–20, N, PPXR, CCP
D2544	A 13–20, N, PPXR, CCP
D2650	A 13–20, N, PPXR, CCP
D2651	A 13–20, N, PPXR, CCP
D2652	A 13–20, N, PPXR, CCP
D2662	A 13–20, N, PPXR, CCP
D2663	A 13–20, N, PPXR, CCP
D2664	A 13–20, N, PPXR, CCP
[Revised] Crowns—Single Restorations Only	
For procedure codes D2710 through D2794, single crown restorations (permanent teeth only), the following limitations apply: • Prior authorization is required for codes D2710 through D2794. Reimbursement for crowns and onlay restorations require submission of post-operative bitewing radiograph(s) (for posterior teeth); post-operative periapical radiograph(s) (for anterior teeth) with the claim to verify that the restoration meets the standard of care. • Radiographs are reviewed to verify that the restoration meets both medical necessity and standard of care to approve reimbursement. Reimbursement for crowns and onlay restorations are payable once per client, per tooth every ten years. Additional crowns and onlays may be considered with prior authorization and documentation of medical necessity.	
D2710	A 13–20, N, PPXR, CCP
D2720	A 13–20, N, PPXR, CCP
D2721	A 13–20, N, PPXR, CCP
D2722	A 13–20, N, PPXR, CCP
D2740	A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2750*	A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2751*	A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2752	A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2780	A 13–20, N, PPXR, CCP
D2781	A 13–20, N, PPXR, CCP
D2782	A 13–20, N, PPXR, CCP
D2783	Anterior teeth only (#6–11 and 22–27). A 13–20, N, PPXR, CCP
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	
D2790	Posterior teeth only (#1–5, 12–21, and 28–32). A 13–20, N, PPXR, CCP
D2791*	Posterior teeth only (#1–5, 12–21, and 28–32). A 13–20, N, PPXR
D2792*	Posterior teeth only (#1–5, 12–21, and 28–32). A 13–20, N, PPXR, CCP
D2794	A 13–20, N, PPXR, CCP
Other Restorative Services	
D2910	A 13–20, PXR. Denied if billed with the following procedure codes within one rolling year, same TID, same provider: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663 or D2664.
D2915	A 4–20
D2920	A 1–20, PXR
D2930*	A Birth–20, PXR
D2931*	A 1–20, PXR. A benefit for clients who are 21 years of age and older residing in an ICF-IID facility.
D2932*	A 1–20, PXR (TID #C-H, M-R, and 1-32), all permanent teeth. A benefit for clients who are 21 years of age and older residing in an ICF-IID facility.
D2933*	Limited to anterior primary teeth only (TID #C–H, M–R). A Birth–20, N, CCP, PXR
D2934*	Limited to anterior primary teeth only (TID #C–H, M–R). A Birth–20, N, CCP, PXR
D2940*	Not allowed on the same date as permanent restoration. A Birth–20, PXR
D2950*	Provider payments received in excess of $45.00 for restorative work performed within six months of a crown procedure on the same tooth will be deducted from the subsequent crown procedure reimbursement. Not allowed on primary teeth. A 4–20, N, CCP, PXR
D2951	Limited to two times per lifetime for permanent teeth, same TID, any provider. Additional services will be considered with documentation of medical necessity. A 4–20, PXR
D2952	Not payable with D2950. Not allowed on primary teeth. A 13–20, CCP, PXR
D2953	Must be used with D2952. Not allowed on primary teeth. A 13–20
D2954*	Not payable with D2952 or D3950 on the same TID by the same provider. Not allowed on primary teeth. A 13–20, N, CCP, PXR
D2955	For removal of posts (for example, fractured posts) not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348). Not allowed on primary teeth. A 4–20, CCP, PXR
D2957	Must be used with D2954. Not allowed on primary teeth. A 13–20, PXR, CCP
D2960	A 13–20, N, PPXR, CCP
D2961	A 13–20, N, PPXR, CCP
D2962	A 13–20, N, PPXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	
D2971*	May be reimbursed up to four services per lifetime for each tooth. Payable to any THSteps dental provider who performed the original cementation of the crown. A 13–20
D2980	A 1–20, PXR (permanent teeth only)
D2999	A 1–20, N, CCP, PXR
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

The following dental restoration procedure codes will be limited to once per rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2391	D2392	D2393
D2394									

Procedure codes D2335 and D2390 when provided to primary teeth will be limited to once per lifetime, same TID, any provider, and will be denied if any of the following anterior restoration procedure codes have been paid within a rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2930
D2932	D2933	D2934							

Total reimbursement for direct restorations on primary teeth cannot exceed the total dollar amount for a prefabricated stainless steel crown on a primary tooth (procedure code D2930) per TID, per date of service.

Total reimbursement for direct restorations on permanent teeth cannot exceed the total dollar amount for a prefabricated stainless steel crown on a permanent tooth (procedure code D2931) per TID, per date of service. This limitation does not apply to procedure code D2335 for primary or permanent teeth.

3.2.16.1 Direct Restorations and Other Restorative Services

Direct restoration of a primary tooth with the use of a prefabricated crown will be considered as a once in a lifetime restoration, same TID, any provider. Exceptions may be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity for the replacement of the prefabricated crown (procedure codes D2930, D2932, D2933, and D2934) during pre-payment review.

Procedure code D2930 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2391
D2392	D2393	D2394							

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Procedure codes D2933 and D2934 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider:

Procedure Codes								
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390

Procedure codes D2931 and D2932 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2391
D2392	D2393	D2394	D2931	D2932					

3.2.17 Endodontics Services

Therapeutic pulpotomy (procedure code D3220) and apexification and recalcification procedures (procedure codes D3351, D3352, and D3353) are considered part of the root canal (procedure codes D3310, D3320, and D3330) or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348). When therapeutic pulpotomy or apexification and recalcification procedures are submitted with root canal codes, the reimbursement rate is adjusted to ensure that the total amount reimbursed does not exceed the total dollar amount allowed for the root canal procedure.

Reimbursement for a root canal includes all appointments necessary to complete the treatment. Pulpotomy and radiographs performed pre, intra, and postoperatively are included in the root canal reimbursement.

Root canal therapy that has only been initiated, or taken to some degree of completion, but not carried to completion with a final filling, may not be submitted as a root canal therapy code. It must be submitted using code D3999 with a narrative description of what procedures were completed in the root canal therapy.

Documentation supporting medical necessity must be kept in the client's record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be documented in the client's record.

If the client is pregnant and does not want radiographs, use alternative treatment (temporary) until after delivery.

Direct pulp caps (procedure code D3110) and indirect pulp caps (procedure code D3120) are a benefit for permanent teeth only (TID 1-32).

Direct pulp caps may be reimbursed when billed with the following procedure codes for the same tooth ID on the same date of service by the same provider.

Procedure Codes								
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390
D2391	D2392	D2394	D2510	D2520	D2530	D2542	D2543	D2544
D2650	D2651	D2652	D2662	D2663	D2664	D2710	D2720	D2721
D2722	D2740	D2750	D2751	D2752	D2780	D2781	D2782	D2783
D2790	D2791	D2792	D2794	D2931	D2932			

Indirect pulp caps (procedure code D3120) may be reimbursed when billed with procedure code D2940 for the same tooth ID, on the same date of service by the same provider.

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Procedure Code	Limitations
Pulp Capping	
D3110	A 1–20, N, PXR, CCP
D3120	A 1–20, N, PXR, CCP
Pulpotomy	
D3220*	Denied when performed within six months of D3230, D3240, D3310, D3320, or D3330 for the same primary TID, same provider. Denied when performed within six months of D3310, D3320, or D3330 on the same permanent TID, same provider. A Birth–20, PXR. Limited to once per lifetime, per primary tooth (TIDs A-T). Re-treatment claims for an incomplete pulpotomy performed by a dentist not associated with the original treating dentist or dental group will be considered for reimbursement upon appeal. Documentation of medical necessity and the incomplete initial pulpotomy must be submitted with the appeal. The appeal must include a written narrative and pre- and post-treatment X-rays, which will be reviewed by a Texas licensed dentist. ***Note:*** *The identified, original treating dentist or dental group will not be considered for reimbursement.*
Endodontic Therapy on Primary Teeth	
D3230*	Anterior primary incisors and cuspids. TIDs #C–H, M–R. A 1–20, PXR
D3240*	Posterior first and second molars. TIDs #A, B, I, J, K, L, S, T. A 1–20, PXR
Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)	
D3310*	A 6–20, PPXR
D3320*	A 6–20, PPXR
D3330*	A 6–20, PPXR
Endodontic Retreatment	
D3346*	A 6–20, PPXR
D3347*	A 6–20, PPXR
D3348*	A 6–20, PPXR
Apexification/Recalcification Procedures	
D3351*	A 6–20, N, PXR, CCP
D3352*	A 6–20, N, PXR, CCP
D3353*	A 6–20, PPXR, CCP
Apicoectomy/Periradicular Services	
D3410	A 6–20, N, PPXR, CCP
D3421	A 6–20, N, PPXR, CCP
D3425	A 6–20, N, PPXR, CCP
D3426	A 6–20, N, PPXR, CCP
D3430	A 6–20, N, PPXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D3450	A 6–20, N, PXR, CCP
D3460	Prior authorization required. Submit request with periapical radiographs, for each tooth involved. A 16–20, N, PPXR, CCP
D3470	A 6–20, N, PXR, CCP
Other Endodontic Procedures	
D3910	A 1–20, N, CCP
D3920	A 6–20, N, PXR, CCP
D3950	A 6–20, N, PXR, CCP
D3999	A 1–20, N, PXR, CCP
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

3.2.18 Periodontal Services

Procedure codes D4210 and D4211, when submitted for clients who are 12 years of age and younger, will be initially denied, but may be appealed with documentation of medical necessity. Preoperative and postoperative photographs are required for the following procedure codes: D4210, D4211, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285, D4355, and D4910.

Procedure codes D4283 and D4285 are limited to three teeth per site, same day same provider. Procedure code D4283 must be billed along with procedure code D4273 and procedure code D4285 must be billed along with procedure code D4275 on the same claim, for the same date of service, by the same provider.

Preoperative and postoperative photographs are required when medical necessity is not evident on radiographs for the following procedure codes: D4240, D4241, D4245, D4266, and D4267. Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210, D4211, D4240, D4241, D4245, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285, D4355, and D4910.

Procedure code D4278 must be billed on the same date of service as procedure code D4277 or the service will be denied.

Full mouth debridement (procedure code D4355) will be denied when submitted for the same date of service as the following procedure codes by any provider:

Procedure Codes									
D4210	D4211	D4230	D4231	D4240	D4241	D4245	D4249	D4260	D4261
D4266	D4267	D4270	D4273	D4274	D4275	D4276	D4277	D4278	D4283
D4285	D4381	D4910	D4920	D4999					

Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, and D1351 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes.

Procedure codes D4266 and D4267 may be appealed with documentation of medical necessity. Medical necessity for third molar sites are:

- Medical or dental history documenting need due to inadequate healing of bone following third molar extraction, including the date of third molar extraction.

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- Secondary procedure several months postextraction.
- Position of the third molar preoperatively.
- Postextraction probing depth to document continuing bony defect.
- Postextraction radiographs documenting continuing bony defect.
- Bone graft and barrier material used.

Medical necessity for other than third molar sites are:

- Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injuries).
- Intra- or extra-oral radiographs of treatment site(s).
- If not radiographically evident, intraoral photographs are optional unless requested preoperatively by HHSC or its agent.
- Periodontal probing depths.
- Number of intact walls associated with an angular bony defect.
- Bone graft and barrier material used.

Claims for procedure code D6049 may be reimbursed for clients who are 16 through 20 years of age. Claims may also be reimbursed for clients who are 21 years of age or older if they reside in an ICF-IID facility. Procedure code D6049 may be reimbursed for clients who have received an implant (procedure code D3460) in the previous 5 years, by any provider.

The following procedure codes are a benefit for clients who are 13 through 20 years of age:

Procedure Code	Limitations
Surgical Services (Including Usual Postoperative Care)	
D4210	A 13–20, N, PPXR, PHO, CCP
D4211	A 13–20, N, PHO, CCP
D4230	A 13–20, N, PHO, PXR, CCP
D4231	A 13–20, N, PHO, PXR, CCP
D4240	A 13–20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC, CCP
D4241	Limited to once per year. A 13–20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC
D4245	Per quadrant. A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP
D4249	A six- to eight-week healing period following crown lengthening before final tooth preparation, impression making, and fabrication of a final restoration is required for claims submission of this code. A 13–20, N, PPXR, CCP
D4260	Limited to once per quadrant, per day, same provider. A 13–20, N, FMX, PXR, PC, CCP
D4261	Limited to once per quadrant, per day, same provider. A 13–20, N, FMX, PXR, PC
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	Limitations
D4266	A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP
D4267	A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP
D4270	A 13–20, N, PXR, PHO, CCP
D4273	This procedure is performed to create or augment gingiva, to obtain root coverage or to eliminate frenum pull, or to extend the vestibular fornix. A 13–20, N, PXR, PHO, CCP
D4274	This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are used to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation. A 13–20, N, PXR, CCP
D4275	Limited to once per day, same provider. A 13–20, PXR, PHO
D4276	Prior authorization is required. Not payable in addition to D4273 or D4275 for the same DOS. A 13–20, PXR, PHO
D4277	A 13-20, N, PXR, PHO, CCP
D4278	A 13-20, N, PXR, PHO, CCP
D4283	A 13-20, N, PHO
D4285	A 13-20, N, PHO
Nonsurgical Periodontal Services	
D4341*	Prior authorization is required. Denied when submitted on the same date of service as D4355. Denied when submitted for the same DOS as other D4000 series codes. A 13–20, FMX, PC, N, CCP
D4342	Prior authorization is required. Denied when submitted on the same date of service as D4355. Denied when submitted for the same DOS as other D4000 series codes. A 13–20, PC, FMX, N
D4355*	Denied when submitted for the same DOS as other D4000 series codes. Not payable within 90 days of D4910. A 13–20, N, PXR, PHO, CCP
D4381	This procedure does not replace conventional or surgical therapy required for debridement, respective procedures, or regenerative therapy. The use of controlled-release chemotherapeutic agents is an adjunctive therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy. A 13–20, N, PXR, CCP
Other Periodontal Services	
D4910	Payable only following active periodontal therapy by any provider as evidenced either by a submitted claim for procedure code D4240, D4241, D4260, or D4261 or by evidence through client records of periodontal therapy while not Medicaid-eligible. Not payable for the same DOS as any other evaluation procedure. Limited to once per 12 calendar months by the same provider. A 13–20, N, PXR, PHO, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D4920	A 13–20, N, PXR, CCP
D4999	A 13–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

3.2.19 Prosthodontic (Removable) Services

Procedure Code	Limitations
Complete Dentures (Including Routine Post Delivery Care)	
D5110	A 3–20, PXR
D5120	A 3–20, PXR
D5130	A 13–20, N, PXR, CCP
D5140	A 13–20, N, PXR, CCP
Partial Dentures (Including Routine Post Delivery Care)	
D5211*	A 6–20, PXR, MTID
D5212*	A 6–20, PXR, MTID
D5213	A 9–20, N, PXR, MTID, CCP
D5214	A 9–20, N, PXR, MTID, CCP
Adjustments to Dentures	
D5410	A 3–20, PXR
D5411	A 3–20, PXR
D5421	A 6–20, PXR
D5422	A 6–20, PXR
Repairs to Complete Dentures	
D5511	Cost of repairs cannot exceed replacement costs. A 3–20, PXR
D5512	Cost of repairs cannot exceed replacement costs. A 3–20, PXR
D5520	Cost of repairs cannot exceed replacement costs. A 3–20, PXR
Repairs to Partial Dentures	
Cost of repairs cannot exceed replacement costs. The laboratory portion of the claim, not to exceed $137.50, must be submitted.	
D5611*	A 3-20, PXR
D5612*	A 3-20, PXR
D5630*	A 6–20, PXR
D5640*	A 6–20, PXR
D5650*	A 6–20, PXR
D5660*	A 6–20, PXR

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D5670*	Will be denied as part of procedure codes D5211, D5213, and D5640. A 6–20
D5671*	Will be denied as part of procedure codes D5212, D5214, and D5640. A 6–20
Denture Rebase Procedures	
D5710	A 4–20, PXR.
D5711	A 4–20, PXR.
D5720*	A 7–20, PXR.
D5721*	A 7–20, PXR.
Denture Reline Procedures	
Allowed whether or not the denture was obtained through THSteps or ICF-IID dental services if the reline makes the denture serviceable.	
D5730	A 4–20, N, PXR, CCP.
D5731	A 4–20, N, PXR, CCP.
D5740*	A 7–20, N, PXR, CCP.
D5741*	A 7–20, N, PXR, CCP.
D5750	A 4–20, PXR.
D5751	A 4–20, PXR.
D5760*	A 7–20, PXR.
D5761*	A 7–20, PXR.
Interim Prosthesis	
D5810	A 3–20, N, PXR, CCP
D5811	A 3–20, N, PXR, CCP
D5820	A 3–20, N, PXR, CCP
D5821	A 3–20, N, PXR, CCP
Other Removable Prosthetic Services	
D5850	A 3–20, N, PXR, CCP
D5851	A 3–20, N, PXR, CCP
D5862	A 4–20, N, PXR, CCP
D5863	A 4-20, N, PXR, CCP
D5864	A 4-20, N, PXR, CCP
D5865	A 4-20, N, PXR, CCP
D5866	A 4-20, N, PXR, CCP
D5899	A 1–20, N, PXR, CCP
Maxillofacial Prosthetics	
D5911	A 1–20, N, PXR, CCP
D5912	A 1–20, N, PXR, CCP
D5913	A 1–20, N, PXR, CCP
D5914	A 1–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D5915	A 1–20, N, PXR, CCP
D5916	A 1–20, N, PXR, CCP
D5919	A 1–20, N, PXR, CCP
D5922	A 1–20, N, PXR, CCP
D5923	A 1–20, N, PXR, CCP
D5924	A 1–20, N, PXR, CCP
D5925	A 1–20, N, PXR, CCP
D5926	A 1–20, N, PXR, CCP
D5927	A 1–20, N, PXR, CCP
D5928	A 1–20, N, PXR, CCP
D5929	A 1–20, N, PXR, CCP
D5931	A 1–20, N, PXR, CCP
D5932	A 1–20, N, PXR, CCP
D5933	A 1–20, N, PXR, CCP
D5934	A 1–20, N, PXR, CCP
D5935	A 1–20, N, PXR, CCP
D5936	A 1–20, N, PXR, CCP
D5937	Not for temporo-mandibular dysfunction (TMD) treatment. A 1–20, N, PXR, CCP
D5951	Prior authorization. A Birth–20, N, PXR
D5952	Prior authorization. A Birth–20, N, PXR
D5953	Prior authorization. A 13–20, N, PXR
D5954	Prior authorization. A Birth–20, N, PXR
D5955	Prior authorization. A Birth–20, N, PXR
D5958	Prior authorization. A Birth–20, N, PXR
D5959	Prior authorization. A Birth–20, N, PXR
D5960	Prior authorization. A Birth–20, N, PXR
D5982	A 1–20, N, PXR, CCP
D5983	A 1–20, N, PXR, CCP
D5984	A 1–20, N, PXR, CCP
D5985	A 1–20, N, PXR, CCP
D5986	A 1–20, N, PXR, CCP
D5987	A 1–20, N, PXR, CCP
D5988	A 1–20, N, PXR
D5992*	
D5993*	
D5999	A 1–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Any maxillary denture rebase or reline (procedure codes D5710, D5720, D5730, D5740, D5750, and D5760) will be denied when performed within one rolling year of a maxillary full or partial denture (procedure codes D5110, D5130, D5211 and D5213), any provider.

Any mandibular denture rebase or reline (procedure codes D5711, D5721, D5731, D5741, D5751, and D5761) will be denied when performed within one rolling year of a mandibular full or partial denture (procedure codes D5120, D5140, D5212, and D5214), any provider.

For an existing full or partial maxillary denture, only one denture rebase or reline procedure (procedure code D5710, D5720, D5730, D5740, D5750 or D5760) may be reimbursed every three rolling years, same provider.

For an existing full or partial mandibular denture, only one denture rebase or reline procedure (procedure code D5711, D5721, D5731, D5741, D5751 or D5761) may be reimbursed every three rolling years, same provider.

3.2.20 Prosthodontic (Fixed) Services

Prosthodontic procedure codes require prior authorization.

Refer to: Subsection 3.2.29, "Mandatory Prior Authorization" in this handbook for documentation requirements.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- The space cannot be filled with a removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).
- Each abutment or each pontic constitutes a unit in a bridge.
- Porcelain is allowed on all teeth.

Procedure Code	Limitations
Fixed Partial Dental Pontics	
D6210	A 16–20, PPXR, MTID, CCP
D6211	A 16–20, PPXR, MTID, CCP
D6212	A 16–20, PPXR, MTID, CCP
D6240	A 16–20, PPXR, MTID, CCP
D6241	A 16–20, PPXR, MTID, CCP
D6242	A 16–20, PPXR, MTID, CCP
D6245	A 16–20, PPXR, MTID, CCP
D6250	A 16–20, PPXR, MTID, CCP
D6251	A 16–20, PPXR, MTID, CCP
D6252	A 16–20, PPXR, MTID, CCP
Fixed Partial Dental Retainers—Inlays/Onlays	
A=Age range limitations, N=Narrative required, FMX=Full–mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	Limitations
D6545	A 16–20, PPXR, CCP
D6548	A 16–20, PPXR, CCP
D6549	A 16-20, PPXR, CCP
Fixed Partial Dental Retainers—Crowns	
D6720	A 16–20, PPXR, CCP
D6721	A 16–20, PPXR, CCP
D6722	A 16–20, PPXR, CCP
D6740	A 16–20, PPXR, CCP
D6750	A 16–20, PPXR, CCP
D6751	A 16–20, PPXR, CCP
D6752	A 16–20, PPXR, CCP
D6780	A 16–20, PPXR, CCP
D6781	A 16–20, PPXR, CCP
D6782	A 16–20, PPXR, CCP
D6783	A 16–20, PPXR, CCP
D6790	Permanent posterior teeth only. A 16–20, PPXR, CCP
D6791	Permanent posterior teeth only. A 16–20, PPXR, CCP
D6792	Permanent posterior teeth only. A 16–20, PPXR, CCP
Other Fixed Partial Dental	
D6920	A 16–20, PXR, CCP
D6930	A 16–20, PXR, CCP
D6940	A 16–20, N, PXR, CCP
D6950	A 16–20, N, PXR, CCP
D6980	A 16–20, N, PXR, CCP
D6999	A 16–20, N, PXR, CCP
A=Age range limitations, N=Narrative required, FMX=Full–mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

3.2.21 Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia and visits for routine postoperative care. Suturing is included in oral surgery procedures unrelated to trauma and is not separately reimbursable.

Procedure Code	Limitations
D7111	TIDs #A–T and AS–TS. A Birth–20
D7140*	Replaces procedure codes D7110, D7120, and D7130. A Birth–20, PXR
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	Limitations
Surgical Extractions	
D7210*	Includes removal of the roots of a previously erupted tooth missing its clinical crown. A 1–20, PXR
D7220*	A 1–20, PXR
D7230*	A 1–20, PXR
D7240	A 1–20, PXR
D7241	Document unusual circumstance. A 1–20, N, PXR
D7250*	Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred. A 1–20, N, PXR
Other Surgical Procedures	
D7260	Requires prior authorization. A 1–20, N, PXR; TIDs #1–16 only.
D7261	May not be paid for the same DOS as D7260; TIDs #1–16 only. A 1–20
D7270*	A 1–20, N, PXR, CCP
D7272	Requires prior authorization. A 1–20, N, PXR, CCP
D7280	A 1–20, N, PXR. Procedure code D7280 will be denied unless billed with an authorized procedure code D7283 for the same tooth, on the same day, by the same provider.
D7282	Permanent TIDs #1–32 only; may not be paid for the same DOS as D7280. A 4–20
D7283	Requires prior authorization. A 1–20; TIDs #2-15 and 18-31. To obtain prior authorization, the following items must be submitted: a prior authorization request form, a copy of an authorized Medicaid orthodontic treatment plan, and a current panoramic radiograph to determine medical necessity.
D7285	A 1–20, PXR, PATH, CCP
D7286*	A 1–20, PXR, PATH, CCP
D7290	A 1–20, N, PXR, CCP
D7291	A 4–20, N, PXR, CCP
Alveoloplasty—Surgical Preparation of Ridge for Dentures	
D7310	A 1–20, N, PXR, CCP
D7320	A 1–20, N, PXR, CCP
Vestibuloplasty	
D7340	A 1–20, N, PXR, CCP
D7350	A 1–20, N, PXR, CCP
Surgical Excision of Soft Tissue Lesions	
D7410	A 1–20, PXR, PATH
D7411	A 1–20, PXR, PATH
D7413	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D7414	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
Surgical Excision of Intraosseous Lesions	
D7440	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
D7441	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
D7450	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
D7451	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
D7460	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth–20, N, PXR, PATH, CCP
D7461	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth–20, N, PXR, PATH, CCP
D7465	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
Excision of Bone Tissue	
D7472	Prior authorization is required. A 1–20
Surgical Incision	
D7510*	TID required. A 1–20, PXR
D7520	A 1–20, N, PXR, CCP
D7530	A 1–20, N, PXR
D7540	A 1–20, N, PXR
D7550*	A 1–20, N, PXR
D7560	A 1–20, N, PXR, CCP
D7670	A 1–20, N, PXR, CCP
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions	
D7820	A 1–20, N, PXR
D7880	A 1–20, N, PXR, CCP
D7899	A 1–20, N, PXR, CCP
Repair of Traumatic Wounds	
D7910*	A 1–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
Complicated Suturing	
D7911	A 1–20, N, PXR, CCP
D7912	A 1–20, N, PXR, CCP
Other Repair Procedures	
D7955	A 1–20
D7961	A 12-20. N, PXR
D7962	A 1-20. N, PHO
D7970*	A 1–20, N, PXR, CCP
D7971*	A 1–20, N, PXR, CCP
D7972	TIDs #1, 16, 17, and 32 only; may not be paid in addition to D7971 for the same DOS. A 13–20
D7980	A 1–20, N, PXR, CCP
D7983	A 1–20, N, PXR, CCP
D7997*	Per arch, appliance removal (not by the dentist who placed the appliance). Includes removal of arch bar. Prior authorization is required. A 1–20, N, PXR, CCP
D7999*	A 1–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

3.2.22 Adjunctive General Services

Procedure Code	Limitations
Unclassified Treatment	
D9110*	***Refer to:*** Subsection 3.2.22.1, "Benefit Limitations for Adjunctive General Services" in this handbook for benefit limitations. Emergency service only. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. Each claim submitted for payment must be marked as "Emergency" in the Description field, Block 30, and the original date of treatment or incident must be referenced in the "Remarks" field, Block 35. The appropriate box must be checked in the "Treatment Resulting From" field, Block 45, if applicable, and modifier ET must be used to indicate an emergency. Documentation to support the emergency and the treatment performed must be maintained in the client's dental medical record. Subsection 3.2.27, "Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger" in this handbook
D9120	A 13-20, N, PXR
Anesthesia	

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
Refer to:	Criteria for Dental Therapy Under General Anesthesia on the TMHP website at www.tmhp.com for general anesthesia criteria and additional information.
D9210	Limited to one per day, same procedure, same place of service, by the same provider on the same claim. Claim form narrative must describe the situation if used as a diagnostic tool. Denied if submitted with D9244, D9245, D9246, and D9247, on the same day, any provider. A 1–20, N, CCP
D9211*	Limited to one per day, same procedure, same place of service, by the same provider on the same claim. Denied if submitted with D9244, D9245, D9246, and D9247, on the same day, any provider. A 1–20, N, CCP
D9212*	Limited to one per day, same procedure, same place of service, by the same provider on the same claim. Denied if submitted with D9244, D9245, D9246, and D9247, on the same day, any provider. A 1–20, N, CCP
D9222	Primary procedure code indicating first 15 minutes of deep sedation/general anesthesia. Limited to once per six calendar months, any provider. Prior authorization is required for clients who are six years of age or younger. Providers who do not have proof of anesthesiology residency on file with TMHP will still be eligible for reimbursement. A 1–20
D9223	Prior authorization is required. Add on procedure code indicating additional 15 minute increments of deep sedation/general anesthesia. Limited to two hours and forty five minutes per day, and once per six calendar months, any provider. Providers who do not have proof of anesthesiology residency on file with TMHP will still be eligible for reimbursement. A 1–20
D9224	Limited to once per six calendar months per client, any provider. Limited to 15 minutes per day. Prior authorization is required for clients who are six years of age or younger. A 1-20
D9225	Limited to once per six calendar months per client, any provider. Must be billed with procedure code D9224. Limited to two hours and forty five minutes per day. Prior authorization is required for clients who are six years of age or younger. A 1-20
D9230*	Limited to one per day, same procedure, same place of service, by the same provider on the same claim. May not be submitted more than one per client, per day. Denied if submitted with D9244, D9245, D9246, and D9247, on the same day, any provider. A 1–20
D9239	Primary procedure code indicating first 15 minutes of moderate sedation. Limited to 15 minutes per day, same provider. Denied if submitted with D9222 or D9224, on the same day, any provider. A 1-20
D9243	Add-on procedure code indicating additional 15 minute increments of moderate sedation. Limited to one hour and fifteen minutes per day, same provider. Must be billed with procedure code D9239. A 1–20
D9244	Limited to two per year. Additional services may be considered with prior authorization and documentation of medical necessity. Denied when billed on the same day as procedure codes D9222, D9224, D9239, D9420, or D9920. A 1-20
D9245	Limited to two per year. Additional services may be considered with prior authorization and documentation of medical necessity. Denied when billed on the same day as procedure codes D9222, D9224, D9239, D9420, or D9920. A 1-20

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D9246	Limited to two per year. Additional services may be considered with prior authorization and documentation of medical necessity. Denied when billed on the same day as procedure codes D9222, D9224, D9239, D9420, or D9920. A 1-20
D9247	Limited to two per year. Additional services may be considered with prior authorization and documentation of medical necessity. Denied when billed on the same day as procedure codes D9222, D9224, D9239, D9420, or D9920. A 1-20
Professional Consultation	
D9310	An oral evaluation by a specialist of any type who is also providing restorative or surgical services must be submitted as D0160. A 1–20, N, CCP
Professional Visits	
D9410	Narrative required on claim form. A 1–20, N
D9420	Limited to twice per rolling year, per client, any provider. Documentation supporting the medical necessity of a dental hospital call, including any medical, physical, (e.g.,traumatic event), mental or behavioral disability, and a description of the service performed that requires a hospital call must be retained in the client's dental record and will be subject to retrospective review. Charts are subject to retrospective review. A 1–20, N
D9430	During regularly scheduled hours, no other services performed. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1–20, N
D9440	Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1–20, N
Drugs	
Procedure code D9630 is not payable for take home fluorides or drugs. Prescriptions should be given to clients to be filled by the pharmacy for these medications as the pharmacy is reimbursed by the Texas Vendor Drug Program. Procedure code D9630 is payable for medications (antibiotics, analgesics, etc.) administered to a client in the provider's office. Documentation of dosage and route of administration must be provided in the Remarks section of the claim. The *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*).	
D9610	A 1–20, N
D9612	Prior authorization is required. Limited to two times per rolling year, any provider. A 13-20, N, PXR
D9630	Includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. May not be submitted with codes D9230, D9241, D9610, and D9920. A 1–20, N
Miscellaneous Services	
D9910	Per whole mouth application. Not to be used for bases, liners, or adhesives under or with restorations. Limited to once per six months, any provider. A 18–20, N, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D9920	The provider must indicate the client's medical diagnosis of intellectual disability described as mild, moderate, severe, profound, or unspecified by using the most appropriate diagnosis code in the diagnosis code field of the claim form, or the provider must indicate that the client is ICF-IID eligible in the Remarks field of the claim form. Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client's chart and available to state agencies upon request, and is subject to retrospective review. Documentation of medical necessity must include: A current physician statement detailing the client's the intellectual disability. The statement must be signed and dated within one year prior to the dental behavior management. A description of the service performed (including the specific problem and the behavior management technique applied). Personnel and supplies required to provide the behavioral management. The duration of the behavior management (including session start and end times). Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. A 1–20
D9930*	Prior authorization is required. A 1–20, N
D9944	A 16-20, N, CCP
D9950	A 13–20, N, CCP
D9951	Full mouth procedure. Limited to once every three rolling years, per client, any provider. A 13–20, N, CCP
D9952	Full mouth procedure. Payable once per lifetime, any provider. A 13–20, N, CCP
D9970	One service per day, any provider. A 13–20
D9974*	Claim must include documentation of medical necessity. A 13–20, CCP
D9999*	A 1–20, N, CCP, PPXR
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

3.2.22.1 Benefit Limitations for Adjunctive General Services

Procedure code D9110 is a benefit for the following:

- Sedative or periodontal dressing
- Starting root canal procedure; i.e., open and drain tooth or re-medication of previously opened tooth
- Smoothing fractured tooth that is cutting lips or cheek
- Debridement or curettage of wound
- Excision of operculum over an erupting tooth
- Limited gingivectomy
- Suture removal by dentist other than the dentist who placed suture(s)

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- Placement of a temporary crown by other than the patient's regular dentist and one who is not in the process, has not previously, or does not in the future intend to perform an acrylic, polycarbonate, stainless steel or cast crown on this same tooth
- Tissue conditioning of a full or partial denture
- Removal of spontaneously or post-surgically sequested bone spicule
- Spot or limited scaling and root planing
- Procedures necessary to treat a dry socket
- Procedures necessary to control bleeding
- Non-surgical reduction of TMJ dislocation
- Procedures necessary to relieve pain associated with pericoronitis, particularly third molars

Procedure code D9110 is not a benefit for the following:

- A written prescription
- Medication given or administered
- Application of topical medication to teeth or gums
- Occlusal adjustments
- Oral hygiene instructions

Palliative treatment (procedure code D9110) and interim restoration (procedure code D2940) are not both payable when performed on the same tooth ID, on the same date of service, by the same provider.

3.2.23 Dental Anesthesia

Dental providers must have the following information on file with TMHP to be eligible for reimbursement for dental anesthesia:

- A current anesthesia permit level issued by the TSBDE.
- Providers must have a Level 4 permit and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to bill the enhanced rate for procedure codes D9222, D9223, D9224, and D9225.

All dental providers must comply with the American Academy of Pediatric Dentistry (AAPD) guidelines and TSBDE rules and regulations, including the standards for documentation and record maintenance for dental anesthesia.

3.2.23.1 Anesthesia Permit Levels

The following table shows the levels of anesthesia permits that are issued by the TSBDE:

Permit Level	Description of Level	Permit Privileges
Nitrous oxide/oxygen inhalation conscious sedation		Stand-alone permit
Level 1	Minimal sedation	Stand-alone permit
Level 2	Moderate enteral	Automatically qualifies for Level 1 and Level 2 permit privileges
Level 3	Moderate parenteral	Automatically qualifies for Level 1, Level 2, and Level 3 permit privileges

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Permit Level	Description of Level	Permit Privileges
Level 4	Deep sedation/general anesthesia	Automatically qualifies for Level 1, Level 2, Level 3, and Level 4 permit privileges

All providers must have the appropriate anesthesia permit when proceeding with the procedure codes in the table below. The following table indicates the anesthesia procedure codes and the minimum anesthesia permit level to be reimbursed for the procedure codes:

Procedure Codes	Minimum Anesthesia Permit Level
D9211	Level 3
D9212	Level 3
D9222	Level 4
D9223	Level 4
D9224	Level 4
D9225	Level 4
D9230	Stand-alone permit for nitrous oxide/oxygen inhalation conscious sedation or Level 1
D9239	Level 3
D9243	Level 3
D9244	Level 1
D9245	Level 2
D9246	Level 3
D9247	Level 3

Local anesthesia in conjunction with operative or surgical services (procedure code D9215) is all inclusive with any other dental service and is not reimbursed separately.

3.2.23.2 Method for Counting Minutes for Timed Procedure Codes

All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

Time intervals for 1 through 12 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes
9 units	128 minutes through 142 minutes
10 units	143 minutes through 157 minutes

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Units	Number of Minutes
11 units	158 minutes through 172 minutes
12 units	173 minutes through 187 minutes

All levels of sedation must have clinical documentation and a narrative in the client's dental record to support the necessity of the service. Documentation must include the sedation record that indicates sedation start and end times in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines. The client's dental record must be available for review by representatives of HHSC or its designee.

3.2.24 Hospitalization and ASC/HASC

Dental services performed in an ASC, HASC, or a hospital (either as an inpatient or an outpatient) may be benefits of THSteps based on the medical or behavioral justification provided, or if one of the following conditions exist:

- The procedures cannot be performed in the dental office.
- The client is severely disabled.

To satisfy the preadmission history and physical examination requirements of the hospital, ASC, or HASC, a THSteps medical checkup for dental rehabilitation or restoration may be performed by the child's primary care provider. Physicians who are not enrolled as THSteps medical providers must submit claims for the examination of a client before the procedure with the appropriate evaluation and management procedure code from the following table:

Procedure Code	Place of Service (POS)
99202	POS 1 (office)
99222	POS 3 (inpatient hospital)
99282	POS 5 (outpatient hospital)

Refer to: Subsection 3.2.13.1, "Exceptions to Periodicity" in this handbook.

Note: *The dental provider must submit claims to TMHP using the ADA Dental Claim Form to be considered for reimbursement through THSteps Dental Services.*

The dental provider is responsible for obtaining prior authorization for the services performed under general anesthesia. Hospitals, ASC's, and anesthesiologists must obtain the prior authorization number from the dental provider.

Contact the individual HMO for precertification requirements related to the hospital procedure. If services are precertified, the provider receives a precertification number effective for 90 days.

In those areas of the state with Medicaid managed care, the provider should contact the managed care plan for specific requirements or limitations. It is the dental provider's responsibility to obtain precertification from the client's HMO or managed care plan for facility and general anesthesia services if precertification is required.

To be reimbursed by the HMO, the provider must use the HMO's contracted facility and anesthesia provider. These services are included in the capitation rates paid to HMOs, and the facility or anesthesiologist risk nonpayment from the HMO without such approval. Coordination of all specialty care is the responsibility of the client's primary care provider. The primary care provider must be notified by the dentist or the HMO of the planned services.

Dentists providing sedation or anesthesia services must have the appropriate current permit from the TSBDE for the level of sedation or anesthesia provided.

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The dental provider must be in compliance with the guidelines detailed in General Information.

Note: *Post-treatment authorization will not be approved for codes that require mandatory prior authorization.*

3.2.25 Orthodontic Services (THSteps)

Orthodontic services are a benefit for THSteps clients who are 13 years of age and older who have either permanent dentition and a severe handicapping malocclusion or one of the following special medical conditions:

- Cleft palate
- Post-head trauma injury involving the oral cavity
- Skeletal anomalies involving the oral cavity

A severe handicapping malocclusion is defined by Texas Medicaid as an occlusion that is severely functionally compromised and is described in detail in levels I, II, and III.

Exception to the age restriction may be considered for clients who are 12 years of age and younger if medical necessity has been verified by the dental director for one of the following:

- Crossbite therapy
- Limited orthodontic treatment and minor treatment to control harmful habits
- Special medical conditions

Dental services that are not covered by THSteps Dental Services but are medically necessary and allowable may be a benefit under CCP according to federal Medicaid guidelines and TAC.

As required by the Texas Human Resources Code, clients who are 14 years of age and younger must be accompanied to Texas Health Steps dental checkups and visits by the client's parent, legal guardian, or another adult who is authorized by the parent or legal guardian. The authorized adult can be the client's relative. The individual accompanying the client must wait for the client while the appointment takes place.

Exempt entities (school health clinics, Head Start program, or childcare facilities) that provide services must as a condition of reimbursement:

- Obtain written, unrevoked consent for the services from the client's parent or legal guardian within a one-year period before the date of service.
- Encourage parental involvement in and management of the health care of the clients who receive services from the clinic, program, or facility.

Orthodontic services should not be performed without an in-person examination and review of diagnostic imaging by a licensed dentist to ensure patient safety, as required by Texas Health and Safety Code, Section 431.024.

The following definitions of dentition established by the ADA's Current Dental Terminology (CDT) manual are recognized by Texas Medicaid:

- Primary Dentition: Teeth developed and erupted first in order of time.
- Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

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- Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Texas Medicaid recognizes three orthodontic service levels for severe handicapping malocclusion. Each service level requires a different amount of time for treatment.

Level I Orthodontic Services

Level I orthodontic services are dedicated to resolution of early signs of handicapping malocclusion in the early mixed dentition, which may significantly impact the health of the developing dentition, alveolar bone, and symmetrical growth of the skeletal framework.

Mixed dentition is defined by Texas Medicaid as a presence of the maxillary and mandibular permanent molars, and the maxillary and mandibular incisors fully erupted, and deciduous teeth.

Exceptions for cases of mixed dentition may be considered when the treatment plan includes extractions of the remaining primary teeth or in the case of a cleft palate.

Evidence of one of the following conditions should be clearly visible and submitted in the supporting documentation:

- An anterior crossbite that is associated with clinically apparent severe gingival inflammation and/or gingival recession or severe enamel wear
- A posterior crossbite with an associated midline deviation and asymmetric closure pattern
- Dental crossbites other than those described above will not be eligible for treatment in level I. However, special orthodontic appliances are a benefit for minor treatment to control harmful habits.

Procedure codes D8210 and D8220 may be reimbursed for level I orthodontic services.

Level II Orthodontic Services

Level II orthodontic services are dedicated to the resolution of handicapping malocclusion in the transitional dentition, which is the final phase of the transition from primary to adolescent dentition during which the succedaneous permanent teeth are emerging or about to emerge.

Providers must use the appropriate procedure code that is applicable for banding when billing for level II orthodontic services.

Procedure codes D8010, D8020, and D8070 may be reimbursed for level II orthodontic services.

Level III Orthodontic Services

Level III orthodontic services are dedicated to resolution of handicapping malocclusion in the adolescent dentition, which is indicated by the complete eruption of the permanent dentition with the possible exception of the full eruption of the second molars.

Procedure code D8080 may be reimbursed for level III orthodontic services.

Completion or Premature Termination of Orthodontic Services

The completion of orthodontic services includes the construction of both maxillary and mandibular retainers in addition to the removal of all bands, brackets, and appliances.

Premature termination of orthodontic services includes all the following:

- The removal of brackets and arch wires
- The use of other special orthodontic appliances
- The fabrication of special orthodontic appliances
- The delivery of orthodontic retainers

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Procedure code D8680 may be reimbursed for the completion or premature termination of orthodontic services.

3.2.25.1 Non-covered Services

Single arch comprehensive orthodontic treatment is not a benefit of Texas Medicaid.

Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid. Although aesthetics is an important part of self-esteem, services primarily for self-worth are not within the scope of this Texas Medicaid benefit.

Orthodontic services for a client who initiated orthodontic treatment through a private arrangement while Medicaid-eligible are not a benefit of Texas Medicaid.

An initial orthodontic or pre-orthodontic treatment visit (procedure code D8660) is considered part of the exam in an oral evaluation (procedure codes D0120, D0150, or D0160).

3.2.25.2 Comprehensive Orthodontic Treatment

Comprehensive orthodontic services (procedure code D8080) are restricted to clients who are 13 years of age and older or clients who have exfoliated all primary dentition.

ADA CDT procedure codes do not allow for any work-in-progress or partial submission of a claim by separating the three orthodontic components: diagnostic workup, orthodontic appliance (upper), or orthodontic appliance (lower).

3.2.25.3 Orthodontic Procedure Codes and Limitations

When submitting claims for orthodontic procedures, use the following procedure codes:

Procedure Code	Limitations
Orthodontic Services	
D0330*, D0340*, D0350*, D0470*, and D8660	Denied when submitted with procedure codes D8070 and D8080.
D7280	A 1-20
D7997*	Not payable to the dentist who placed the appliance. Includes removal of arch bar and premature removal of braces. A 1-20
Limited Orthodontic Treatment	
D8010*	Replaces D8050. Limited to one per lifetime, any provider.
D8020*	Replaces D8060. Limited to one per lifetime, any provider.
Comprehensive Orthodontic Treatment	
D8070	Limited to one per lifetime, any provider.
D8080*	Limited to one per lifetime, any provider.
Minor Treatment to Control Harmful Habits	
D8210*	Limited to once per arch, per lifetime, any provider.
D8220*	Limited to once per arch, per lifetime, any provider.
Other Orthodontic Services	
D8660*	Denied when submitted for the same DOS as D0145 by any provider. Denied when submitted for the same DOS as D0120, D0150, or D0160 by the same provider. Denied when submitted with procedure codes D8070 and D8080.
D8670*	Limited to one service per calendar month, same provider.
*** = Services payable to an FQHC for a client encounter.**	

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Procedure Code	Limitations
D8680*	One retainer per arch per lifetime, any provider. May be replaced once because of loss or breakage (prior authorization is required).
D8999	
*** = Services payable to an FQHC for a client encounter.**	

The diagnostic workup is considered part of the pre-orthodontic visit (procedure code D8660). Reimbursement for the pre-orthodontic visit (procedure code D8660) may be considered when all bands, brackets, and appliances have been placed and active treatment has been initiated.

The orthodontic diagnostic workup procedures are considered part of the services provided under procedure codes D8210 and D8220 and are not reimbursed separately.

Panoramic radiographic images (procedure code D0330), cephalometric radiographic images (procedure code D0340), oral or facial photographic images obtained intraorally or extraorally (procedure code D0350), and diagnostic models (procedure code D0470) will be denied when billed with procedure code D8210 or D8220.

The orthodontic diagnostic workup procedures are considered part of the services provided under procedure codes D8010 or D8020 and are not reimbursed separately. Panoramic radiographic images (procedure code D0330), cephalometric radiographic images (procedure code D0340), oral or facial photographic images obtained intraorally or extraorally (procedure code D0350), and diagnostic models (procedure code D0470) will be denied when billed with procedure code D8010 or D8020.

Procedure code D0160 will be denied when submitted on the same date of service as procedure code D8080.

Cleft or craniofacial cases are eligible for more than one level of orthodontic services (level II and level III) per lifetime.

Procedure codes D8660 and D8670 may be reimbursed for additional comprehensive orthodontic services.

The length of treatment depends on the level of orthodontic services that the client receives as indicated below:

- Level I allows up to 10 monthly visits that are expected to be completed within 12 months unless an exception is authorized.
- Level II allows up to 22 monthly visits that are expected to be completed within 24 months unless an exception is authorized.
- Level III allows up to 22 monthly visits that are expected to be completed within 36 months unless an exception is authorized.

3.2.26 Submitting Local Codes for Orthodontic Procedures

To ensure appropriate claims processing, the local code reflecting the specific service is required on the claim.

For electronic submissions other than TexMedConnect submissions, providers must follow the steps below to ensure the correct local code is accurately applied to the appropriate claim detail:

1) Submit the DPC prefix in the first three bytes of NTE02 at the 2400 loop. Submit the DPC prefix only once.
2) Submit the remarks code (local code) in bytes 4–8, based on the order of the claim detail. Do not enter any spaces or punctuation between remarks codes unless to designate that the detail is not billed with procedure code D8210 or D8220.

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Example: *For a claim with three details, where details 1 and 3 are submitted with procedure code D8210 and detail 2 is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D (The space shows that detail 2 needs no local code.)*

Example: *If all three details require a local code, enter DPC and the appropriate local codes in sequence without any spaces between the codes: DPC1024D1055D1056D (The absence of spaces indicates that local codes are needed for all three details.)*

To submit using TexMedConnect, enter the local code into the Remarks Code field located under the Details header. The Remarks Code field is the field following the Procedure Code field. TexMedConnect submitters are not required to enter the DPC prefix because it is automatically placed in the appropriate field on the TexMedConnect electronic claim.

For paper claim submissions, providers must enter the local code in the Remarks section of the claim form.

Failure to follow the above steps does not cause the claim to be denied; however, manual intervention is required to process the claim, and a delay of payment may be the result.

Orthodontic procedure codes that were local codes used for prior authorization and reimbursement have been converted to Current Dental Terminology (CDT) (national) procedure codes.

The following procedures are not included in comprehensive treatment:

CDT Procedure Code	Remarks Code	Description
D8660	Z2009	Initial orthodontic visit
D8670	Z2013	Orthodontic adjustments, per month
D7997*	Z2016	Premature appliance removal, per arch
***May only be paid to a provider not billing for comprehensive treatment.**		

Procedure code D8080 is a comprehensive code and includes a diagnostic workup as well as all upper and lower orthodontic appliances (braces) necessary to treat the client.

CDT Procedure Code	Remarks Code	Description
D8080	Z2009 *or* Z2011 *or* Z2012	Diagnostic workup, approved *or* Orthodontic appliance, upper (braces) *or* Orthodontic appliance, lower (braces)

When a diagnostic workup is not approved, individual components may be considered for separate reimbursement. Use the following procedure codes:

CDT Procedure Code	Remarks Code	Description
D0330	Z2010	Diagnostic workup, not approved
D0340	Z2010	Diagnostic workup, not approved
D0350	Z2010	Diagnostic workup, not approved

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CDT Procedure Code	Remarks Code	Description
D0470	Z2010	Diagnostic workup, not approved

Procedure code D8680 includes all retainers necessary to treat the client. Use the following remarks codes according to the services provided:

Remarks Code	Description
1033D	Mandibular, fixed, 2x4 retainer
1034D	Mandibular, fixed, 3x3 retainer
1035D	Mandibular, fixed, 4x4 retainer
Z2014	Orthodontic retainer, upper
Z2015	Orthodontic retainer, lower

Procedure code D8010 includes a crossbite workup and removable appliance. Use the following remarks codes according to the services provided:

Remarks Code	Description
8110D	Crossbite therapy, removable appliance
Z2018	Crossbite, workup

Procedure code D8020 includes a crossbite workup and the fixed appliance. Use the following remarks codes according to the services provided:

Remarks Code	Description
8120D	Crossbite therapy, fixed appliance
Z2018	Crossbite, workup

The orthodontic diagnostic workup procedures are considered inclusive procedures. Procedure codes D0330, D0340, D0350, and D0470 are denied when billed with a diagnostic workup procedure.

The following tables display the special fixed and removable orthodontic appliances. Under the current provisions of the Health Insurance Portability and Accountability Act (HIPAA), all fixed appliances are designated as procedure code D8220, and all removable appliances are designated as procedure code D8210. These are entered as a line item on the paper American Dental Association (ADA) Dental Claim Form with the appropriate fee. However, the remarks codes (former local procedure codes), as appropriate and listed below, also need to be entered on the authorization request form and in the Remarks field of the dental claim form (paper and electronic) to ensure correct authorization, accurate records, and reimbursement. *Failure to bill the correct procedure codes may result in claim processing delays.*

Note: *Prior authorization must be requested using both the CDT procedure code and the remarks codes for orthodontia services.*

Use the following remarks codes in the Remarks field for fixed appliances (procedure code D8220):

Remarks Code	Fixed Appliances Description
1000D	Appliance for horizontal projections
1001D	Appliance for recurved springs
1002D	Arch wires for crossbite correction, for total treatment
1003D	Banded maxillary expansion appliance

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Remarks Code	Fixed Appliances Description
1008D	Bonded expansion device
1012D	Crib
1015D	Distalizing appliance with springs
1016D	Expansion device
1018D	Fixed expansion device
1019D	Fixed lingual arch
1020D	Fixed mandibular holding arch
1021D	Fixed rapid palatal expander
1025D	Herbst appliance, fixed or removable
1026D	Interocclusal cast cap surgical splints
1028D	Jasper jumpers
1029D	Lingual appliance with hooks
1030D	Mandibular anterior bridge
1031D	Mandibular bihelix, similar to a quad helix for mandibular expansion to attempt nonextraction treatment
1036D	Mandibular lingual, 6x6, arch wire
1042D	Maxillary lingual arch with spurs
1043D	Maxillary and mandibular distalizing appliance
1044D	Maxillary quad helix with finger springs
1045D	Maxillary and mandibular retainer with pontics
1049D	Modified quad helix appliance
1050D	Modified quad helix appliance, with appliance
1051D	Nance stent
1052D	Nasal stent
1057D	Palatal bar
1058D	Post surgical retainer
1059D	Quad helix appliance held with transpalatal arch horizontal projections
1060D	Quad helix maintainer
1061D	Rapid palatal expander (RPE), i.e., quad helix, haas, or menne
1068D	Stapled palatal expansion appliance
1072D	Thumb sucking appliance, requires submission of models
1076D	Transpalatal arch
1077D	Two bands with transpalatal arch and horizontal projections forward
1078D	W-appliance

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Use the following remarks codes in the Remarks field for removable appliances (procedure code D8210):

Remarks Code	Removable Appliances Description
1004D	Bite plate/bite plane
1005D	Bionator
1006D	Bite block
1007D	Bite plate with push springs
1010D	Chateau appliance (face mask, palatal expander, and hawley)
1011D	Coffin spring appliance
1013D	Dental obturator, definitive (obturator)
1014D	Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)
1017D	Face mask (protraction mask)
1022D	Frankel appliance
1023D	Functional appliance for reduction of anterior open bite and crossbite
1024D	Head gear (face bow)
1027D	Intrusion arch
1032D	Mandibular lip bumper
1037D	Mandibular removable expander with bite plane (crozat)
1038D	Mandibular ricketts rest position splint
1039D	Mandibular splint
1040D	Maxillary anterior bridge
1041D	Maxillary bite-opening appliance with anterior springs
1046D	Maxillary Schwarz
1047D	Maxillary splint
1048D	Mobile intraoral arch (MIA), similar to a bihelix for nonextraction treatment
1053D	Occlusal orthotic device
1054D	Orthopedic appliance
1055D	Other mandibular utilities
1056D	Other maxillary utilities
1062D	Removal bite plane
1063D	Removable mandibular retainer
1064D	Removable maxillary retainer
1065D	Removable prosthesis
1066D	Sagittal appliance, 2-way
1067D	Sagittal appliance, 3-way
1069D	Surgical arch wires
1070D	Surgical splints (surgical stent/wafer)
1071D	Surgical stabilizing appliance

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Remarks Code	Removable Appliances Description
1073D	Tongue thrust appliance, requires submission of models
1074D	Tooth positioner, full maxillary and mandibular
1075D	Tooth positioner with arch

The following procedure codes are used to bill orthodontic services:

ADA Procedure Codes									
D7997	D8010	D8020	D8070	D8080	D8210	D8220	D8660	D8670	D8680
D8999									

3.2.27 Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger

THSteps clients who are birth through 5 months of age are not eligible for routine dental checkups; however:

- They can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries, or other oral health problems.
- They may be referred to a dentist by their primary care provider when a medical checkup identifies the medical necessity for dental services.

Prior authorization is not required for emergency or trauma-related dental services. Claims for these dental services must be filed separately from nonemergency dental services. Only one emergency or trauma-related dental claim per client, per day, may be considered for reimbursement. Routine therapeutic procedures are not considered emergency or trauma-related procedures.

When submitting a claim for emergency or trauma-related dental services, the provider must:

- Enter the word "Emergency" or "Trauma" in the description field (Block 30) of the claim form (also enter a brief description of the CDT procedure code used). Claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.
- If checking the Other Accident box, briefly describe in the Remarks field, Block 35 of the claim form, what caused the emergency or trauma.
- Check the appropriate box in Block 45, Treatment Resulting From, of the claim form (the options to check are Occupational Illness/Injury, Auto Accident, or Other Accident).

Documentation to support the diagnosis and treatment of trauma must be retained in the client's record.

Note: *Indicating Trauma in the description field allows the provider to be reimbursed for treatment on an emergency, continuing, and long-term basis without regard to periodicity, subject to the client's eligibility and program limitations. An exception to periodicity for THSteps dental services is granted automatically for immediate treatment and any future follow-up treatment, as long as each claim submitted for payment is marked "Trauma" in the Description field, Block 30, and the original date of treatment or incident is referenced in the Remarks field, Block 35.*

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Refer to: Subsection 6.7, "American Dental Association (ADA) Dental Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 4.1, "General Medicaid Eligibility" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

Subsection 9.4, "Doctor of Dentistry Practicing as a Limited Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.2.15, "Medicaid Dental Benefits, Limitations, and Fee Schedule" in this handbook.

3.2.28 Emergency Services for Medicaid Clients Who Are 21 Years of Age and Older

Limited dental services are available for clients who are 21 years of age and older (not residing in an ICF-IID facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition.

Refer to: Subsection 9.4, "Doctor of Dentistry Practicing as a Limited Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for complete description and details.

3.2.28.1 Long Term Care (LTC) Emergency Dental Services

HHSC provides a limited range of dental services for Medicaid-eligible residents of LTC facilities. All claims for dental services provided to LTC residents are submitted to HHSC. For information, providers should contact the appropriate LTC facility or HHSC at 1-800-252-9240.

3.2.28.2 Laboratory Requirements

Dental laboratories must be registered with TSBDE laboratories, and technicians must not be under restrictions imposed by TSBDE or a court.

3.2.29 Mandatory Prior Authorization

Mandatory prior authorization is required for consideration of reimbursement to dental providers who render the following services:

- Orthodontia
- Endodontic endosseous implants
- Fixed prosthetic services
- Removable prosthodontics (procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960)
- Dental general anesthesia
- All inlays/onlays or permanent crowns
- Procedure code D4276
- Nonsurgical periodontal service (procedure codes D4341 and D4342)
- Procedure code D7272
- Procedure code D7283
- Procedure code D7472

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- Limited dental services for clients who are 21 years of age and older (not residing in an ICF-IID facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition
- Cone beam imaging

Approved orthodontic treatment plans must be initiated before the client's loss of Medicaid eligibility and before the 21st birthday, and must be completed within 36 months of the authorization date. Authorization for other procedures is valid for up to 90 days.

To obtain prior authorization for crowns, onlays, endodontic endosseous implants, and fixed prosthodontics, a prior authorization form together with documentation supporting medical necessity and appropriateness must be submitted. Required documentation includes, but is not limited to:

- The THSteps Dental Mandatory Prior Authorization Request Form.
- Current, dated, pre-operative periapical radiographs completely showing the apex of the tooth to be treated.
- Current, dated, pre-operative full arch radiographs are required for fixed prosthodontics.
- Documentation supporting that the mouth is free of disease; no untreated periodontal or endodontic disease, or rampant caries.
- Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown unless a Maryland Bridge is being considered.
- Provider documentation supporting the medical necessity and appropriateness of the recommended treatment.
- Tooth Identification (TID) System noting only permanent teeth.
- Documentation supporting that a removable partial is not a viable option to fill the space between the teeth.

Prior authorization will not be given when films show two abutment teeth (virgin teeth do not require a crown, except for Maryland Bridge) or there is untreated periodontal or endodontic disease, or rampant caries which would contraindicate the treatment.

Refer to: Subsection 9.4, "Doctor of Dentistry Practicing as a Limited Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Removable prosthodontics (procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960) for clients with cleft lip or cleft palate requires prior authorization with a completed THSteps Dental Mandatory Prior Authorization Request Form and narrative documenting the medical need for these appliances. Additional information may be requested by the TMHP Dental Director if necessary before making a determination.

The prior authorization number is required on claims for processing. If the client is not eligible for Medicaid on the DOS or the claim is incomplete, it will affect reimbursement. Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Note: *Post-treatment authorization will not be approved for codes that require mandatory prior authorization.*

Refer to: THSteps Dental Mandatory Prior Authorization Request Form on the TMHP website at www.tmhp.com.

3.2.29.1 Cone Beam Imaging

Prior authorization is required for procedure code D0367.

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Cone beam imaging is used to determine the best course of treatment for cleft palate repair, skeletal anomalies, post-trauma care, implanted or fixed prosthodontics, and orthodontic or orthognathic procedures. Cone beam imaging is limited to initial treatment planning, surgery, and postsurgical follow up.

To obtain prior authorization, a THSteps Dental Mandatory Prior Authorization Request Form must be submitted with documentation supporting medical necessity and appropriateness. Required documentation includes, but is not limited to, the following:

- Presenting conditions
- Medical necessity
- Status of the client's treatment

3.2.29.2 General Anesthesia for Dental Treatment

Prior authorization is required for the use of general anesthesia while rendering treatment (to include the dental service fee, the anesthesia fee, and facility fee) regardless of place of service. A client must meet the minimum requirement of 22 total points on the Criteria for Dental Therapy Under General Anesthesia form.

Refer to: Criteria for Dental Therapy Under General Anesthesia on the TMHP website at www.tmhp.com.

In those areas of the state with Medicaid Managed Care, precertification or approval is required from the client's health maintenance organization (HMO) for anesthesia and facility charges. It is the dental provider's responsibility to obtain precertification from the client's HMO or managed care plan for facility and general anesthesia services. A medical checkup prior to a dental procedure requiring general anesthesia is considered an exception to THSteps periodicity. A referral to the client's primary care physician is not required. Prior authorization is available for exceptions to periodicity. Providers must include all appropriate supporting documentation with the submittal. The criteria for general anesthesia applies only to treatment of clients who are 20 years of age and younger or ICF-IID program clients.

3.2.29.2.1 Dental Therapy Under General Anesthesia

Providers must comply with TSBDE Rules and Regulations, Title 22 TAC, Part 5, Chapter 110, §§110.6 –110.10. Any anesthesia type services are paid only to the provider. The dental provider is responsible for determining whether a client meets the minimum criteria necessary for receiving general anesthesia. A local anesthesia fee is not paid in addition to other restorative, operative, or surgical procedure fees.

For clients who are six years of age or younger, the following will apply:

- All Level 4 sedation/general anesthesia services provided by a dentist (procedure codes D9222, D9223, D9224, and D9225), and any anesthesia services provided by an anesthesiologist (M.D./D.O.) or certified registered nurse anesthetist (CRNA) to be provided in conjunction with dental therapeutic services (procedure code 00170 with modifier U3) must be prior authorized.
- The dentist performing the therapeutic dental procedure is responsible for obtaining prior authorization from TMHP and is responsible for providing the anesthesia prior authorization information to the anesthesiology provider.
- Prior authorization for both dental services and Level 4 sedation/general anesthesia service is mandatory for the reimbursement of either service.

Dental general anesthesia using procedure code D9222, D9223, D9224, D9225, or 00170 with modifier U3 is limited to once per six calendar months per client, by any provider. Add-on procedure code D9223 must be billed in conjunction with primary procedure code D9222, same provider.

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Each distinct dental procedure code to be performed that requires prior authorization must be listed on the Texas Health Steps Dental Mandatory Prior Authorization Request Form. Repetitive dental procedure codes must be listed to indicate the total quantity to be performed.

Requests for prior authorization must include, but is not limited to, the following client-specific documents and information:

- A completed Criteria for Dental Therapy Under General Anesthesia form
- A completed THSteps Dental Mandatory Prior Authorization Request Form
- The location of where the procedure(s) will be performed (office, inpatient hospital, or outpatient hospital)
- A narrative unique to the client, detailing the reasons for the proposed level of sedation (indicate procedure code D9222, D9223, or 00170). The narrative must include a history of prior treatment, information about failed attempts at other levels of sedation, behavior in the dental chair, proposed restorative treatment (tooth ID and surfaces), urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and any relevant medical condition(s).
- Diagnostic quality radiographs or photographs

  Note: *When appropriate radiographs or photographs cannot be taken prior to general anesthesia, the narrative must support the reasons for an inability to perform diagnostic services. For special cases that receive authorization, diagnostic quality radiographs or photographs will be required for payment and will be reviewed by the TMHP dental director.*

The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or reimbursement for clients who are six years of age and younger.

Note: *In cases of an emergency medical condition, accident, or trauma, prior authorization is not necessary. However, a narrative and appropriate pre- and post-treatment radiographs or photographs must be submitted with the claim, which will be reviewed by the TMHP dental director.*

A copy of the Criteria for Dental Therapy Under General Anesthesia form must be maintained in the client's dental record. The client's dental record must be available for review by representatives of the Health and Human Services Commission (HHSC) or its designee.

Prior authorization is required for medically necessary dental general anesthesia that exceeds once per six months, per client, any provider. The dental provider is responsible for obtaining prior authorization for the services performed under general anesthesia. Hospitals, ASCs, and anesthesiologists must obtain the prior authorization number from the dental provider.

Refer to: Criteria for Dental Therapy Under General Anesthesia on the TMHP website at www.tmhp.com. Dental rehabilitation or restoration services requiring general anesthesia may be performed in an office, inpatient, or outpatient facility.

Surgical services related to THSteps dental services requiring general anesthesia must be coded as follows:

- Procedure code 00170 with modifier U3 is for the anesthesiologist or certified registered nurse anesthetist (CRNA) to use on the claim form.
- Procedure code G0330 may be reimbursed for facility services in the outpatient hospital setting to ASCs and Hospital-based Ambulatory Surgical Centers (HASCs) for dental rehabilitation procedure(s) performed on a client who requires monitored anesthesia (e.g., general, intravenous sedation and the use of an operating room).
- An appropriate diagnosis code must be used on the claim form.

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- Modifier U3 identifies that the service is associated with THSteps.

The claim forms used are the CMS-1500 or the UB-04 CMS-1450 paper claim forms. The examining physician, anesthesiologist, hospital, ASC, or HASC must submit claims to TMHP separately for the medical and facility components of their services.

Refer to: THSteps Dental Mandatory Prior Authorization Request Form on the TMHP website at www.tmhp.com.

The dental provider must include dental procedure codes and modifiers on the Texas Health Steps Dental Mandatory Prior Authorization Request Form for prior authorization to be considered for any Texas Health Steps dental services.

3.2.29.3 Orthodontic Services

Prior authorization is required for all levels of orthodontic services. Prior authorization includes the number of monthly visits and expected completion time according to the corresponding treatment level.

Orthodontic services do not include any related services outside those listed in this section (e.g., extractions or surgeries); however, all services must be included in the orthodontic treatment plan.

Approved orthodontic treatment plans must be initiated before clients lose Medicaid eligibility or reach 21 years of age, and all active orthodontic treatments must be completed within 36 months of the authorization date. Services cannot be added or approved after eligibility has expired.

Note: *If a client reaches 21 years of age or loses Medicaid eligibility before the authorized orthodontic services are completed, reimbursement is provided to complete the orthodontic treatment plan that was authorized and initiated while the client was 20 years of age or younger and eligible for Texas Medicaid as long as the orthodontic treatment plan is completed within the appropriate time frames.*

Any non-orthodontic service that is included as part of the treatment plan (extractions or surgeries) must be completed before the client loses eligibility or reaches 21 years of age in order to be reimbursed through Texas Medicaid. Services cannot be added or approved after Texas Medicaid eligibility has expired.

Once prior authorization is obtained, the provider is obligated to advise the client that he or she is able to receive the approved orthodontic service (including monthly orthodontic adjustment visits and retainers) even if the client loses eligibility or reaches his or her 21st birthday.

All requests must be reviewed by the TMHP Dental Director or other state dental contractor's board-eligible or board-certified orthodontist employee or consultant who is licensed in Texas.

To avoid unnecessary denials, providers must submit correct and complete information, including documentation for medical necessity for the services requested. Providers must maintain documentation of medical necessity in the client's medical record. Requesting providers may be asked for additional information to clarify or complete a request.

A completed Texas Health Steps (THSteps) Dental Mandatory Prior Authorization Request Form must be signed and dated by the performing dental provider. The completed authorization form must include the procedure codes for all services requested along with a written statement of medical necessity for the proposed orthodontic treatment.

Level I Orthodontic Services

The following documentation must be submitted with the prior authorization request for level I orthodontic services (procedure code D8210 or D8220):

- Radiographs (X-rays)
- Photographs
- Treatment plan

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- Narrative of medical necessity

The completion of level I orthodontic services does not disqualify future level II or level III orthodontic services.

Level I orthodontic services will not be prior authorized if there is an indication that the client will qualify for level II or level III orthodontic services in the future.

Level II Orthodontic Services

The following documentation must be submitted with the prior authorization request for level II orthodontic services (procedure codes D8010, D8020, and D8070):

- Digital diagnostic models or other type of 3D diagnostic images
- Radiographs (X-rays)
- Cephalometric radiographic image with tracings
- Photographs
- Treatment plan
- Narrative of medical necessity

Evidence of four of the following conditions must be submitted in the supporting documentation:

- Full cusp class II malocclusion with the distal buccal cusp of the maxillary first molar occluding in the mesial buccal groove of the mandibular first molar
- Full cusp class III malocclusion with the maxillary first molar occluding in the embrasure distal to the mandibular first molar or on the distal incline of the mandibular molar distal buccal cusp
- Overbite measurement of more than 5 mm
- Overjet measurement of more than 8 mm
- More than four congenitally absent teeth, including at least one anterior tooth
- Anterior crowding of more than 6 mm in the mandibular arch
- Anterior crossbite of at least two of the four maxillary incisors
- Generalized spacing in both arches of more than 6 mm in each arch
- Early impacted maxillary canine or mandibular canines, supported by radiographs indicating a severe mesial angulation of the erupting canine and the crown of the canine superimposed on and crossing the image of the maxillary lateral incisor

Level III Orthodontic Services

The following documentation must be submitted with the prior authorization request for level III orthodontic services (procedure code D8080):

- Digital diagnostic models or other type of 3D diagnostic images
- Radiographs (X-rays)
- Cephalometric radiographic image with tracings
- Photographs
- Treatment plan
- Narrative of medical necessity

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Evidence of four of the following conditions must be submitted in the supporting documentation:

- Full cusp class II malocclusion with the distal buccal cusp of the maxillary first molar occluding in the mesial buccal groove of the mandibular first molar
- Full cusp class III malocclusion with the maxillary first molar occluding in the embrasure distal to the mandibular first molar or on the distal incline of the mandibular molar distal buccal cusp
- Anterior tooth impaction: unerupted with radiographic evidence to support a diagnosis of impaction (lack of eruptive space, angularly malposed, and totally imbedded in the bone) as compared to ectopically erupted anterior teeth that may be malposed but have erupted into the oral cavity and are not a qualifying element
- Anterior crowding of more than 6 mm in the mandibular arch
- Anterior open bite demonstrating that all maxillary and mandibular incisors have no occlusal contact and are separated by a measurement more than 6 mm
- Posterior open bite should demonstrate a vertical separation by a measurement more than 5 mm for several posterior teeth, not to be confused with the delayed natural eruption of a few teeth
- Posterior crossbite with an associated midline deviation and mandibular shift, a Brodie bite with a mandibular arch totally encumbered by an overlapping buccally occluding maxillary arch, or a posterior maxillary arch totally lingually malpositioned to the mandibular arch
- Anterior crossbite should include more than two incisors in crossbite and demonstrate gingival inflammation, gingival recession, or severe enamel wear
- Overbite of more than 5 mm
- Overjet of more than 8 mm

Additional Services

There may be exceptional circumstances that require additional treatment time, including but not limited to cases of craniofacial anomalies and cleft palate. Prior authorization for additional services will be reviewed and evaluated on an individual basis for medical necessity.

Prior authorization requests for additional services (procedure code D8670) must include the following:

- The reason for the additional monthly visits and the number of visits requested
- The name of the additional appliance in the case of a cleft palate treatment plan, if needed
- Recent radiographs (X-rays) showing the progress made to date
- Current photographs
- Current treatment plan

Additional treatment months may be considered for one of the following circumstances:

- The client is a child of a migrant farm worker.
- The client's orthodontic services were delayed because the client was temporarily in state custodial care (foster care).

Completion of All Levels of Orthodontic Services

Prior authorization is required for the completion of treatment (last payment) and must be reviewed for proof of the completion of the case.

A prior authorization request for the completion of level II or level III (procedure code D8680) services must include the following:

- A post-treatment panoramic radiographic image

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- Photographs
- A signed statement from the treating provider that the treatment is complete

3.2.29.3.1 Premature Termination of Orthodontic Services

Prior authorization for the premature termination of orthodontic services (procedure code D8680) is required.

The prior authorization must include all of the following for consideration:

- A release form (or a copy) that must be signed by the parent or legal guardian or by the client if they are 18 years of age or older or an emancipated minor.
- Documentation of one of the following:
  - The client is uncooperative or noncompliant.
  - The client requested the removal of orthodontic appliances.
  - The client requested the removal of appliances due to exceptional circumstances, such as incarceration.
  - The client has mental health complications with a recommendation from the treating physician.
  - The client is in a foster care placement.
  - The client is a child of a migrant farm worker and intends to complete treatment later if Medicaid eligibility for orthodontic services continues.

3.2.29.3.2 Transfer of Services

Prior authorization that is issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the orthodontic treatment that was initiated by the original provider. The original prior authorization will be end-dated when services are transferred to another provider.

The new provider must obtain his or her own records, and the new request for orthodontic services must include the date of service on which the documentation was obtained (the date of service on which the records were produced) and the following supporting documentation:

- All of the documentation that is required for the original request
- The reason the client left the previous provider
- An explanation of the treatment status

The authorization request for clients who are undergoing orthodontic treatment services and subsequently become eligible for Medicaid are subject to the same requirements.

3.2.29.3.3 Orthodontic Cases Initiated Through a Private Arrangement

Authorization may be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement before becoming eligible for Medicaid.

Authorization will not be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement and were eligible for Medicaid at the start of service.

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3.2.30 THSteps and ICF-IID Dental Prior Authorization

Submit claims, dental correspondence, and THSteps and ICF-IID prior authorization requests to the appropriate address listed in the following table:

Correspondence	Address
ADA dental claim forms	Texas Medicaid & Healthcare Partnership PO Box 200555 Austin, TX 78720-0555
All dental correspondence Prior authorization requests	Texas Medicaid & Healthcare Partnership Fee-for-Service and ICF-IID Dental Authorizations PO Box 204206 Austin, TX 78720-4206

3.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including dental services. Dental services are subject to retrospective review and recoupment if documentation does not support the service submitted for payment.

The provider must educate all staff members, including dentists, about the following documentation requirements and charting procedures:

- For THSteps and ICF-IID dental claims, providers are not required to submit preoperative and postoperative radiographs unless these are specifically requested by HHSC, the TMHP Dental Director, or are needed for prior authorization or pre-payment review.
- Documentation of all restorative, operative, crown and bridge, and fixed and removable prosthodontics procedures must support the services that were performed and must demonstrate medical necessity that meets the professional standards of health care that are recognized by TSBDE. Documentation must include appropriate pretreatment, precementation and postcementation radiographs, study models and working casts, laboratory prescriptions, and invoices. Documentation must include the correct DOS. A panoramic radiograph without additional bitewing radiographs is considered inadequate as a diagnostic tool for caries detection. OIG may retrospectively recoup payment if the documentation does not support the services submitted for payment.
- All documentation must be maintained in the client's record for a period of five years to support the medical necessity at the time of any post-payment utilization review. All documentation, including radiographs, must be of diagnostic and appropriate quality.
- In any situation where radiographs are required but cannot be obtained, intraoral photographs must be in the chart.
- Any complications, unusual circumstances encountered, morbidity, and mortality must be entered as a complete narrative in the client's record.
- A provider must maintain a minimum standard of care through appropriate and adequate records, including a current history, limited physical examination, diagnosis, treatment plan, and written informed consent as a reasonable and prudent dentist would maintain. These records, as well as the actual treatment, must be in compliance with all state statutes, the Dental Practice Act, and the TSBDE Rules.
- Documentation for endodontic therapy must include the following: the medical necessity, pretreatment, during treatment, and post-treatment periapical radiographs, the final size of the file to which the canal was enlarged, and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be entered in the chart. Endodontic therapy must be in compliance with the American Association of Endodontists quality assurance guidelines.

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- Documentation for most periodontal services requires a six-point per tooth depth of pocket charting, a complete mouth series of periapical and bitewing radiographs, and any other narratives or supporting documentation consistent with the nationally accepted standards of care of the specialty of periodontics, and which conform to the minimum standard of care for periodontal treatment required of Texas dentists. A panoramic radiograph without additional bitewing or periapical radiographs is considered inadequate for diagnosis of periodontal problems.
- Documentation for surgical procedures requiring a definitive diagnosis for submitting a claim for a specific CDT code necessitates that a pathology report and a written record of clinical observations be present in the chart, together with any appropriate radiographs, operative reports, and appropriate supporting documentation. All impactions, surgical extractions, and residual tooth root extractions require appropriate preoperative periapical or panoramic radiographs (subject to limitations) be present in the chart.
- Any documentation requirements or limitations not mentioned in this manual that are present in the CDT are applicable. The written documentation requirements or limitations in this manual supercede those in the CDT.

3.3.1 General Anesthesia

When proceeding with Level 4 sedation/general anesthesia the dental provider is required to maintain the following documentation in the client's dental record:

- The medical evaluation justifying the need for anesthesia
- Description of relevant behavior and reference scale
- Other relevant narratives justifying the need for general anesthesia
- client's demographics, including date of birth
- Relevant dental and medical history
- Dental radiographs, intraoral/perioral photography, or diagram of dental pathology
- Proposed dental plan of care
- Consent signed by parent or guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained
- Completed Criteria for Dental Therapy Under General Anesthesia form
- The parent or guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist's assessment of their child's behavior
- Dentist's attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the client's dental record as a stand alone form

3.4 Utilization Review

HHSC or a designated entity may conduct utilization reviews through automated analysis of a provider's pattern(s) of practice, including peer group analysis. Such analysis may result in a subsequent on-site utilization review. HHSC or its claims processing contractor may conduct utilization reviews at the direction of the Office of Inspector General (OIG), according to HHSC rules.

DSHS may also conduct dental utilization reviews of randomly selected THSteps dental providers. These reviews compare Medicaid dental services that have been reimbursed to a dental provider to the results of an oral examination of the client as conducted by DSHS regional dentists.

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Refer to: 26 TAC §256.72 for more information about utilization review.

3.5 Claims Filing and Reimbursement

3.5.1 Reimbursement

The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §§355.455(b), 355.8085, and 355.8441(11). Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

3.5.2 Claim Submission After Loss of Eligibility

The Texas Medicaid 95-day filing deadline applies to all THSteps and ICF-IID dental services. If a client has lost Medicaid eligibility or turned 21 years of age, continue to file claims for services provided on the DOS the client was eligible. Indicate the actual DOS on the claim form, and enter the authorization number in the appropriate block on each claim filed.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

3.5.3 Third Party Liability

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

3.5.4 Claims Information

Dental services must be submitted to TMHP in an approved electronic format or on the ADA Dental Claim Form. Providers may purchase ADA Dental claim forms from the vendor of their choice. TMHP does not supply the forms. A sample of the ADA Dental Claim form can be found on the ADA website at www.ada.org/publications/cdt/ada-dental-claim-form.

When completing an ADA Dental claim form, all required information must be included on the claim, as TMHP does not key information from attachments. Superbills or itemized statements are not accepted as claim supplements.

All THSteps and ICF-IID claims must be received by TMHP within 95 days from each DOS and submitted to the following address:

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

Claims for emergency, orthodontic, or routine dental services must each be filed on separate forms. A claim submitted for either emergency or orthodontic services must be identified as such in Block 35 (Remarks) of the claim form.

A THSteps and ICF-IID dental provider cannot submit claims to Texas Medicaid under his individual NPI for the services provided by one or more associate dentists practicing in his office as employees or independent contractors with specific employer-employee or contractual relationships. All dentists providing services to Medicaid clients must enroll as THSteps dental providers regardless of employer relationships. The individual provider submitting claims may be reimbursed into a single accounting office to maintain these described relationships.

Claims submitted by newly-enrolled providers must be received within 95 days of the date the new NPI is issued, and within 365 days of the DOS.

Providers should submit claims to Texas Medicaid for their usual and customary fees.

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Claims for dental services provided to children in foster care must be filed with DentaQuest, the dental claims processor for Superior HealthPlan.

Refer to: Subsection 3.2.7.2, "Children in Foster Care" in this handbook.

Claims must not be submitted to Texas Medicaid for appointments missed by clients. A client with Medicaid cannot be billed for failure to keep an appointment. Only claims for actual services rendered are considered for payment.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 1.7.12, "Billing Clients" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

3.5.5 Claim Appeals

A claim denied because of age restrictions or other limitations listed in the Medicaid dental fee schedule may be considered for reimbursement on appeal when client medical necessity is provided to the TMHP Dental Director.

All denied claim appeals must be submitted to TMHP with the exception of a request to waive late filing deadlines. TMHP does not have the authority to waive state or federal mandates regarding claim filing deadlines.

If, after all appeal processes at TMHP have been exhausted, the provider remains dissatisfied with TMHP's decision concerning the appeal, the provider may file a complaint with the HHSC Claims Administrator Operations Management Unit.

Refer to: Subsection 7.1.5, "Paper Appeals" in "Section 7: Appeals" (*Vol. 1, General Information*).

Subsection 7.3.1, "Administrative Claim Appeals" in "Section 7: Appeals" (*Vol. 1, General Information*).

Note: *Providers must exhaust the appeals process with TMHP before filing a complaint to the HHSC Claims Administrator Operations Management Unit.*

Providers may use one of three methods to appeal Medicaid claims to TMHP: telephone (AIS), paper, or electronic.

All appeals of denied claims or requests for adjustments on paid claims must be received by TMHP within 120 days of the date of disposition of the R&S Report on which the claim appears. If the 120-day appeal deadline falls on a weekend or TMHP-recognized holiday, the deadline will be extended to the next business day.

Certain claims must be appealed on paper; they cannot be appealed either electronically or by telephone.

Refer to: Subsection 7.1.5, "Paper Appeals" in "Section 7: Appeals" (*Vol. 1, General Information*) for information about appeals that may not be appealed electronically and claims that may not be appealed through AIS.

To appeal in writing:

If a claim cannot be appealed electronically or by telephone, appeal the claim on paper by completing the following steps:

1) Provide a copy of the R&S Report page where the claim is reported.
2) Circle one claim per R&S Report page.
3) Identify the information that was incorrectly provided and note the correct information that should be used to appeal the claim. If necessary, specify the reason for appealing the claim.

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4) Attach radiographs or other necessary supporting documentation.
5) If available, attach a copy of the original claim. Claim copies are helpful when the appeal involves dental policy or procedure coding issues.
6) Do not copy supporting documentation on the opposite side of the R&S Report.
7) It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It is also recommended that paper documentation be sent by certified mail with a return receipt requested to establish TMHP's receipt of the claim and the date the claim was received. The provider is urged to retain copies of multiple claim submissions if the NPI is pending.

   Note: *Claims submitted by newly-enrolled providers must be received within 95 days of the date the new NPI is issued, and within 365 days of the DOS.*

8) Submit the paper appeal with supporting documentation and any radiographs and adjustment requests to the following address:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12365-A Riata Trace Parkway
Austin, TX 78727-6418

To appeal by telephone:

1) Contact the Dental Line at 1-800-568-2460.
2) For each claim in question, have the R&S Report listing the claim and any supporting documents readily available.
3) Identify the claim submitted for appeal. The internal control number (ICN) will be requested.
4) Supply the information necessary to correct the claim, such as the missing tooth number or letter, the corrected procedure code, surface ID, or Medicaid number.

The appeal will appear as finalized or pending on the following week's R&S Report.

Providers may also appeal electronically.

Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer. The electronic appeals feature can be accessed directly through the TMHP EDl Gateway or by using TexMedConnect. For additional information, contact the TMHP EDI Help Desk at 1-888-863-3638.

Electronic appeals can increase accuracy of claims processing, resulting in a more efficient case flow to the provider:

- Download and printout capabilities help maintain audit trails for the provider.
- Appeal submission windows can be automatically filled in with electronic R&S Report information, thereby reducing data entry time.

3.5.6 Frequently Asked Questions About Dental Claims

Q Why is routine dental treatment not a benefit when performed at the same visit as an emergency visit?

A The following are reasons routine dental treatment is not a benefit when performed at the same visit as an emergency visit:

- The purpose of an emergency claim is to allow the provider to treat a true emergency without the concern that routine dental procedures may be denied.
- Medicaid program policy guidelines do not allow payment for both emergency and routine services to the same provider at the same visit. True emergency claims process through the audit system correctly when "emergency" is checked on either the paper or electronic claim and the Remarks or Narrative section of the claim form describes the nature of the emergency.

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Q *Why are some claims for oral exams and emergency exams on the same date for the same client denied?*

A *Medicaid program policy does not allow claims for an initial oral exam and an emergency exam to be submitted for the same DOS for the same client. An emergency exam performed by the same provider in the same six-month time period as an initial exam may be considered for reimbursement only when the claim for the emergency exam indicates it is an emergency and the emergency block is marked and the Remarks or Narrative section is completed. If the claim is not marked as an emergency, the claim will be denied.*

Q *Why could an appeal of a denied claim take a long time?*

A An appeal can take a long time if TMHP is required to research the denied claim and determine the reason the claim did not go through the system. For faster results, providers should submit appeals as soon as possible and not use the entire 120 days allowed to submit the appeal.
The following are guidelines on filing claims efficiently:

- Use R&S Report dates to track filed claims.
- File claims electronically through TMHP EDI. Electronic claims submission does not allow a claim with an incorrect date to be accepted and processed, which saves time for the provider submitting claims and TMHP in processing claims. Call 1-888-863-3638, for more information about TMHP EDI.
- File claims with the correct information included. Most denied claims result from the omission of dates, signature, or narrative, or incorrect ID numbers such as client Medicaid numbers or NPIs.

Q *Why are only ten appeals allowed per call?*

A There is a limit on appeals per call to allow all providers equal access.

Q *Why do reimbursement checks sometimes take a long time to arrive?*

A Reimbursement may be delayed if a provider fails to submit claims in a timely manner.

Q *Does electronic claims submission result in delayed payment?*

A No. Providers who submit claims electronically report faster results than when submitting claims on paper. Providers are encouraged to use TMHP EDI for claims submission.

The following are helpful hints to a more efficiently processed claim:

- Ensure the NPI is on all claims.
- Include the performing provider's signature on all paper claims.
- Verify client eligibility for procedures.
- Verify if the procedure code requires a narrative on the claim; the narrative is for medical necessity.
- Include the required client information, including name, birth date, and client number.
- Dental auxiliary staff (i.e., the hygienist or the chairside assistant) cannot enroll in Texas Medicaid; therefore, they cannot submit claims to Texas Medicaid. Any procedure performed by the auxiliary must be submitted by the supervising dentist, using the dentist's NPI.

Claim Submission Reminders:

- Procedure code D8660 is allowed at different age levels, per provider. If a claim for procedure code D8660 is submitted within six months of procedure code D8080, procedure code D8080 will be reduced by the amount that was paid for procedure code D8660.
- Prior authorization is required with documentation of medical necessity when replacing lost or broken orthodontic retainers (procedure code D8680). Clients may not be billed for covered services.

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- Prior authorization of orthodontic services is nontransferable. If a client changes an orthodontic provider for any reason, or a provider ceases to be a Medicaid provider, the new orthodontic services provider must submit a separate request for prior authorization. The provider requesting and receiving authorization for the service also must perform the service and submit the claim. Codes listed on the authorization letters are the only codes considered for payment. All other codes submitted for payment are denied. Providing the authorization number on the submitted claim results in more efficient claims processing.
- Prior authorization is required for clients who are 7 through 20 years of age that are in need of general anesthesia and do not meet the Criteria for Dental Therapy Under General Anesthesia requirements (22 point threshold). Prior authorization is required for medically necessary dental general anesthesia that exceeds once per six months, per client, any provider. The dentist providing therapeutic services under general anesthesia is responsible for obtaining prior authorization for both services.
- General anesthesia (provided in the dentist office, ambulatory service clinic, and inpatient/outpatient hospital settings) does not require prior authorization for clients who are 7 through 20 years of age, unless the client does not meet the minimum required points for general anesthesia in Criteria for Dental Therapy Under General Anesthesia on the TMHP website at www.tmhp.com. All THSteps dental charts for dental general anesthesia are subject to retrospective, random review for compliance with the Criteria for Dental Therapy Under General Anesthesia and requirements for chart documentation.
- Providers must not bill a client unless a formal denial for the requested item or service has been issued by TMHP stating the service is not a benefit of Texas Medicaid and the client has signed the Client Acknowledgment Statement in advance of the service being provided for that specific item or service. A provider must not bill Medicaid clients if the provided service is a benefit of Texas Medicaid.

Refer to: Subsection 1.7.12.1, "Client Acknowledgment Statement" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

THSteps clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- Dental services that are free from abuse or harm from the provider or the provider's staff.
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

4 THSteps Medical

4.1 THSteps Medical and Dental Administrative Information

4.1.1 Overview

This section describes the administrative requirements for THSteps, including provider requirements, client eligibility requirements, and billing and claims processing information. Providers that need additional information may call 1-800-757-5691 or refer to "Appendix F. Texas Health Steps Quick Reference Guide" in this handbook for a more specific list of resources and telephone numbers. Providers may also contact the Texas Department of State Health Services (DSHS) THSteps Provider Relations staff located in DSHS regional offices by calling the appropriate regional office as listed in"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*). THSteps Provider Relations contact information is also available on the DSHS website at www.dshs.texas.gov/contact-us.

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In addition, THSteps has developed online educational modules to provide additional information about the program, components of the medical checkup, and other information. These modules provide free continuing education hours for a variety of providers. Providers do not have to be enrolled in THSteps. These courses may be accessed at www.txhealthsteps.com.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive preventive child health service for clients who are birth through 20 years of age. In Texas, EPSDT is known as THSteps and includes periodic screening, vision, hearing, and dental preventive and treatment services. EPSDT was created by the 1967 amendments to the federal Social Security Act and defined by the Omnibus Budget Reconciliation Act (OBRA) of 1989. The periodic screening for a checkup consists of five federally required components as noted on the THSteps Periodicity Schedule. In addition, Section 1905(r)(5) of the Social Security Act (SSA) requires that any medically necessary health-care service listed in the Act be provided to EPSDT clients even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. A service is medically necessary when it corrects or ameliorates the client's disability, physical or mental illness, or chronic condition. These additional services are available through CCP. For questions about coverage, providers can call CCP at 1-800-846-7470.

4.1.2 Statutory Requirements

Several specific legislative requirements affect THSteps and the providers participating in the program. These include, but are not limited to, the following:

- Newborn Screening, Health and Safety Code, Chapter 33, Section §33.011 Newborn Screening Test Requirement.
- Subsection D.5, "Parental Accompaniment" in this handbook.
- Requirements for Reporting Abuse or Neglect, as outlined in subsection 1.7.1, "Compliance with Texas Family Code" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).
- Early Childhood Intervention (ECI), 34 Code of Federal Regulations (CFR) Part 303; Chapter 73, Texas Human Resources Code, and Title 40 TAC, Chapter 108.
- Newborn Hearing Screening, Health and Safety Code, Chapter 47.
- Teen Confidentiality Issues. There are many state statutes that may affect consent to medical care for a minor, depending on the facts of the situation. Among the relevant statutes are Chapters 32, 33, 153, and 266 of the Texas Family Code. Providers may want to consult an attorney, their licensing board, or professional organization if guidance is needed or questions arise on matters of medical consent.

Refer to: "Appendix D. Texas Health Steps Statutory State Requirements" in this handbook for more information.

4.1.3 Referrals for Medicaid-Covered Services

When a provider performing a checkup determines that a referral for diagnosis or treatment is necessary for a condition found during the medical checkup, that information must be discussed with the parents or guardians. A referral must be made to a provider who is qualified to perform the necessary diagnosis or treatment services. If the performing provider is competent to treat the condition found, a referral elsewhere is not necessary, unless it is to the primary care provider to assure continuity of care.

Providers that need assistance finding a specialist who accepts clients with Medicaid coverage can call the THSteps toll-free helpline at 1-877-847-8377, or they can find one using the Online Provider Lookup on the TMHP website at www.tmhp.com.

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Continuity of care is an important aspect of providing services and follow-up. Efforts should be made to determine that the appointment was kept and that the provider who received the referral has provided a diagnosis and recommendations for further care to the referring provider.

In addition to referrals for conditions discovered during a checkup or for specialized care, the following referrals may be used:

- *Case Management for Children and Pregnant Women*. Case Management for Children and Pregnant Women provides health-related case management services to eligible children and pregnant women. Case Management for Children and Pregnant Women services include assessing the needs of eligible clients, formulating a service plan, making referrals, problem-solving, advocacy, and follow-up regarding family and client needs. For more information about eligibility and client referral, see subsection 3.1.1, "Eligibility" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) or subsection 3.1.2, "Referral Process" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).
- *Hearing Services referrals*. If the hearing screening returns abnormal results, clients who are birth through 20 years of age must be referred to a Texas Medicaid provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.
- *Routine Dental Referrals.* The provider must refer clients to establish a dental home beginning at 6 months of age or earlier if trauma or early childhood caries are identified. For established clients after the 6-month medical checkup, the provider must confirm if a dental home has been established and is ongoing; if not, additional referrals must be made at subsequent medical checkups until the parent or caregiver confirms that a dental home has been established for the client. Clients who are birth through 5 months of age are not eligible for routine dental checkups but should be referred to a dentist if any dental issues are identified during a THSteps medical checkup or acute care visit. When possible, clients should be referred to a provider who has completed the required benefit education and is certified by Texas Health Steps to perform First Dental Home services. The First Dental Home provider may be located through the advanced search function in the Online Provider Look Up or by calling 1-877-847-8377.
- *Referrals for Dental Treatment*. If a THSteps medical provider identifies the medical necessity of dental services, the provider must refer the client to a THSteps dental provider. The THSteps medical provider can accomplish this by providing the parent or guardian a listing of THSteps dentists from the Online Provider Lookup. The parent or guardian can receive assistance in locating a THSteps dentist and assistance with scheduling of dental appointments by contacting the THSteps toll-free helpline at 1-877-847-8377. Clients who are birth through 5 months of age also can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries, or other oral health problems. Clients who are birth through 20 years of age may self-refer for dental care.
- *Emergency Dental Referrals.* If a medical checkup provider identifies an emergency need for dental services, such as bleeding, infection, or excessive pain, the client may be referred directly to a participating dental provider. Emergency dental services are covered at any time for all Medicaid clients who are birth through 20 years of age.

  Note: *Assistance in coordinating dental referrals can be obtained from the THSteps toll-free helpline at 1-877-847-8377 or the DSHS Regional THSteps Coordinator for the respective region (lists are provided in "Appendix A: State, Federal, and TMHP Contact Information" (Vol. 1, General Information). In cases of both emergency and nonemergency dental services, clients are able to make a choice when selecting a dental provider who is participating in the THSteps Dental Program.*
- *Family Planning and Genetic Services Referrals.* For clients eligible for Medicaid who need genetic services or family planning services, a referral should be made. Information about Medicaid-covered genetic services is available in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) and information about family planning services

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is available in Section 2, "Medicaid Title XIX Family Planning Services". If a THSteps medical provider also provides family planning, the provider may inform clients that these services are available.

- *ECI Referrals*. Federal and state law requires providers to refer children as soon as possible, but no longer than 7 days after identification of a suspected developmental delay or disability to the local ECI program for children who are birth through 35 months of age regardless if a referral was made to another qualified provider. The provider may call the local ECI program or the Health and Human Services Office of the Ombudsman at 1-877-787-8999 to make referrals. Children who are 3 years of age and older with a suspected developmental delay or disability should be referred to the local school district.
- *WIC Referrals.* Clients who are birth through 5 years of age or who are pregnant are eligible for WIC and should be referred to WIC for nutrition education and counseling, and food benefits.

4.1.4 THSteps Medical Checkup Facilities

All THSteps medical checkup policies apply to checkups completed in a physician's office, a health department, clinic setting, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a physician or clinic name. Mobile units can be a van or any area away from the primary office and are considered extensions of that office and are not separate entities.

The physical setting must be appropriate so that all elements of the checkup can be completed.

Refer to: Subsection 4.3.11, "THSteps Medical Checkups Periodicity Schedule" in this handbook on the THSteps Periodicity Schedule.

Subsection 4.3.12, "Mandated Components" in this handbook for additional information on checkup components.

4.1.5 THSteps Dental Services

Access to THSteps dental services is mandated by Texas Medicaid and provides reimbursement for the early detection and treatment of dental health problems, including oral health preventive services, for Medicaid clients who are birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and to incorporate the recommendations of representatives of national and state dental professional groups.

OBRA 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which FFP is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as CCP.

Refer to: Section 2, "Medicaid Children's Services Comprehensive Care Program (CCP)" in this handbook for more information.

THSteps-designated staff (HHSC, DSHS, or its designee), through outreach and education, encourage the parents or caregivers of eligible clients to use THSteps dental checkups and preventive care when clients first become eligible for Medicaid and each time clients are due for their next periodic dental checkup.

Upon request, THSteps-designated staff (HHSC, DSHS, or its designee) assist the parents or caregivers of eligible clients with scheduling appointments and transportation. Medicaid clients have freedom of choice of providers and are given names of enrolled providers. Call the THSteps toll-free helpline at 1-877-847-8377 for a list of THSteps dental providers in a specific area.

For additional information about dental health, providers can refer to the THSteps online educational modules "Oral Health For Primary Care Providers" and "Oral Health Examinations for Dental Professionals" at www.txhealthsteps.com.

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4.2 Enrollment

4.2.1 THSteps Medical Provider Enrollment

Providers cannot be enrolled if their professional license is due to expire within 30 days of application. Facility providers must submit a current copy of the supervising practitioner's license. To provide Medicaid services, each NP or CNS must be licensed as an RN and be recognized as an APRN by Texas BON.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for information about enrollment procedures.

The following provider types may provide THSteps preventive services within his or her scope of practice, must be enrolled in Texas Medicaid, but do not have to be enrolled as a THSteps provider:

- A federal qualified health center (FQHC)
- A rural health clinic (RHC)

The following provider types may provide THSteps preventive services within his or her scope of practice and must be enrolled in Texas Medicaid as a THSteps provider:

- A physician (doctor of medicine [M.D.] or doctor of osteopathy [D.O.]) or physician group
- A physician assistant (PA)
- A clinical nurse specialist (CNS)
- A nurse practitioner (NP)
- A certified nurse midwife (CNM)
- A health-care provider or facility with physician supervision including, but not limited to:
  - Community-based hospital and clinic
  - Family planning clinic
  - Home health agency
  - Local or regional health department
  - Maternity clinic
  - Migrant health center
  - School-based health center

Medical Residents

Medical residents may provide medical checkups in a teaching facility under the guidance of the attending staff as long as the facility's medical staff by-laws and requirements of the Graduate Medical Education (GME) Program are met, and the attending physician has determined the intern or resident to be competent to perform checkups. THSteps does not require the supervising physician to examine the client as long as these conditions are met.

Clinics

In a clinic, a physician is not required to be present at all times during the hours of operation unless otherwise required by federal regulations. A physician must assume responsibility for the clinic's operation.

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4.2.1.1 Requirements for Registered Nurses Who Provide Medical Checkups

RNs without a CNS, NP, or CNM recognition as an APRN by the Texas BON may provide medical checkups only under direct physician supervision, meaning the physician is either on site during the checkup or immediately available to furnish assistance and direction to the RN during the checkup.

Required online education modules developed by THSteps must be completed prior to providing checkup services. All modules are approved for continuing education units (CEUs) for RN's as well as other medical disciplines. Required THSteps online education modules are available on the RN Information page of the THSteps website. The RN or the RN's employer must maintain documentation that the required modules were completed.

Online modules are updated regularly to include new content. RNs that have completed the required modules previously are encouraged, but not required to retake online modules.

Before a physician delegates a THSteps checkup to an RN, the physician must establish the RN's competency to perform the service as required by the physician's scope of practice. The delegating physician is responsible for supervising the RN who performs the services. The delegating physician remains responsible for any service provided to a client.

Refer to: Subsection 4.2.1, "THSteps Medical Provider Enrollment" in this handbook for more information about enrollment procedures.

4.3 Services, Benefits, Limitations, and Prior Authorization

4.3.1 Eligibility for THSteps Services and Checkup Due Dates

Through outreach, THSteps staff (DSHS, HHSC, or contractors) encourage clients to use THSteps preventive medical checkup services when they first become eligible for Medicaid and each time thereafter when they are periodically due for their next medical checkup. THSteps will send clients a letter when they are due for a medical checkup.

A client is eligible for THSteps services, including medical checkups, from birth through 20 years of age.

Although the Medicaid Eligibility Verification Letter (Form H1027) identifies eligible clients when the client's Your Texas Benefits Medicaid card is lost or has not yet been issued, Form H1027 does not indicate whether the client is due for medical checkup services. Providers can verify the client's eligibility through TexMedConnect, the Medicaid Client Portal for Providers, or the TMHP Contact Center.

A client is due for a THSteps medical checkup based on his or her date of birth and the ages indicated on the periodicity schedule. Children younger than three years of age are due at frequent intervals. Children and youth three years of age and older are considered due for a checkup on their birthday and are encouraged to have a yearly checkup as soon as practical. In addition, for children enrolled in Medicaid managed care, a new member is due for a THSteps medical checkup as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child members.

Providers should schedule checkups based on the ages in the periodicity schedule, but circumstances may support the need for a checkup prior to the client's birthday (for example, a 4-year checkup could be performed prior to the child's 4th birthday if the child is a member of a migrant family that is leaving the area). THSteps fee-for-service policy creates this flexibility by allowing a total number of checkups at each age range.

Refer to: "Subsection 4.3.6, "THSteps Medical Checkups" in this handbook for additional details.

Providers are encouraged to notify the client when they are due for the next checkup according to the THSteps periodicity schedule.

A checkup that is necessary more frequently than indicated on the periodicity schedule is considered an exception-to-periodicity.

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Refer to: Subsection 4.3.7, "Exception-to-Periodicity Checkups" in this handbook for additional details about billing for a checkup performed as an exception-to-periodicity checkup.

4.3.2 Prior Authorization

Prior authorization is not required for preventive care medical checkups.

4.3.3 Additional Consent Requirements

Additional parental or guardian consent may be required if online or web-based screening tools are used that could result in client data being stored electronically in an outside database other than the provider's electronic medical record system, or if the data is used for purposes other than THSteps screening. The provider should seek legal advice regarding the need for this consent.

4.3.4 Verification of Medical Checkups

The first source of verification that a THSteps medical checkup has occurred is a paid claim or encounter. THSteps encourages providers to file a claim either electronically or on a CMS-1500 paper claim form as soon as possible after the date of service, as the paid claim updates client information. The provider may contact TMHP through the TMHP website at www.tmhp.com or AIS at 1-800-925-9126 to verify that the client is due for a checkup.

A second source of acceptable verification is a physician's written statement that the checkup occurred. If the provider chooses to give the client written verification, it must include the client's name, Medicaid ID number, date of the medical checkup, and a notation that a complete THSteps medical checkup was performed.

Note: *Verification of medical checkups must not be sent to THSteps but must be maintained by the client to be provided as needed by an HHSC eligibility caseworker.*

If neither the first nor the secondary source of verification is available, a THSteps outreach worker may contact the provider's office for verification.

4.3.5 Medical Home

HHSC and DSHS encourage the provision of the THSteps medical checkup as part of a medical home. Texas Medicaid defines a medical home as a model of delivering care that is accessible, continuous, comprehensive, family-centered, and coordinated. In providing a medical home for the client, the primary care clinician directs care coordination together with the client or youth and/or family.

Medical checkup providers with mobile units should encourage the families to establish a medical home for their child(ren) and obtain future checkups from their primary care provider.

When a checkup is provided in the home setting, mobile unit, or clinic other than the medical home, it should be in coordination with the medical home and the results must be provided to the medical home as soon as possible.

A mobile unit is an extension of the provider's office and must be able to provide a complete checkup.

For additional information on the medical home, providers can refer to the "Introduction to the Medical Home" module provided by THSteps at www.txhealthsteps.com.

4.3.6 THSteps Medical Checkups

THSteps medical checkups reflect the federal and state requirements for a preventive checkup. Preventive care medical checkups are a benefit of the THSteps program if they are provided by enrolled THSteps providers and all of the required components are completed. An incomplete preventive medical checkup is not a benefit. The THSteps periodicity schedule specifies screening procedures required at each stage of the client's life to ensure that health screenings occur at age-appropriate points in a client's life.

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Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup, with the exception of initial point-of-care blood lead testing, mental health screening for adolescents, postpartum depression screening, tuberculin skin test (TST), developmental and autism screening, vaccine administration, and oral evaluation and flouride varnish (OEFV).

Note: *Initial blood lead testing, other than point-of-care, must be sent to the DSHS Laboratory for testing.*

Reminder: *Incomplete medical checkups are subject to recoupment unless there is documentation supporting why a component was not completed.*

Refer to: Subsection 4.3.12.1.3, "Mental Health Screening" in this handbook for more information about required mental health screenings.

Sports physical examinations are not a benefit of Texas Medicaid. If the client is due for a THSteps medical checkup and a comprehensive medical checkup is completed, a THSteps medical checkup may be reimbursed and the provider may complete the documentation for the sports physical.

THSteps preventive medical checkups are not a benefit under telemedicine or telehealth.

Refer to: The THSteps Medical Checkups Periodicity Schedule which may be found at www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers.

Checkups should be scheduled, to the extent possible, based on the ages on the periodicity schedule to accommodate the need for flexibility when scheduling checkup appointments.

The following table lists the number of visits allowed at each age range:

Age Range	Number of Visits
Birth through 11 months (does not include 12 month checkup)	6
1 through 4 years	7
5 through 11 years	7
12 through 17 years	6
18 through 20 years	3

All of the checkups listed on the periodicity schedule were developed according to the recommendations of the AAP and in consultation with recognized authorities in pediatric preventive health. In Texas, the THSteps periodicity schedule may differ from the AAP periodicity schedule based on the scheduling of laboratory or other tests in federal EPSDT or state regulations.

For more information about conducting a THSteps checkup, providers can refer to the THSteps online educational modules at www.txhealthsteps.com.

The following table includes the procedure codes, required condition indicators, and the resulting referral status for medical checkups. Condition indicators must be used in addition to a provider type modifier at each THSteps checkup. A condition indicator must be submitted on the claim with the periodic medical checkup procedure code. Condition indicators are required whether a referral was made or not. If a referral is made, then providers must use the Y referral status. If no referral is made, then providers must use the N referral status.

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Procedure Codes	Condition Indicators	Referral Status
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (Established client preventive visit)	NU (not used)	N (no referral given)
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (established client preventive visit)	S2 (under treatment) or ST* (new services requested)	Y (yes THSteps or EPSDT referral was given to the client)
*** The ST condition indicator should only be used when a referral is made to another provider or the client must be rescheduled for another appointment with the same provider. It does not include treatment initiated at the time of the checkup.**		

THSteps preventive care medical checkups for clients who are 18 through 20 years of age must be submitted with procedure codes 99385 or 99395 and diagnosis code Z0000 or Z0001.

Claims for procedure codes 99381, 99382, 99383, 99384, 99391, 99392, 99393, and 99394 must be submitted with the appropriate age related diagnosis code listed in the following table:

Client Age	Diagnosis Code
Birth through 7 days	Z00110
8 through 28 days	Z00111
29 days through 17 years	Z00121, Z00129
18 through 20 years	Z0000, Z0001

The age-appropriate diagnosis code for a preventive care medical checkup must be submitted on the claim. If an immunization is administered as part of the preventive care medical checkup, diagnosis code Z23 may also be included on the claim, in addition to the age-appropriate diagnosis.

If an immunization is the only service provided during an office visit, providers may submit only diagnosis code Z23 on the claim.

Note: *Note: A THSteps preventive care medical checkup will not be reimbursed if the office visit is only for immunization.*

Modifier AM, SA, TD, or U7 must be submitted with the THSteps medical checkups procedure code to indicate the practitioner who performed the unclothed physical examination during the medical checkup.

Modifier	Practitioner
AM	Physician, team member service
SA	Nurse practitioner rendering service in collaboration with a physician
TD	Registered nurse
U7	Physician assistant

THSteps medical checkups performed in an FQHC or RHC setting are paid an all-inclusive rate per encounter, which includes immunizations, developmental screening, autism screening, mental health screening for adolescents, postpartum depression screening, TST, blood lead test, and OEFV. When

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submitting claims for THSteps checkups and services, RHC providers must use the national POS code 72, and FQHC providers must use modifier EP in addition to the modifiers used to identify who performed the medical checkup. In accordance with the federal rules for RHCs and FQHCs, an RN in an RHC or FQHC may not perform THSteps checkups independently of a physician's interactions with the client.

Refer to: Section 4, "Federally Qualified Health Center (FQHC)" for information related to billing.

Section 8, "Rural Health Clinic" for information related to billing.

Checkups, exception-to-periodicity checkups, and follow-up visits are limited to once per day any provider.

A checkup and the associated follow-up visit may not be reimbursed on the same date of service. The follow-up visit will be denied.

An incomplete checkup is subject to recoupment unless there is documentation to support why the component was not completed as part of the checkup.

A new patient is one who has not received any professional services within the preceding three years from the provider or from another provider of the same specialty who belongs to the same group practice. As an exception, a new preventive care medical checkup (procedure code 99381, 99382, 99383, 99384, or 99385) may be billed when no prior checkups have been billed by the same provider or provider group, even if an acute care new patient E/M service was previously performed by the same provider.

An additional new checkup is allowed only when the client has not received any professional services in the preceding three years from the same provider or another provider who belongs to the same group practice, because subsequent acute care visits to the new patient THSteps checkup continues the established relationship with the provider.

If the provider that performs the medical checkup provides treatment for an identified condition on the same day, the provider may submit a separate claim for an acute care established-client office visit. The separate claim must include the established-client procedure code that is appropriate for the diagnosis and treatment of the identified problem. Treatment of minor illnesses or conditions (e.g., follow-up of a mild upper respiratory infection) during the THSteps medical checkup may not warrant additional billing.

Acute Care Visits

When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.

Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a checkup. Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provided for a different diagnosis. Providers must bill an appropriate level E/M procedure code with the diagnosis that supports the acute care visit. The medical record must contain documentation that supports the medical necessity and the level of service of the E/M procedure code that is submitted for reimbursement.

An acute care E/M visit for an insignificant or trivial problem or abnormality billed on the same date of service as a checkup or exception-to-periodicity checkup is subject to recoupment.

Providers must bill an acute care visit with their NPI on a separate claim without benefit code EP1.

Refer to: Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup on the TMHP website at www.tmhp.com for a claim form example.

THSteps Preventive Visit Checkup with Immunization and Vaccine Administration on the TMHP website at www.tmhp.com for a claim form example.

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4.3.7 Exception-to-Periodicity Checkups

Exception-to-periodicity checkups are complete medical checkups completed outside the timeframes listed in the THSteps Periodicity Schedule due to extenuating circumstances.

Exception-to-periodicity checkups are complete medical checkups, which are medically necessary and might cause the total number of checkups to exceed the number allowed for the client's age range if the client were to have all regular scheduled checkups. An exception-to-periodicity checkup is allowed when:

- Medically necessary, for example, for a client with developmental delay, suspected abuse, or other medical concerns or a client in a high-risk environment, such as living with a sibling with elevated blood lead.
- Required to meet state or federal exam requirements for Head Start, day care, foster care, or preadoption.
- When needed before a dental procedure requiring general anesthesia.

As noted in the Periodic Checkup Age Range table, the number of checkups is set for each age range. This may avoid an exception-to-periodicity checkup and allow flexibility for the provider and family to schedule a checkup including before the child's birthday.

If a client is due for a medical checkup, a checkup outside of the regular THSteps schedule must be billed as a regular checkup rather than an exception to periodicity.

The checkup is considered complete when all the required components are documented in the client's medical record or supporting documentation, which details the reason a component(s) was not completed. A plan to complete the component(s) if not due to reasons of conscious or parental concerns must be included in the documentation.

Note: *A sports physical is not a reason for an exception-to-periodicity checkup.*

When billing for an exception-to-periodicity visit, provider must also include the most appropriate exception-to-periodicity modifiers. Claims for periodic THSteps medical checkups exceeding periodicity that do not include one for these modifiers will be denied as exceeding periodicity.

Modifier	Description
SC	Medically necessary service or supply
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.
32	Mandated Services: Services related to mandated consultation 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.

THSteps medical exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup. Additionally, providers must use modifiers 23, 32, and SC to indicate the exception.

4.3.8 Medical Checkups During a Declaration of State Disaster

During a Declaration of State Disaster, Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of telemedicine or telehealth services to include the use of synchronous telephone (audio-only) platform to provide coverage of services outside of the allowances

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described herein. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

The following limitations apply to all THSteps preventive medical checkups and exception-to-periodicity checkups during a Declaration of State Disaster when HHSC issues direction regarding the use of synchronous audiovisual and synchronous telephone (audio-only) technologies:

- Clients who are 2 years through 20 years of age may receive a THSteps medical checkup or exception-to-periodicity checkup using synchronous audiovisual or synchronous telephone (audio-only) technologies.
- Clients from birth through 2 years of age may not receive a THSteps checkup or exception-to-periodicity checkup using synchronous audiovisual or synchronous telephone (audio-only) technologies.
- Clients from birth through 24 months of age must receive in-person checkups.

A medical checkup provided using synchronous audiovisual or synchronous telephone (audio-only) technologies must be completed according to the age-specific checkup requirements listed on the THSteps Periodicity Schedule.

Synchronous audiovisual delivery for medical checkups is preferred over synchronous telephone (audio-only) delivery.

An in-person THSteps follow-up visit must be completed within six months of the synchronous audiovisual or synchronous telephone (audio-only) checkup in order for the checkup to be considered a complete THSteps checkup.

When HHSC issues direction, the following THSteps medical checkup services are authorized for delivery using synchronous audiovisual or synchronous telephone (audio-only) technologies during a Declaration of State Disaster:

Procedure Codes									
99382*	99383	99384	99385	99392*	99393	99394	99395		
*** Limited to checkups for clients who are over 24 months of age and who received their 24-month checkup in-person.**									

Medical checkups and exception-to-periodicity checkups provided using synchronous audiovisual or synchronous telephone (audio-only) technologies are limited to checkups for clients who are over 24 months of age for the following procedure codes:

Procedure Codes									
99382	99383	99384	99385	99392	99393	99394	99395		

Medical checkups for clients who are 2 years of age or younger must be completed in-person and may not be completed using synchronous audiovisual or synchronous telephone (audio-only) technologies (procedure codes 99381, 99382, 99391 and 99392).

THSteps providers should use their clinical judgement regarding which checkup components may be appropriate for completion using synchronous audiovisual or synchronous telephone (audio-only) technologies.

THSteps providers are encouraged to ensure that clients receiving a medical checkup using synchronous audiovisual or synchronous telephone (audio-only) technologies receive age-appropriate vaccines and laboratory screenings in a timely manner.

Medical checkup services using synchronous audiovisual or synchronous telephone (audio-only) technologies should only be provided if agreed to by the client or parent/guardian.

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Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on restrictions for services delivered by synchronous telephone (audio-only) technologies.

4.3.8.1 THSteps Required Follow-up Visit

An in-person follow-up visit (procedure code 99211) is required for all clients who receive an initial synchronous audiovisual or synchronous telephone (audio-only) checkup.

The in-person follow-up visit (procedure code 99211) is required within six months of the synchronous audiovisual or synchronous telephone (audio-only) checkup.

All age-appropriate checkup components noted on the THSteps Periodicity Schedule that are not completed during the synchronous audiovisual or synchronous telephone (audio-only) checkup must be completed at the in-person follow-up visit (procedure code 99211).

4.3.8.2 Documentation Requirements

Documentation in the client's medical record for synchronous audiovisual or synchronous telephone (audio-only) checkups must meet all documentation requirements for an in-person checkup and include all the following:

- Whether the checkup was completed using synchronous audiovisual or synchronous telephone (audio-only) technology
- All checkup components that were not completed at the time of the synchronous audiovisual or synchronous telephone (audio-only) checkup, the reason that the component(s) were not completed and a plan to complete the components
- For the required in-person THSteps follow-up visit: documentation must indicate that the visit is related to a previously provided synchronous audiovisual or synchronous telephone (audio-only) checkup or exception-to-periodicity checkup
- For the required in-person THSteps follow-up visit: documentation should include all age-appropriate checkup components completed during the follow-up visit
- All anticipatory guidance and information on the next scheduled medical checkup or follow-up visit

4.3.8.3 Reimbursement

THSteps checkups billed as a synchronous audiovisual or synchronous telephone (audio-only) checkup (procedure codes 99381, 99391, 99382, or 99392) for children who are 24 months of age or younger will be denied.

THSteps checkups and exception-to-periodicity checkups delivered using synchronous audiovisual technology must be billed with modifier 95.

THSteps checkups and exception-to-periodicity checkups delivered using synchronous telephone (audio-only) technology must be billed with modifier 93.

Checkups billed as exception-to-periodicity checkups must also include the appropriate exception-to-periodicity checkup modifier (23, 32, or SC).

Records are subject to retrospective review, and incomplete checkups are subject to recoupment.

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4.3.9 Medical Checkup Follow-up Visit

Use procedure code 99211 with the NPI and THSteps benefit code when billing for a follow-up visit.

Note: *Reimbursement for the follow-up visit includes all elements of the visit. Reimbursement may not be allowed for the follow-up visit when submitted with certain procedure codes. For example: In accordance with CMS NCCI requirements, modifier 25 guidelines do not apply for procedure code 99211 when billed with other procedure codes that are included in the visit as related elements, including, but not limited to, administration of immunizations.*

Refer to: Subsection 6.4.1, "National Correct Coding Initiative (NCCI) Guidelines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for additional information.

Medical Checkup Follow-up Visit with Immunization Administration on the TMHP website at www.tmhp.com for a claim form example.

Medical Checkup Follow-up Visit with TB Skin Test on the TMHP website at www.tmhp.com for a claim form example.

A follow-up visit may be required to complete necessary procedures related to a checkup or exception-to-periodicity checkup, such as:

- Reading the TST.
- Administering immunizations in cases where the client's immunizations were not up-to-date, medically contraindicated, or unable to be given during the checkup.
- Collection of specimens for laboratory testing that were not obtained during the checkup or the original specimen could not be processed.
- Completion of sensory or developmental screening that was not completed at the time of the checkup due to the client's condition.

A return visit to follow up on treatment initiated during a checkup or to make a referral is not a follow-up visit, but is considered an acute care visit under an appropriate E/M procedure code for an established client.

Refer to: Subsection 9.2.60.1.1, "New and Established Patient Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about established patient E/M services.

If the parent or guardian did not give consent for a component during the initial checkup, and supporting documentation is provided, no follow-up visit is necessary.

4.3.10 Newborn Examination

Providers do not have to be enrolled as THSteps providers to bill newborn examination procedure codes 99460, 99461, or 99463.

Newborn examinations that are billed with procedure code 99460, 99461, or 99463 may qualify as a THSteps medical checkup when all required components are completed according to the THSteps Periodicity Schedule and documented in the medical record.

Providers must use their NPI without benefit code EP1 when billing newborn examination services.

Note: *In Texas, the mandated newborn hearing screening and newborn screening test is included as part of the in-hospital newborn exam.*

A newborn hearing screening is included in the reimbursement to the hospital for the newborn hospital stay and is not reimbursed separately. The screening is covered as part of the newborn delivery. A newborn hearing screening must be offered to each newborn by the facility where the birth occurs,

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through a program mandated by the Texas Legislature and certified by the Department of State Health Services (DSHS). If a facility is not required by legislative mandate to perform newborn hearing screenings, a referral must be made to a facility that offers the screening.

If an infant is not born in a birthing facility and is not admitted to a birthing facility, the infant must be referred to a facility that provides newborn hearing screening.

State-mandated newborn screening for critical congenital heart disease (CCHD) is offered by and performed in the birth facility in accordance with Health and Safety Code (HSC) § 33.011 and 25 TAC §§37.75–37.79.

Providers billing these newborn codes are not required to be THSteps providers, but they must be enrolled as Medicaid providers. TMHP encourages THSteps enrollment for all providers that offer a medical home for clients and provide them with medical checkups and immunizations. Physicians and hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps checkup on the periodicity schedule should be scheduled from discharge to five days of age and that regular checkups should be scheduled during the first year and after.

Refer to: Subsection 9.2.47, "Newborn Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information on inpatient newborn services.

The THSteps online education module "Newborn Hearing Screening" on the THSteps website at www.txhealthsteps.com for additional information about conducting a newborn hearing screen.

4.3.11 THSteps Medical Checkups Periodicity Schedule

The client is periodically eligible for medical checkup services based on the THSteps Medical Checkups Periodicity Schedule. All the checkups listed on the periodicity schedule have been developed based on recommendations of the AAP and recognized authorities in pediatric preventive health. In Texas, THSteps has modified the AAP periodicity schedule based on the scheduling of a laboratory or other test in federal EPSDT or state regulations.

The THSteps Medical Checkups Periodicity Schedule is available on the HHSC website at www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers.

4.3.12 Mandated Components

THSteps medical checkups must include regularly scheduled examinations and screenings of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.

The following federal and state mandated components must be documented in the client's medical record for the checkup to be considered complete:

- Comprehensive health and developmental history, including physical and mental health development
- Comprehensive unclothed physical examination
- Immunizations appropriate for age and health history
- Laboratory test appropriate to age and risk, including lead toxicity at specific federally-mandated ages
- Health education including anticipatory guidance
- Dental referral

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The client's medical record must include documentation to support the rationale a component was not completed, and a plan to complete the component(s) if not due to parent or caregiver concern or reasons of conscience, including religious beliefs. THSteps provides optional clinical records to assist the provider in the documentation of the required components.These forms may be found at www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers.

The provider must offer checkups in accordance with the Texas Health Steps Medical Checkup Periodicity Schedule (periodicity schedule), found at www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers, to ensure the preventive health screenings occur at age appropriate points in the client's life. The periodicity schedule specifies screening procedures that are required at each stage of development. There are 11 checkups before 3 years of age (excluding the newborn exam) and then annual checkups from 3 through 20 years of age.

If the client has a condition that has been previously diagnosed and is currently receiving treatment, the associated standardized screening may be omitted with proper documentation.

Documented test or screening results obtained within the preceding 30 days for clients who are two years of age and younger, and the preceding 90 days for clients who are three years of age and older may be used to meet the testing or screening requirements. Results must include the dates of service and one of the following:

- A clear reference to the previous visit by the same provider
- Results obtained from another provider

4.3.12.1 Comprehensive Health and Developmental History

4.3.12.1.1 Nutritional Screening

Dietary practices must be evaluated at each checkup to identify and address nutritional issues or concerns.

4.3.12.1.2 Developmental Surveillance or Screening

Developmental surveillance or screening is a required component of every checkup for clients who are birth through 6 years of age. Autism screening is required at 18 months of age and again at 24 months of age. If not completed at 24 months of age, or if there is a particular concern it should be completed at 30 months of age.

As THSteps medical services, developmental screening (procedure code 96110) and autism screening (procedure code 96110 with modifier U6) are limited to once per day, per client, by the same provider or provider group. This service will be denied unless a checkup, exception-to-periodicity checkup, or follow-up visit was reimbursed for the same date of service by the same provider.

Standardized developmental screening is required at the ages listed in the "Required Screening Ages and Recommended Tools" table. Providers must use one of the validated, standardized tools listed in the table when performing a developmental or autism screening. A standardized screen is not required at other checkups up to and including the 6-year checkup; however, developmental surveillance is required at these checkups and includes a review of milestones (gross and fine motor skills, communication skills, speech-language development, self-help/care skills, and social, emotional, and cognitive development) and mental health and is not considered a separate service.

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Providers may be reimbursed separately when using one of the required screening tools listed in the following table in addition to the checkup visit at specific age visits. THSteps requires one of the following required standardized tools at the following ages for a checkup to be considered complete:

Required Screening Ages and Recommended Tools		
Screening Ages	Developmental Screening Tools	Autism Screening Tools
9 months	Ages and Stages Questionnaire (ASQ), Parents' Evaluation of Development Status (PEDS) or Survey of Well-being of Young Children (SWYC)	N/A
18 months	ASQ, PEDS or SWYC	Modified Checklist for Autism in Toddlers (M-CHAT) or M-CHAT Revised with Follow-Up (M-CHAT R/F)
24 months	ASQ, PEDS or SWYC	M-CHAT or M-CHAT R/F
3 years	ASQ, Ages and Stages Questionnaire: Social-Emotional (ASQ:SE), PEDS or SWYC	N/A
4 years	ASQ, ASQ:SE, PEDS or SWYC	N/A

If a developmental screening that is required in the Required Screening Ages and Recommended Tools table is not completed during a checkup or if the client is being seen for the first time, standardized developmental screening must be completed through 6 years of age.

If a provider administers a standardized and validated developmental screening at additional checkups other than those listed in the Required Screening Ages and Recommended Tools table, the provider must document the rationale for the additional screening, which may be due to provider or parental concerns.

Developmental screening that is completed without the use of one of the required standardized screening tools is not a separately payable benefit, and the checkup will be considered incomplete.

Standardized developmental screening as part of a medical checkup and for ages other than required on the periodicity schedule is not covered when completed for the sole purpose of meeting day care, Head Start, or school program requirements.

Standardized developmental screening may be performed outside a THSteps medical checkup as part of development and neurological assessment testing.

Refer to: Subsection 9.2.25, "Developmental Screening and Testing and Aphasia Assessment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information related to developmental screening testing outside a THSteps medical checkup.

Referral for an in-depth developmental evaluation is determined by the criteria of the specific tool or at the provider's discretion. Referral for in-depth evaluation of development should be provided when parents express concern about their child's development, regardless of scoring on a standardized development screening tool. A medical diagnosis or a confirmed developmental delay is not required for referrals.

The ECI program serves clients who are birth through 35 months of age with disabilities or developmental delays. Under federal and state regulations, all health-care professionals are required to refer children to the Texas HHS ECI program as soon as possible, but no longer than 7 days after identifying a disability or a suspected delay in development, even if referred to an appropriate provider for further testing. If the client is 3 years of age or older, referral should be made to the local school district's special education program.

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4.3.12.1.3 Mental Health Screening

Mental health screening for behavioral, social, and emotional development is required at each THSteps checkup. Comparable to the American Academy of Pediatrics (AAP) Recommendations for Preventive Health Care guidelines, THSteps allows clients who are 12 through 18 years of age to receive a mental health screening using one of THSteps recognized mental health screening tools.

The following validated, standardized mental health screening tools are recognized by THSteps for mental health screening in adolescents who are 12 through 18 years of age:

- Pediatric Symptom Checklist (PSC-17)
- Pediatric Symptom Checklist (PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Patient Health Questionnaire (PHQ-9) Modified for Adolescents (PHQ-A [depression screen])
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)
- Patient Health Questionnaire (PHQ-A [anxiety, eating problems, mood problems and substance use])
- Rapid Assessment for Adolescent Preventive Services (RAAPS)

A mental health screening must be submitted with procedure code 96160 for a screening tool completed by the adolescent, or procedure code 96161 for a screening tool completed by the parent or caregiver on behalf of the adolescent. When claims with procedure code 96160 or 96161 are submitted for mental health screenings, one of the validated, standardized mental health screening tools recognized by THSteps must be used.

Only one procedure code (96160 or 96161) may be reimbursed for the mental health screening per client per calendar year based on the description of the procedure code and the service rendered. Procedure codes 96160 and 96161 will not be reimbursed for the same client for any date of service.

Procedure code 96160 or 96161 must be submitted on the same date of service by the same provider as procedure code 99384, 99385, 99394, or 99395, and reimbursement is limited to once per calendar year, any provider.

The client's medical record must include documentation identifying the tool that was used, the screening results, and any referrals that are made.

When the clinician conducting the mental health screen has the appropriate training and credentials to conduct the mental health evaluation and provide treatment, the clinician may choose to provide the mental health services or refer the client to an appropriate clinician. Clinicians who do not have these qualifications must refer clients to a qualified Medicaid-enrolled mental health specialist for such care.

For additional information about conducting a mental health screen, providers can refer to the THSteps online educational module "Mental Health Screening" at www.txhealthsteps.com.

4.3.12.1.4 Postpartum Depression Screening

Postpartum depression screening is a benefit of Texas Medicaid. Procedure codes G8431 and G8510 may be reimbursed when billing for postpartum depression screening in the office setting.

THSteps medical providers may receive separate reimbursement for postpartum depression screening, in addition to the infant's Texas Health Steps medical checkup or follow-up visit. The reimbursement amount for procedure codes G8431 and G8510 covers all postpartum depression screenings provided during the infant's medical checkup or follow-up visit.

Postpartum depression screening must be submitted under the infant's Medicaid client number and will be restricted to clients who are 12 months of age and younger.

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Procedure codes G8431 and G8510 must be submitted on the same claim, for the same date of service, by the same provider as one of the following THSteps medical checkup or follow-up visit procedure codes:

Procedure Codes				
99211	99381	99382	99391	99392

Only one procedure code, either G8431 or G8510, may be reimbursed per provider in the 12 months following the infant's birth.

Postpartum Depression Screening and Referral Services

The American Academy of Pediatrics (AAP) recommends the infant's provider screen mothers for postpartum depression. Postpartum depression is the most common form of postpartum mood disturbance. Screening mothers for postpartum depression is appropriate for the general postpartum population and is recommended within the first few months following birth, up to the infant's first birthday.

Postpartum depression meets the same clinical criteria as major depressive disorder, with the main difference being onset during pregnancy or after delivery.

While postpartum depression is the most common form of postpartum mood disturbance, providers should be aware that other mood disorders that may arise during the postpartum period include anxiety and panic disorders, obsessive-compulsive disorder, and postpartum psychosis.

Postpartum psychosis is a much more severe form of postpartum depression accompanied by psychotic features. Postpartum psychosis is rare, typically develops in the first few days to weeks after delivery, and is a psychiatric emergency requiring immediate medical attention.

In addition to postpartum psychosis, immediate or emergent medical attention may be necessary when the risk of imminent harm or danger is present.

Screening Guidelines

Screening using a validated tool is required. At a minimum, screening should occur at least once during the postpartum period. Validated tools may include the following:

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9

Screening alone is inadequate for improving clinical outcomes. A positive screening for postpartum depression requires the THSteps provider to develop a referral plan with the mother.

Positive Screenings: Referrals and Follow-Up

THSteps providers must discuss the screening results with the mother, discuss the possibility of depression, and the impact depression may have on the mother, family, and health of the infant.

The THSteps provider and mother should discuss the mother's options so the provider can refer her to an appropriate provider. Screening and referral is not contingent upon the mother's Medicaid eligibility. When needed, referrals should be made regardless of the funding source, including referral to local mental health authorities and local behavioral health authorities.

THSteps providers should refer the mother to a provider who can perform further evaluation and determine an appropriate course of treatment. Appropriate providers include, but are not limited to:

- Mental health clinicians
- The mother's primary care provider

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- Obstetricians and gynecologists
- Family physicians
- Community resources such as Local Mental Health Authorities (LMHAs)

Note: *Referral to an emergency center may be necessary when the risk for imminent harm or danger is present, such as mothers who report suicidal thoughts or thoughts of harming herself or the baby.*

Resources should be provided for support in the interim until the mother is able to access care.

Scheduling a return visit for the infant sooner than the next scheduled visit may be appropriate in some cases.

Prior Authorization Requirements

Screening for postpartum mood disorders at the checkup or follow up visit does not require prior authorization.

Note: *While recommended, screening for postpartum depression at the THSteps visit is not a compulsory requirement of the infant visit.*

Documentation Requirements

Documentation in the infant's record must include the name of the screening tool used and date the screening was completed.

If the mother screens positive for depression, at a minimum, the provider must note that a referral plan was discussed with the mother and a referral to a provider was made.

Providers may give the mother a copy of the completed screening tool to take with her to referral appointments.

Documentation should also include any health education or anticipatory guidance provided, along with the time period recommended for the infant's next appointment.

4.3.12.1.5 Tuberculosis (TB) Screening

Administer the TB risk screening tool annually beginning at 12 months of age and thereafter at other medical checkups.

The TB risk screening tool is available on the HHSC website at www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/health-services-providers/thsteps/ths-tb-questionnaire.pdf.

A TST is to be administered when the screening tool indicates a risk for possible exposure. Providers must use procedure code 86580 when a TST is administered.

A TST may be reimbursed separately when performed as part of a THSteps medical checkup. TB screenings are part of the encounter rates for FQHCs and RHCs and are not reimbursed separately.

A follow-up visit (procedure code 99211) is required to read all TSTs. The provider may bill the follow-up visit with an NPI and THSteps benefit code.

If further evaluation is required to diagnose either latent TB infection or active TB disease, the provider may bill the appropriate E/M office visit code. Diagnosis and treatment are provided as a medical office visit. Providers can also call the TB program at 1-512-533-3000 for additional clinical information.

Refer to: "TB Policies and Procedures" at www.dshs.texas.gov/idcu/disease/tb/ for guidance on skin testing children in various settings. Click TB Control Standards, and then look under "Texas TB Policies and Procedures."

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4.3.12.2 Comprehensive Unclothed Physical Examination

An age-appropriate unclothed physical examination is required at each checkup.

Recording of measurements and percentiles as appropriate to age to document growth and development including:

- Length or height and weight.
- The World Health Organization (WHO) growth charts, which are recommended for clients from birth to 2 years of age.
- The Centers for Disease Control and Prevention (CDC) growth charts, which are recommended for clients from 2 years of age and older.
- Fronto-occipital circumference (FOC) through the first 24 months of age.
- Body mass index (BMI) calculated beginning at 2 years of age.
- Blood pressure beginning at 3 years of age.

4.3.12.2.1 Oral Health Screening

Oral health screening is a part of the medical checkup physical examination.

4.3.12.2.2 Sensory Screening

Documentation of test results from a school vision or hearing screening program may replace the required audiometric or visual acuity screening if conducted within 12 months prior to the checkup.

Clients who are birth through 35 months of age with suspected or confirmed hearing or visual impairment must be referred to ECI as soon as possible, but no longer than 7 days after identification.

4.3.12.2.3 Hearing Screening

State-mandated newborn hearing screening is offered by and performed in the birth facility in accordance with Health and Safety Code (HSC), Chapter 47, §§ 47.001–47.009 and 25 TAC §§ 37.501–37.507.

A newborn hearing screening must be completed at the birthing facility. Automated auditory brainstem response (AABR) or transient evoke or distortion product otoacoustic emissions (OAE) may be performed.

Screening Results

Birthing facilities must report all newborn hearing screening results to DSHS within five business days using the web-based Texas Early Hearing Detection and Intervention (TEHDI) Management Information System (MIS) if written parental consent is obtained. Documented written consent must be maintained in the infant's medical record.

Birthing facilities must provide written newborn hearing screening results to the parent or caregiver as well as the newborn's primary care provider or medical home.

Primary care providers and medical homes (Texas Health Steps [THSteps] providers) must obtain a copy of the newborn hearing screening results within the TEHDI MIS if not provided by the birthing facility. The primary care provider or medical home must review all newborn hearing screening results with the parent or caregiver at the first checkup and determine if any additional follow-up is necessary.

> ***Note:*** *The primary care provider or medical home is responsible for managing and coordinating care for the child. Refer to the American Academy of Pediatrics Position Statement at https://publications.aap.org/pediatrics/article/129/5/996/73753/Home-Care-of-Children-and-Youth-With-Complex. Additional information related to TEHDI and Early Hearing Detection & Intervention Action Center (EHDI) can also be found at https://publications.aap.org/pediatrics/article/120/4/898/71218/Year-2007-Position-Statement-Principles.*

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Newborns who pass the newborn hearing screening must have their hearing monitored per the THSteps periodicity schedule. The primary care provider or medical home may opt to use the following tools to monitor developmental milestone benchmarks in newborns that pass their newborn hearing screening:

- TEHDI: A Roadmap for Families (English)
- Hearing Checklist for Parents (English)
- Hearing Checklist for Parents (Spanish)

Newborns who do not pass the initial screen must be rescreened a second time in the birthing facility before discharge.

Outpatient Rescreening

Newborns who do not pass the second screen in the birthing facility must be referred to a Medicaid-enrolled provider for an outpatient follow-up rescreen. The rescreen provider must have access to AABR or OAE screening and must be experienced with the pediatric population under age three.

Newborns who do not receive a referral from the birthing facility, after not passing the second screen in the birthing facility, must be referred by their primary care provider or medical home to a Medicaid-enrolled provider for an outpatient follow-up rescreen, unless their primary care provider or medical home is adequately equipped to provide the service. The optimal time frame for the outpatient follow-up rescreen is when the infant is between 10 and 30 days old.

Outpatient follow-up rescreens must be completed by AABR or OAE screening. Results must be reported as soon as possible to the DSHS TEHDI MIS, as well as the infant's primary care provider or medical home.

Newborns who pass the outpatient rescreen must have their hearing monitored by their primary care provider or medical home per the THSteps periodicity schedule.

Diagnostic Audiological Evaluation

Newborns who do not pass the outpatient rescreen must be referred to a Medicaid-enrolled audiologist for a diagnostic audiological evaluation using the Texas Pediatric Protocol for Evaluation. Referrals should be made upon consultation with the primary care provider or medical home.

> ***Note:*** *Additional information about the Texas Pediatric Protocol for Evaluation is available at www.dshs.texas.gov/texas-early-hearing-detection-intervention-tehdi*

Unless the newborn or infant has been hospitalized since birth, the diagnostic audiological evaluation must be completed no later than the third month after birth, or upon referral by the primary care provider or medical home.

Diagnostic audiological evaluations completed by audiologists using the Texas Pediatric Protocol for Evaluation must include a diagnostic auditory brainstem response (ABR) and, if not previously done, a diagnostic OAE to determine cochlear involvement.

Audiologists will use equipment norms for newborns, preferably ones they have collected on their equipment.

Protocols include air and bone conduction testing using tone burst ABR, as well as click ABR, so the amplification may be appropriate to fit the individual.

> ***Note:*** *Additional information about technologies that have been evaluated by an independent investigator and DSHS, and have been found to meet the requirements for conducting newborn hearing screening is available at www.dshs.texas.gov/texas-early-hearing-detection-intervention-tehdi.*

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Evaluation Results

Audiologists must report all diagnostic results to DSHS TEHDI MIS and provide written hearing screening results to the primary care provider or medical home.

The newborn or infant will be fitted for hearing aids by the audiologist when appropriate and should receive continued audiological assessments and monitoring as needed.

ECI Referrals

Newborns or infants not passing the outpatient rescreen must also be referred by the primary care provider or medical home to ECI for provision of services. The referral should be made within the TEHDI MIS.

Newborns or infants, as required by federal law under the Individuals with Disabilities in Education Act (IDEA), may be referred to ECI twice under the following circumstances:

- Upon suspicion that the child is deaf or hard of hearing, for service coordination and possible confirmation of eligibility for ECI services
- Upon confirmation that the child is deaf or hard of hearing, for a referral to other Local Education Agency for auditory impairment services

Late Onset Hearing Loss

When one or more risk factors for late onset hearing loss has been identified and the newborn or infant passed their hearing screen, the outcome will not be "normal hearing" but will be "in process." Noting the infant as "in process" allows all health-care providers in the care of the infant to be aware of the presence of risk factors to determine the frequency of risk monitoring to identify audiological issues as soon as possible. This determination depends on the type and number of the following risks identified:

- Craniofacial anomalies
- Exchange transfusion for elevated bilirubin
- Family history of deafness
- NICU > 5 days
- Apgar 0-4 at 1 minute
- Apgar 0-6 at 5 minutes
- Bacterial meningitis
- Birth weight < 1500g
- Congenital infection
- Head injury
- Neurodegenerative disorder
- Other postnatal infection
- Otitis media > 3 months (middle ear infection)
- Ototoxic medications administered
- Parental concern regarding hearing status
- Persistent pulmonary hypertension of the newborn associated with mechanical ventilation

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- Syndrome

Note: *Information about risk factors for late onset hearing loss and a risk monitoring periodicity schedule is available in Chapter 3, "Tracking, Reporting, & Follow-Up," in The NCHAM E-Book on the National Center for Hearing Assessment and Management (NCHAM) website at http://infanthearing.org.*

Hearing screening must be performed at each checkup for clients who are birth through 20 years of age. Audiometric screening must be performed at specific ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report is required at the other checkups.

Clients at high risk or with abnormal screening results must be referred to an appropriate Medicaid-enrolled provider who specializes in pediatric audiology services. Clients who are birth through 20 years of age enrolled with Texas Medicaid for the date(s) of service are eligible for Texas Medicaid hearing services benefits.

4.3.12.2.4 Vision Screening

Vision screening must be performed at each checkup. A visual acuity test must be performed at ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report is done at the other checkups.

All clients must be screened for eye abnormalities by history, observation, and physical exam and referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population if at high risk.

Clients with abnormal visual acuity screening results must be referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population.

4.3.12.3 Immunizations

The TVFC program provides vaccines at no cost to the provider. The vaccines are recommended according to the Recommended Childhood and Adolescent Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], AAP, and the American Academy of Family Physicians [AAFP]). Medicaid does not reimburse for vaccines/toxoids that are available from TVFC. THSteps providers are strongly encouraged to enroll in TVFC at DSHS and must do so in order to obtain free vaccines for clients who are birth through 18 years of age. Local and public health departments that are not otherwise enrolled as a provider that is authorized to receive reimbursement for vaccine administration fees should enroll as a Comprehensive Care Program (CCP) provider. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed $13.75, is considered for reimbursement.

For additional information about immunizations, providers can refer to the THSteps online educational module "Immunization" at www.txhealthsteps.com.

Refer to: Section 4.5, "Vaccine Services" in this handbook.

"Immunizations" in this handbook.

Providers must assess the immunization status at every medical checkup to ensure all age requirements have been met. The necessary vaccines and toxoids must be administered at the time of the checkup unless medically contraindicated or because of parent's or caregiver's reasons of conscience including religious beliefs. If an indicated vaccine or toxoid was not administered, the reason must be documented in the client's medical record.

Vaccines and toxoids must be administered according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule - United States." Providers must not refer clients to the local health department or other entity for immunization administration.

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THSteps providers are strongly encouraged to obtain vaccines from TVFC for clients who are birth through 18 years of age. Vaccines that are identified as being distributed through TVFC are not reimbursed separately.

Vaccines and toxoids may be reimbursed through Texas Medicaid at a fee determined by HHSC when the vaccine is medically necessary for THSteps clients who are 19 through 20 years of age.

The specific diagnosis necessitating the vaccine and toxoid is required when billing with the following administration procedure codes in combination with an appropriate vaccine/toxoid procedure code:

Procedure Codes					
90460	90461	90471	90472	90473	90474

The age-appropriate diagnosis code for a preventive care medical checkup must be submitted on the claim. If an immunization is administered as part of a preventive care medical checkup, diagnosis code Z23 may also be included on the claim, in addition to the age-appropriate diagnosis.

Vaccine and toxoid administration must be billed with the following age appropriate diagnosis codes:

Client Age	Diagnosis Code
Birth through 7 days	Z00110
Eight through 28 days	Z00111
29 days through 17 years	Z00121, Z00129
18 years or older	Z0000, Z0001

Refer to: "Immunizations" in this handbook.

The DSHS website for TVFC provider enrollment information at www.dshs.texas.gov/immunizations/providers/overview.

The THSteps online education module "Immunizations," located on the THSteps website at txhealth-steps.com, for more information about immunizations.

4.3.12.4 Health Education and Anticipatory Guidance

Anticipatory guidance is a federally mandated component of the THSteps medical checkup and includes health education and counseling. Health education and counseling with parents or guardians and clients are required to assist parents in understanding what to expect in terms of the client's development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Written material may also be given but does not replace counseling. The optional THSteps clinical records include age-appropriate topics on the back of each form. These forms can be found at www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers/ths-forms.

4.3.12.5 Dental Referral

Based on the AAPD definition of a dental home, Texas Medicaid defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. In Texas, establishment of a client's dental home should begin at 6 months of age but no later than 12 months of age and includes referral to dental specialists when appropriate.

The physician must refer clients to establish a dental home beginning at 6 months of age or earlier if trauma or early childhood caries are identified. For established clients after the six-month medical checkup, the provider must confirm if a dental home has been established and is on-going; if not,

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additional referrals must be made at subsequent medical checkup visits until the parent or caregiver confirms that a dental home has been established for the client. The parent or caregiver of the client may self-refer for dental care at any age, including 12 months of age or younger.

4.3.12.6 Laboratory Test

Age-appropriate and risk-based laboratory testing as noted on the periodicity schedule is considered part of the medical checkup. The DSHS Laboratory provides supplies for specimen collection and mailing and shipping; and reporting of test results to enrolled THSteps medical providers that submit specimens to the DSHS Laboratory. These services and supplies are limited to THSteps medical checkup laboratory services provided in the course of a medical checkup to THSteps clients. Unauthorized use of services and supplies is a violation of federal regulations.

DSHS Laboratory services are available at no cost to all enrolled THSteps medical providers for THSteps medical checkups only.

Example: *If a provider needs immediate results for the anemia screening, the specimen may be processed in the office/clinic, but will not be separately reimbursed. The test results must be documented in the client's medical record.*

Exception: *For tests related to screening for type 2 diabetes, dyslipidemia, HIV, and syphilis, the client or specimen may be sent to the laboratory of the provider's choice. Point-of-care testing that is performed in the provider's office to obtain the initial blood lead specimen may be reimbursed separately.*

The date of service for the laboratory testing is to be the date the specimen was obtained as part of the medical checkup, follow-up, or exception-to-periodicity checkup.

The procedure codes for any laboratory testing services other than screening for type 2 diabetes, dyslipidemia, HIV, and syphilis are informational when obtained on the same day a checkup is completed, even if an acute care visit is performed on the same date of service.

If the laboratory testing as identified on the THSteps Medical Checkup Periodicity Schedule is obtained as part of an E/M visit on a different date of service than a checkup, the services may be considered as separate services and may be sent to the laboratory of the provider's choice.

Laboratory specimens obtained for diagnostic evaluation, rather than for screening purposes and performed on the same day as a checkup, may be considered as separate services unless the test is required as part of a checkup. If the test is required as part of the checkup, the laboratory specimens, with the exception of screening tests for dyslipidemia, type 2 diabetes, HIV, and syphilis must be submitted to the DSHS Laboratory for testing. Diagnostic specimens that are not part of the checkup can be sent to the laboratory of the provider's choice.

Laboratory services that are related to a THSteps medical checkup are available from the DSHS Laboratory and may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup.

All of the laboratory tests that are listed on the THSteps Periodicity Schedule may be submitted to the DSHS Laboratory if the specimen submission requirements can be met. Tests that are listed in the "Laboratory Test Procedure Codes" table must be submitted to the DSHS Laboratory. Tests that must be sent to the DSHS laboratory but that are processed elsewhere are not reimbursed; however, the documentation results may be used to meet the requirements for a checkup.

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The following procedure codes may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup either by a provider or laboratory. Claims for the following procedure codes submitted by a provider or a commercial laboratory for the same DOS as a THSteps medical checkup are denied and are subject to retrospective review:

Laboratory Test Procedure Codes									
83655*	85018^	87491^	87494	87591^					
*** Unless performed using point-of-care testing, the initial lead specimen must be sent to the DSHS Laboratory ^QW Modifier**									

For specimens sent to the DSHS Laboratory, the complete medical checkup includes the specimen collection and supplies, mailing and shipping supplies, and the review of the test results from the DSHS Laboratory.

For specimens sent to a laboratory of the provider's choice, the checkup includes the specimen collection or ordering of the test and the review of the test results from the laboratory.

4.3.12.6.1 Laboratory Supplies

The DSHS Laboratory verifies enrollment of THSteps medical providers before sending laboratory supplies and the informational packet to the medical providers. Newly enrolled providers should contact the DSHS Laboratory to request laboratory supplies. Upon request, the DSHS Laboratory provides THSteps medical providers with laboratory supplies associated with specimen collection, submission, and mailing and shipping of required laboratory tests related to medical checkups. Requests for specimen submission forms are routed to the DSHS Laboratory reporting staff and mailed separately to the providers. The Child Health Laboratory Supplies Order Form lists the laboratory supplies that the DSHS Laboratory provides to THSteps medical providers.

To obtain a THSteps Child Health Laboratory Supplies Order Form, providers can call 1-512-776-7661 or download the form online at www.dshs.texas.gov/sites/default/files/lab/PDF/NBS/G-399-2018-THSteps-order-form%20(1).pdf.

4.3.12.6.2 Newborn Screening Supplies

Providers that perform newborn screening (NBS) can order supplies by submitting a Newborn Screening Supplies Order Form to the DSHS Laboratory. The Newborn Screening Supplies Order Form lists the NBS supplies that the DSHS Laboratory provides to medical providers.

> ***Note:*** *For newborn screening, only the specimen collection form (NBS 3), mailing envelope and provider address labels are provided. Lancets, mailing, and shipping costs are the responsibility of the submitter.*

To obtain a Newborn Screening Supplies Order Form, medical providers can call 1-512-776-7661 or download the form online at www.dshs.texas.gov/lab/MRS_forms.shtm.

Contact information for requesting laboratory supplies:

Container Preparation
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
1-512-776-7661
Fax: 1-512-776-7672

4.3.12.6.3 Newborn Screening (NBS) Specimens

- NBS Collection Kit Order Form, G-6D is available at www.dshs.texas.gov/sites/default/files/lab/forms/SUBMITTER-ID-Jan-2025-FINAL.pdf.

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  - Submit the completed and signed order form to DSHS Container Prep Group by email Containerprepgroup@dshs.texas.gov or fax to 512-776-7672. For ordering questions, call 512-776-7661.
- NBS specimen collection, submission, and testing questions, call 512-776-7585 or email newbornscreeninglab@dshs.texas.gov.
- Test result inquiries, call 512-776-7578 or fax 512-776-7533, or email labinfo@dshs.texas.gov.
- Access NBS test results online using the Texas NBS Web Application, Neometrics. To gain access, download, complete, and submit the required access forms, visit www.dshs.texas.gov/laboratory-services/remote-data-systems.

4.3.12.6.4 Additional NBS Educational Resources

- NBS Health Care Provider Resources
  - www.dshs.texas.gov/laboratory-services/programs-laboratories/newborn-screening-laboratory/newborn-screening-healthcare-provider
- THSteps Specimen Collection Online Module
  - www.txhealthsteps.com/course/3020

4.3.12.6.5 Laboratory Submission

All required laboratory testing for THSteps clients must be performed by the Department of State Health Services (DSHS) Laboratory in Austin, TX, with the following exceptions:

- Specimens collected for type 2 diabetes, dyslipidemia, HIV, and syphilis screening may be sent to the laboratory of a provider's choice or to the DSHS Laboratory in Austin if submission requirements can be met.
- Initial blood lead testing using point-of-care testing.

THSteps medical checkup laboratory specimens submitted to the DSHS Laboratory must be accompanied with the DSHS Laboratory Specimen Submission Form (Newborn Screening NBS 3 or G-THSTEPS as appropriate) for test(s) requested. All forms must include the client's name and Medicaid number as they appear on the Your Texas Benefits Medicaid card. If a number is not currently available but is pending (i.e., a newborn or a newly certified client verified by a Medicaid Eligibility Verification [Form H1027] as eligible for Medicaid), providers must write "pending" in the Medicaid number space, which is located in the payor source section of the laboratory specimen submission form.

Laboratory specimens received at the DSHS Laboratory without a Medicaid number or the word "pending" written on the accompanying specimen submission form will be analyzed, and the provider will be billed.

Specimens submitted to the laboratory must also meet specific acceptance criteria. For additional information on specimen submission, providers can refer to the DSHS Laboratory web page at: www.dshs.texas.gov/lab/MRS_specimens.shtm.

> ***Note:*** *If an extreme health problem exists and telephone results are needed quickly, providers should make a request on the laboratory form. With the exception of weekends and holidays, routine specimens are analyzed and reported within three business days after receipt by the DSHS Laboratory. Critical abnormal test results (e.g., hemoglobin equal to or below 7g/dL or blood lead levels greater than or equal to 40 mcg/dL) are identified in the laboratory within 36 hours after receipt of specimens and are reported to the submitter by telephone within one hour of confirmation.*

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The THSteps laboratory specimens that can be mailed at ambient temperature can be sent to the DSHS Laboratory Services Section through the U.S. Postal Service at no cost using the provided business reply labels:

DSHS Laboratory Services Section
Walter Douglass
PO Box 149163
Austin, TX 78714-9803
1-512-776-7318 or 1-888-963-7111 Ext. 7318

THSteps laboratory specimens that require overnight shipping on cold packs through a courier service must be sent to the DSHS Laboratory Services Section at:

DSHS Laboratory Services Section, MC-1947
1100 West 49th Street
Austin, TX 78756-3199

Newborn Screening specimens can be sent through the U.S. Postal Service to:

Texas Department of State Health Services
Laboratory Services Section
PO Box 149341
Austin, TX 78714-9341

Gonorrhea and Chlamydia specimens for regular delivery are sent to:

Department of State Health Services
Laboratory - MC 1947
Walter Douglass, 1-512-776-7569
PO Box 149163
Austin, TX 78714-9803

Gonorrhea and Chlamydia specimens that are shipped cold overnight by courier are sent to:

Department of State Health Services
Laboratory - MC 1947
Walter Douglass, 1-512-776-7569
1100 W. 49th Street
Austin, TX 78756-3199

Collectors are available from the DSHS Austin Laboratory. To order collectors, providers must complete the Order Form for Gonorrhea/Chlamydia (GC/CT) Laboratory Supplies (G-6C) available at www.dshs.texas.gov/sites/default/files/lab/PDF/MRS/G-6C-Form.pdf and fax the completed form to 1-512-776-7672.

Providers can call 1-512-776-6236 for questions about submission requirements such as collection, supplies, and mailing of specimens for THSteps gonorrhea and chlamydia adolescent screening.

4.3.12.6.6 Send Comments

Providers with comments or feedback about THSteps specimen collection supplies should contact the DSHS Laboratory. Supplies are evaluated continually, and feedback from supply users is useful. Documented comments may support, justify, or initiate a change in a provided item. Providers can send a brief letter or fax to the following address:

Quality Assurance Unit
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-512-776-7294

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4.3.12.6.7 Laboratory Reporting

A computer-generated result report is mailed or faxed to the submitting THSteps medical checkup provider. A monthly statistical report card is only available online for providers documenting their total number of Total Hemoglobin and Blood Lead submissions by diagnosis and adequacy. The DSHS Laboratory has web-based services (remote order or result reporting) available for THSteps and Newborn Screening laboratory services. For more information, providers can visit the DSHS website at www.dshs.texas.gov/lab/remoteData.shtm or call 512-776-6030.

4.3.12.6.8 Required Laboratory Tests Related to Medical Checkups

The following laboratory screening procedures are required components of the THSteps medical checkup and are to be performed in accordance with the age and frequency specified on the THSteps medical checkup periodicity schedule. Due to changes in specimen collection, handling, and submission criteria, providers should contact the DSHS Laboratory for the most current specimen requirements by calling 512-776-6236, emailing ClinicalChemistry@dshs.texas.gov, or visiting the DSHS website at www.dshs.texas.gov/laboratory-services/programs-laboratories/clinical-chemistry-testing-services.

Anemia Screening

Anemia screening by hemoglobin or hematocrit levels is required at ages as noted on the THSteps Periodicity Schedule and the specimen must be sent to the DSHS Laboratory. If there is an urgent need for test results, these tests may be completed in a provider's office or clinic, but they will not be reimbursed separately. These test results must be documented in the client's medical record.

Lead Screening and Testing

In accordance with current federal regulations, THSteps requires blood lead screening at ages notated on the THSteps Periodicity Schedule and must be performed during the medical checkup.

Environmental lead risk assessments, as part of anticipatory guidance, should be completed at all checkups through age 6 when testing is not mandated, and may be performed using the Lead Risk Questionnaire, Form Pb-110, which is provided in both English and Spanish at www.dshs.texas.gov/blood-lead-surveillance-group/for-providers#environment. Providers may also opt to use an equivalent form of their choice.

The initial lead testing may be performed using a venous or capillary specimen, and must either be sent to the DSHS Laboratory or performed in the provider's office using point-of-care testing. If the client has an elevated blood lead level of 3.5 mcg/dL or greater, the provider must perform a confirmatory test using a venous specimen. The confirmatory specimen may be sent to the DSHS Laboratory, or the client or specimen may be sent to a laboratory of the provider's choice.

All blood lead levels in clients who are 14 years of age or younger must be reported to DSHS Texas Childhood Lead Poisoning Prevention Program (TXCLPPP). Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Point-of-Care Blood Lead Testing report Form Pb-111, which can be found at www.dshs.texas.gov/lead/providers.shtm or by calling 1-800-588-1248.

Information related to blood lead screening and reporting for clients who are 15 years of age or older is available on the DSHS Blood Lead Surveillance Branch's website at www.dshs.texas.gov/lead/providers.shtm.

Initial blood lead testing using point-of-care testing (procedure code 83655 with modifier QW) may be reimbursed to THSteps medical providers when performed in the provider's office. Providers must have a *Clinical Laboratory Improvement Amendments of 1988* (CLIA) certificate of waiver. For waived tests, providers must use modifier QW as indicated on the CMS website.

Blood lead testing is part of the encounter rates for FQHCs and RHCs and is not reimbursed separately.

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Providers may obtain more information about the medical and environmental management of lead-poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling 1-800-588-1248 or visiting the web page at www.dshs.texas.gov/lead.

Refer to: "Appendix C. Lead Screening" in this handbook for more information on lead screening procedures and follow-up.

Dyslipidemia

Screening for dyslipidemia is required once for clients who are 9 through 11 years of age and once again for clients who are 18 through 20 years of age, regardless of risk. These are in addition to the current risk-based screening for clients who are 24 months through 20 years of age. Clients or specimens may be sent to the laboratory of the provider's choice, including the DSHS Laboratory. THSteps does not provide a formal risk assessment tool. Providers may refer to the AAP policy statement on cholesterol screening for more information.

Diabetes

Screening for type 2 diabetes is based on risk assessment. THSteps does not provide a formal risk assessment tool. Clients and specimens may be sent to the laboratory of the provider's choice, including the DSHS Laboratory.

Newborn Screening

Each newborn delivered in Texas must be subjected to two screens to test for a number of genetic and heritable disorders. Each newborn screen is indicated on the THSteps Periodicity Schedule. A current list of screened disorders is available at www.dshs.texas.gov/newborn/screened_disorders.shtm.

Additional information about newborn screening, is available on the Newborn Screening Program website at www.dshs.texas.gov/newborn/default.shtm.

The initial newborn screen specimen must be obtained between 24 and 48 hours after birth. Newborns discharged from a hospital or birthing facility before this time criteria is met must have a newborn screen blood specimen obtained immediately prior to discharge. When the newborn is an inpatient in the hospital, the hospital shall ensure that the appropriate screens are done. When the newborn is not in the hospital, the physician or health-care practitioner who attends the newborn outside of the hospital shall be responsible for causing the appropriate screens to be done. TAC Title 25, Part 1, Chapter 37, Subchapter D, Rule §37.55.

A second screen is to be obtained between one and two weeks of age by the newborn's physician or health-care practitioner, and is a required component of the THSteps medical checkup. Clients may not be referred to the local health department or other providers for this service. If there is any doubt that a client younger than 12 months of age was properly tested, the provider should submit a screen on DSHS Form NBS 3 to the Texas Department of State Health Services, Laboratory Services Section, Austin, Texas.

Newborn screening tests may be performed in special circumstances, such as adoption, if there is not record of previous test results. Newborn screen results are mailed or faxed to the address that the provider indicated on DSHS Form NBS 3. Providers may sign up to receive results online through the DSHS Laboratory web-based services. For more information visit the DSHS website at www.dshs.texas.gov/lab/newbornscreening.shtm or call 512-776-7578.

Note: *Recommendations for necessary follow-up procedures are included with the newborn screen results. Newborn Screening (NBS) Clinical Care Coordination staff will contact providers when there are significant out of range newborn screening laboratory results.*

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4.3.12.6.9 Additional Required Laboratory Tests Related to Medical Checkups for Adolescents

The following is a list of required and risk-based laboratory tests related to medical checkups for adolescents and guidelines for testing for sexually transmitted diseases (STDs).

Testing for Sexually Transmitted Diseases

Syphilis Testing

Syphilis testing should be performed on adolescents that are at high risk for infection. Clients and specimens may be sent to the laboratory of the provider's choice, including the DSHS Laboratory.

Gonorrhea and Chlamydia Infection Testing

Testing for gonorrhea and Chlamydia should be performed on adolescents that are at high risk for infection. Specimens must be sent to the DSHS Laboratory in Austin.

HIV Testing

Clients should be informed that the HIV test is routinely available, confidential, and completely anonymous. It is critical to maintain confidentiality when caring for clients, as well as their specimens. Testing should be performed only after informed consent is obtained from the adolescent. Informed consent does not have to be written as long as there is documentation in the medical record that the test has been explained and consent has been obtained.

Screening for HIV is required once for clients who are 16 through 18 years of age, regardless of risk. Clients or specimens may be sent to the laboratory of the providers' choice including the DSHS Laboratory.

Screening for HIV is also based on risk assessment for clients who are 11 through 20 years of age based on risk assessment. Clients or specimens may be sent to the laboratory of the providers' choice, including the DSHS Laboratory.

THSteps does not provide a formal HIV risk assessment tool. Providers may refer to the AAP policy statement on HIV screening and CDC guidelines on HIV screening for more information.

HIV testing may be performed for adolescents without requirement of parental consent. Adolescents at risk for HIV infection should be offered confidential HIV screening. If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in the medical record that notification of the HIV test and the right to refuse was given. Providers may call the HIV/STD InfoLine for referrals to HIV/AIDS testing sites; prevention, case management, and treatment providers; STD clinics; and other related service organizations. The HIV/STD InfoLine is 1-800-299-2437. This toll-free HIV/AIDS and STD information and referral service is available for English- and Spanish-speaking callers and for those who are hearing-impaired.

Communicable Disease Reporting

Diagnoses of STDs, including HIV, are reportable conditions under 25 TAC, Chapter 97. Providers must report confirmed diagnoses of STDs as required by 25 TAC §97.132.

4.3.12.6.10 Zika Virus Testing

Refer to: Subsection 2.2.11.1, "Zika Virus Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for information about Zika virus testing.

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4.3.13 Non-mandated Components

4.3.13.1 Oral Evaluation and Fluoride Varnish (OEFV) in the Medical Home

An OEFV (procedure code 99429) is aimed at improving oral health outcomes for clients who are 6 through 35 months of age by initiating a limited set of preventive dental services (not a dental checkup) in the medical home.

The OEFV must be billed on the same date of service as a medical checkup (procedure codes 99381, 99382, 99391, and 99392) and is limited to six services per lifetime by any provider. Procedure code 99429 must be billed with modifier U5 and diagnosis code Z00121 or Z00129 for an intermediate oral evaluation with fluoride varnish application.

An OEFV is not a required component of a THSteps medical checkup, but providers are encouraged to participate in this preventive intervention. OEFV is limited to THSteps medical checkup providers who have completed the required benefit education and are certified by Texas Health Steps to perform OEFV services.

Training for certification is available as a free continuing education course on the THSteps website at www.txhealthsteps.com.

The OEFV add-on includes the following components:

- Intermediate oral evaluation
- Inspection of teeth for signs of early childhood caries, and other caries
- Inspection of the oral soft tissues for any abnormalities
- Inspection for bleeding, swelling, or infection
- Indications of lack of cleaning of the mouth

The intermediate oral evaluation components that may be performed by a trained staff member are:

- Fluoride varnish application
- Dental anticipatory guidance to include:
  - The need for thorough daily oral hygiene practices
  - Education in potential gingival manifestations for clients with diabetes and clients under long-term medication therapy
  - THSteps eligibility qualifies the client for dental services
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Antimicrobials, medications, and oral health

If the client has no erupted teeth, additional dental anticipatory guidance is expected.

> ***Note:*** *A THSteps-certified OEFV provider must complete the intermediate oral evaluation but can delegate all other components.*

4.4 Documentation Requirements

All THSteps services require documentation to support the medical necessity of the services rendered including THSteps medical services. THSteps services are subject to retrospective review and recoupment if documentation does not support the services billed.

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The following federal and state mandated components must be documented in the client's medical record for the checkup to be considered complete:

- Comprehensive health and developmental history, including physical and mental health development
- Comprehensive unclothed physical examination
- Immunizations appropriate for age and health history
- Laboratory test appropriate to age and risk, including lead toxicity at specific federally mandated ages
- Health education including anticipatory guidance
- Dental referral

The client's medical record must include documentation to support the rationale a component was not completed, and a plan to complete the component(s) if not due to parent or caregiver concern or reasons of conscience, including religious beliefs.

4.4.1 Separate Identifiable Acute Care Evaluation and Management Visit

If an acute or chronic condition that requires E/M beyond the required components for a medical checkup is discovered, a separate E/M procedure code may be considered for reimbursement for the same date of service as a checkup or the client can be referred for further diagnosis and treatment.

- The client's medical record must contain documentation that the separate identifiable service(s) were medically necessary and include a diagnosis in addition to Z0000, Z0001, Z00110, Z00111, Z00121 or Z00129 and treatment. Documentation must be made available to Texas Medicaid upon request.
- An insignificant or trivial problem or abnormality that is encountered in the process of performing a checkup and does not require additional work and performance of the key components of a problem-oriented E/M service cannot be considered a separate established patient E/M acute care visit.
- Modifier 25 must be used to identify a significant, separately identifiable E/M service rendered by the same provider on the same day of the procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Refer to: Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup on the TMHP website at www.tmhp.com for a claim form example.

THSteps Preventive Visit Checkup with Immunization and Vaccine Administration on the TMHP website at www.tmhp.com for a claim form example.

4.5 Vaccine Services

Vaccines and vaccine administration as recommended by the Advisory Committee on Immunization Practices (ACIP) are benefits of Texas Medicaid.

Immunization is the process by which a client becomes immune or resistant to an infectious disease, typically by vaccination.

Vaccination is the action of introducing a vaccine into the body.

A vaccine stimulates a client's immune system to produce immunity to a disease, thereby providing protection from that disease.

Vaccines may be administered orally, nasally, or via subcutaneous or intramuscular injection.

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The following are categories of vaccines:

- Live, attenuated
- Inactivated
- Toxoid
- Subunit
- Conjugate
- Messenger RNA (mRNA)

Providers must follow current ACIP general usage recommendations and adhere to the National Vaccine Advisory Committee's (NVAC) Standards for Adult Immunization Practice and Standards for Pediatric Immunization Practice; however, in the event of conflict, providers are required to follow more specific Texas Vaccines for Children (TVFC) guidelines.

Providers must provide the current vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC) to clients. VISs explain the benefits and risks of the vaccine(s) administered.

4.5.1 Texas Vaccines for Children (TVFC) Program

The TVFC program provides vaccines at no cost to the provider. The vaccines are recommended according to the Recommended Childhood and Adolescent Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], AAP, and the American Academy of Family Physicians [AAFP]). Medicaid does not reimburse for vaccines/toxoids that are available from TVFC. THSteps providers are strongly encouraged to enroll in TVFC at DSHS and must do so in order to obtain free vaccines for clients who are birth through 18 years of age. Local and public health departments that are not otherwise enrolled as a provider that is authorized to receive reimbursement for vaccine administration fees should enroll as a Comprehensive Care Program (CCP) provider. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed $13.75, is considered for reimbursement.

For additional information about immunizations, providers can refer to the THSteps online educational module "Immunization" at www.txhealthsteps.com.

Refer to: "Appendix B. Immunizations" in this handbook.

4.5.1.1 TVFC Distributed Vaccines

When single antigen vaccine(s)/toxoid(s) or comparable antigen vaccine(s)/toxoid(s) are available for distribution through TVFC, but the provider chooses to use an ACIP-recommended product that is not distributed through TVFC, the vaccine/toxoid will not be covered; however, the administration fee will be considered.

4.5.2 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) requires health-care providers to report to VAERS:

- Any adverse event reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the VAERS Table of Reportable Events that occurs within the specified time period after vaccination.

VAERS encourages providers to report vaccine administration errors and any adverse event that occurs after the administration of any vaccine licensed in the United States even if it is clear whether a vaccine caused the adverse event.

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NCVIA requires health-care providers to report certain adverse events that occur following vaccination. As a result, VAERS was established by CDC and FDA in 1990. VAERS provides a mechanism for the collection and analysis of adverse events (side effects) associated with vaccines currently licensed in the United States. Adverse events are defined as health effects that occur after immunization that may or may not be related to the vaccine. VAERS data are monitored continually to detect unknown adverse events or increases in known side effects.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from vaers.hhs.gov/reportevent.html.

For additional information about NCVIA, providers can refer to www.dshs.texas.gov/immunizations/data/vaccine-adverse-event-reporting.

4.5.2.1 Vaccine Reporting to Department of State Health Services (DSHS)

Administered vaccines must be reported to DSHS. DSHS submits all vaccines reported with consent to a centralized repository of immunization histories. This lifespan registry is known in Texas as ImmTrac2.

4.5.2.2 Rabies Vaccine Availability and Animal Bite Reporting

Providers that determine a client requires the rabies vaccination series may obtain the biologicals directly from the manufacturer or through one of the Texas Department of State Health Services (DSHS) depots around the state.

Animal bites to people must be reported as soon as possible to the designated Local Rabies Control Authority (LRCA).

Refer to: Subsection 9.2.38, "Rabies Prophylaxis" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information about rabies vaccination.

4.5.3 Documentation Requirements

Providers must document the following information for every vaccine administered to a client in the client's medical record:

- Vaccine given
- Date the vaccine was administered (day, month, year format)
- Name of the vaccine manufacturer
- Vaccine lot number
- Signature and title of the person administering the vaccine
- Organization name and address
- Publication date of the VIS issues to the client, parent, or guardian

If a vaccine is given outside of ACIP's recommended routine immunization schedules for children or adults, the reason for the vaccination must be included in the client's medical record. Reasons for vaccinating outside the routine schedule may include but are not limited to:

- Pregnancy
- An impaired immune system
- Suspected exposure to a disease
- Occupation
- Travel

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These records are subject to retrospective review to determine appropriate utilization and reimbursement for this service.

4.5.4 Vaccine Reimbursement

Vaccines and vaccine administration are reimbursed at a fee determined by HHSC.

Each vaccine and its administration must be submitted on the same claim in the following sequence: the vaccine procedure code immediately followed by the applicable vaccine administration procedure code(s).

All of the vaccine administration procedure codes that correspond to a single vaccine procedure code must be submitted on the same claim as the vaccine procedure code.

Vaccines for clients who are birth through 18 years of age are available through TVFC and administered at a site that is eligible for TVFC enrollment will not be reimbursed through Texas Medicaid.

Providers may not bill clients who are birth through 18 years of age for vaccines available through TVFC.

Preventive Health Visits

If a vaccine is administered as part of a preventive health visit, including but not limited to a THSteps preventive care medical checkup, then the age-appropriate diagnosis code for the preventive health visit must be submitted on the claim. Diagnosis code Z23 may also be included on the claim as secondary.

For a vaccine administration at a visit for which the administration is the only purpose of a visit (i.e. the vaccine administration is not part of a preventive health visit), provider should submit the appropriate vaccine diagnosis code Z23.

Vaccine administration must be billed with the following age-appropriate diagnosis codes:

Client Age	Diagnosis Code
Birth through 7 days	Z00110
Eight through 28 days	Z00111
29 days through 17 years	Z00121, Z00129
18 years or older	Z0000, Z0001

Vaccines should be obtained through TVFC for clients who are birth through 18 years of age. Provider purchased vaccines are not reimbursed separately unless they meet the definition of "not available" as defined in this section. A vaccine may be defined as "not available" in one or more of the following situations:

- TVFC, based on their federal resolution (distribution guidelines), does not distribute a Texas Health and Human Services Commission (HHSC)-approved vaccine that has an ACIP-recommended use.
- ACIP approves a new vaccine with established guidelines, but the vaccine has not yet been negotiated or added to a TVFC contract.
- TVFC has not established funding for a new vaccine.
- TVFC reports to HHSC that there is an insufficient supply of a vaccine due to national supply or distribution issues.

Vaccines that meet the definition of "not available" as defined in this section may be reimbursed through the Comprehensive Care Program (CCP).

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Providers may use the state-defined modifier U1 in addition to the associated administered vaccine procedure code for clients who are birth through 18 years of age and the vaccine was unavailable through TVFC.

Modifier	Description
U1	State-defined modifier: Vaccine(s)/toxoid(s) privately purchased by provider when TVFC vaccine/toxoid is unavailable

The state will notify providers if a vaccine meets the definition of "not available" and when the provider's privately purchased vaccine can be billed with the modifier U1.

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine inventory, or clients who are 19 through 20 years of age.

Vaccines for clients who are 19 years through 20 years of age may be reimbursed through THSteps when provided as part of a THSteps preventive care medical checkup, or CCP when provided as part of an acute medical visit outside of a THSteps preventive care medical checkup. Providers must bill acute care services under their existing NPI.

Vaccines for clients who are 21 years of age or older may be reimbursed through traditional Texas Medicaid when the vaccine is medically necessary.

Reimbursement for each vaccine is limited to one per client per day, by any provider.

The following vaccine procedure codes are a benefit of Texas Medicaid and distributed by TVFC (does not include COVID-19, influenza, and RSV vaccines):

Procedure Codes	Age Range	Number of Recognized Components
90619	2 years of age or older	1
90620	10 years of age or older	1
90621	10 years of age or older	1
90623	10 years through 23 years of age	1
90624	10 through 23 years of age	1
90632	18 years of age or older	1
90633	Birth through 18 years of age	2
90647	6 weeks through 18 years of age	1
90648	6 weeks of age or older	1
90651	9 years through 45 years of age	1
90670	2 months of age or older	1
90671	6 weeks of age or older	1
90677	2 months of age or older	1
90680	Birth through 8 months of age	1
90681	Birth through 8 months of age	1
90696	4 years through 6 years of age	4
90697	Birth through 4 years of age	6
90698	Birth through 5 years of age	5
90700	Birth through 6 years of age	3
90702	Birth through 6 years of age	2
90707	1 year of age or older	3

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Procedure Codes	Age Range	Number of Recognized Components
90710	1 year through 12 years of age	4
90713	2 months of age or older	1
90714	7 years of age or older	2
90715	7 years of age or older	3
90716	1 year of age or older	1
90723	6 weeks through 6 years of age	5
90732	2 years of age or older	1
90734	2 months through 55 years of age	1
90743	11 years through 17 years of age	1
90744	Birth through 17 years of age	1
90746	18 years of age or older	1

Note: *A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

COVID-19 Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for COVID-19:

Procedure Codes	Age Range
91320	12 years of age or older
91322	12 years of age or older
91323	12 years of age or older

Because the ACIP frequently reviews the composition of COVID-19 vaccines and makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of COVID-19 vaccines that TVFC is distributing for clients who are birth through 18 years of age.

Procedure code 90480 must be used in conjunction with one of the vaccine procedure codes listed above for reimbursement of COVID-19 vaccine administration.

COVID-19 vaccine counseling (procedure code G0315) may be reimbursed for clients who are birth through 20 years of age.

Procedure code G0315 will be denied if billed on the same day by the same provider as procedure code 90480.

Procedure code G0315 is limited to once per day, by the same provider, and three per rolling year by any provider.

Influenza Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for influenza:

Procedure Codes	Age Range
90655	6 months through 35 months of age
90656	6 months of age or older
90657	6 months through 35 months of age
90658	6 months of age or older

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Procedure Codes	Age Range
90660	2 years through 49 years of age
90661	6 months of age or older
90672	2 years through 49 years of age
90673	18 years of age or older
90674	6 months of age or older
90682	18 years of age or older
90685	6 months through 35 months of age
90686	6 months of age or older
90687	6 months through 35 months of age
90688	6 months of age or older
90756	6 months of age or older

Because the ACIP reviews the composition of influenza vaccines annually and frequently makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the influenza vaccines that TVFC is distributing for clients who are birth through 18 years of age for the current flu season.

Peak influenza activity generally occurs from October of one year through February of the next year, although activity can last through May. This time period is commonly referred to as "flu season."

The first time a client who is 6 months of age through 8 years of age receives the influenza vaccine, he/she should receive a second dose of the vaccine during the same flu season at least 4 weeks after the first dose. If the client turns 9 years old between the first and second doses, he/she should still receive the second dose.

Excepting the scenario described in the previous line, clients who are 9 years of age or older should only receive one dose of the influenza vaccine per flu season, even if it is their first time receiving the influenza vaccine.

The following vaccine procedure codes are a benefit of Texas Medicaid and are not distributed by TVFC:

Procedure Codes	Age Range	Number of Recognized Components
90476	19 years through 50 years of age	1
90477	19 years through 50 years of age	1
90581	19 years through 65 years of age	1
90585	All ages	1
90586	All ages	1
90589	19 years of age or older	1
90593	12 years of age or older	1
90611	18 years of age or older	1
90625	19 years through 64 years of age	1
90626	19 years of age or older	1
90627	19 years of age or older	1
90636	19 years of age or older	2
90675	All ages	1

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Procedure Codes	Age Range	Number of Recognized Components
90684	19 years of age or older	1
90690	19 years of age or older	1
90691	19 years of age or older	1
90717	19 years of age or older	1
90738	19 years of age or older	1
90739	18 years of age or older	1
90740	20 years of age or older	1
90747	20 years of age or older	1
90758	18 years of age or older	2
90759	18 years of age or older	1
J9030	All ages	1

Vaccine Administration

Vaccine administration for clients who are birth through 20 years of age may be reimbursed through THSteps when provided as part of a THSteps preventive care medical checkup or CCP when provided as part of an acute medical visit outside of a THSteps preventive care medical checkup. Providers must bill acute care services under their existing NPI.

Vaccine administration for clients who are 21 years of age or older may be reimbursed through traditional Texas Medicaid when the vaccine is medically necessary.

The specific diagnosis necessitating the vaccine and toxoid is required when billing with the following administration procedure codes in combination with an appropriate vaccine procedure code:

Procedure Codes									
90460	90461	90471	90472	90473	90474	90480	M0201		

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471, 90472, 90473 and 90474 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

Each vaccine and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable vaccine administration procedure code(s). All of the vaccine administration procedure codes that correspond to a single vaccine procedure code must be submitted on the same claim as the vaccine procedure code.

Each vaccine procedure code must be submitted with the appropriate "administration with counseling" procedure code(s) (procedure codes 90460 and 90461) or the most appropriate "administration without counseling" procedure code (procedure code 90471, 90472, 90473, or 90474). If an "administration with counseling" procedure code is submitted with an "administration without counseling" procedure code for the same vaccine, the second administration of the vaccine will be denied.

Procedure code 90480 is a benefit for clients who are 6 months of age or older. Procedure code 90480 includes counseling and may only be reported with a COVID-19 vaccine procedure code.

Procedure code M0201 is a benefit for clients of any age. Procedure code M0201 may be reported, in addition to the vaccine and vaccine administration procedure codes when a pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine is administered inside a client's home.

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Administration With Counseling

Providers must submit claims for immunization administration procedure codes 90460 or 90461 based on the number of components per vaccine. Providers must specify the number of components per vaccine by billing procedure codes 90460 and 90461 as defined by the procedure code descriptions:

- Procedure code 90460 is submitted for the administration of the 1st component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client's medical record.

Procedure code 90461is used to report the administration of additional components of a vaccine and is not reimbursable for providers when administering TVFC-eligible vaccines under the TVFC program.

Administration Without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route of administration.

4.5.5 Respiratory Syncytial Virus (RSV)

Because the ACIP reviews the composition of certain seasonal vaccines annually and frequently makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the RSV vaccines and RSV monoclonal antibodies that TVFC is distributing for clients who are birth through 18 years of age for the current RSV season.

Vaccine administration (procedure code 90460 or 90471) must be used in conjunction with RSV vaccine (procedure code 90678) for reimbursement of RSV vaccine administration.

RSV vaccine (procedure code 90678) may be administered to clients who are 10 years of age or older.

RSV monoclonal antibody nirsevimab (procedure codes 90380 and 90381) may be administered to clients who are birth through 19 months of age and are limited to two per lifetime.

RSV monoclonal antibody clesrovimab (procedure code 90382) may be administered to clients who are birth through 7 months of age and are limited to one per lifetime.

RSV monoclonal antibody administration (procedure code 96380 or 96381) must be used in conjunction with one of the monoclonal antibody procedure codes (90380, 90381, or 90382) for reimbursement of RSV monoclonal antibody administration.

4.5.6 Exclusions

Vaccines that are not approved by the U.S. Food and Drug Administration, and are not recommended by the ACIP are not benefits of Texas Medicaid.

4.5.7 Vaccine Administration and Preventive E/M Visits

For claims that are submitted with an immunization administration procedure code and a preventive E/M visit, providers may append modifier 25 to the preventive E/M visit procedure code to identify a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

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Refer to: Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup on the TMHP website at www.tmhp.com for a claim form example.

THSteps Preventive Visit Checkup with Immunization and Vaccine Administration on the TMHP website at www.tmhp.com for a claim form example.

4.5.8 Vaccine Information Statement (VIS)

A VIS is required by federal mandate to inform parents and vaccine recipients of the risks and benefits of the vaccine they are about to receive. Not only is it important to explain the risks and benefits before a vaccine is administered, it is also important that providers use the most current forms available. For more about immunizations, vaccine-preventable diseases, or literature and forms, providers can call the DSHS Immunization Branch at 1-800-252-9152 or review information at www.dshs.texas.gov/immunize.

Refer to: "Appendix B. Immunizations" in this handbook.

The DSHS website for TVFC provider enrollment information at www.dshs.texas.gov/immunization-unit/texas-vaccines-children-program-immunizations-unit.

The THSteps online education module "Immunizations," located on the THSteps website at https://www.txhealthsteps.com/, for more information about immunizations.

4.6 Claims Filing and Reimbursement

Providers may refer to Volume 1 for general information about claims filing and reimbursement.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions.

"Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information.

4.6.1 Claims Information

THSteps Medical providers are not required to bill other insurance before billing Medicaid. If a provider is aware of other insurance, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client's other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the client's other insurance, the provider is indicating that he or she accepts the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.

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- If the provider learns that a client has other insurance coverage after Medicaid has paid a claim, and the provider chooses to bill the other insurance, the provider must refund the payment to Medicaid before billing the other insurance.

Providers should bill their usual and customary fee except for vaccines obtained from TVFC. Providers may not charge Medicaid or clients for the vaccine received from TVFC. Providers may charge a usual and customary fee not to exceed $13.75 for vaccine administration when providing immunizations to a client eligible for TVFC. Providers are reimbursed the lesser of the billed amount or the maximum allowable fee.

THSteps medical checkups may be billed electronically or on a 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. Providers may request information about electronic billing or the paper claim form by contacting the TMHP THSteps Contact Center at 1-800-757-5691.

All procedures, including the informational-only procedures, must have a billed amount associated with each procedure listed on the claim. Informational-only procedure codes must be billed in the amount of at least $.01.

Providers must record the following on the CMS-1500 claim form to receive reimbursement for a medical checkup, exception to periodicity checkup, or follow-up visit:

- The NPI and benefit code EP1 (exception: FQHC providers do not use benefit code EP1)
- The appropriate Texas Health Steps medical checkup procedure code (all ages) with diagnosis code Z0000, Z0001, Z00110, Z00111, Z00121, or Z00129. Diagnosis code Z23 may also be included.
  - The condition indicator codes, which must be placed in 24C (ST, S2, or NU only to identify a checkup resulting in a referral)
  - The provider type modifiers
  - The exception-to-periodicity modifier, when applicable

Refer to: Subsection 4.3.6, "THSteps Medical Checkups" in this handbook for a listing of modifiers.

- The immunization administration and vaccine procedure codes if any were administered (all ages)
- The place of service must be 72 for RHCs
- The EP modifier must be used for FQHCs

Immunizations performed outside of a THSteps medical checkup must be billed without the benefit code EP1.

4.6.2 Reimbursement

As with all Medicaid services, providers acknowledge compliance with all Texas Medicaid requirements when they submit a claim for reimbursement. THSteps-enrolled providers are reimbursed for THSteps medical checkups and administration of immunizations in accordance with 1 TAC §355.8441.

Note: *NP, CNS, and PA providers who are enrolled in Texas Medicaid as THSteps providers may receive 92 percent of the rate paid to a physician for THSteps services.*

FQHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8261.

RHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8101.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

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5 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

6 Contact TMHP

For a complete list of TMHP communications, refer to subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

6.1 Automated Inquiry System (AIS)

AIS (1-800-925-9126, Option 1) is available 7 days a week, 23 hours a day, with scheduled downtime between 3 a.m. and 4 a.m., and is the main point of contact for client eligibility information. AIS requires the use of a touch-tone telephone in order to access the system.

6.2 TMHP Website

Additional information about Medicaid enrollment, general customer service, and provider education/training is available on the TMHP website at www.tmhp.com.

6.3 Dental Information and Assistance

For assistance with claims, dental providers may contact a TMHP Contact Center representative on the Dental Inquiry Line (1-800-568-2460).

6.3.1 Dental Inquiry Line

The Dental Inquiry Line (1-800-568-2460) is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about dental services and appeals.

Any dental service claim denial may be appealed by telephone if it was not denied as an incomplete claim and does not require one of the following items or conditions:

- Narratives
- Radiographs

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- Models
- Other tangible documentation
- Review by the TMHP Dental Director

6.4 THSteps Information and Assistance

Providers with questions, concerns, or problems about claims should contact the TMHP Contact Center (1-800-925-9126). For contact information for their regional TMHP Provider Representative, providers can refer to the TMHP website at www.tmhp.com.

6.4.1 THSteps Inquiry Line

The THSteps Medical Inquiry Line at 1-800-757-5691 is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about THSteps medical services.

6.5 Assistance with Program

Providers with questions, concerns, or problems with program rules, policies, or procedures should contact DSHS regional program staff. THSteps staff contact numbers can be found in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*), on the THSteps website at www.hhs.texas.gov/providers/health-services-providers/texas-health-steps-providers or by calling THSteps at 1-512-776-7745.

THSteps regional staff make routine contact with providers to educate and assist them with THSteps policies and procedures.

Clients who are eligible for Medicaid and have questions about THSteps, need to locate medical or dental providers, or need assistance with arranging transportation to appointments should call the THSteps toll-free helpline (1-877-847-8377). Clients with questions about their Medicaid eligibility for THSteps should be directed to their caseworker at the local HHSC office or site.

7 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
CCP Prior Authorization Request Form Instructions
CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services
CCP Prior Authorization Request Form
CCP Prior Authorization Private Duty Nursing 6-Month Authorization
Criteria for Dental Therapy Under General Anesthesia
DME Certification and Receipt Form
Home Health Plan of Care (POC)
Home Health Plan of Care (POC) Instructions
Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Center
THSteps Dental Mandatory Prior Authorization Request Form
THSteps Referral Form Instructions
THSteps Referral Form

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Forms
Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP)

8 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup
Diagnosis and Treatment (Referral from THSteps Checkup)
Durable Medical Equipment (CCP Only)
Inpatient Rehabilitation Facility (Freestanding) (CCP Only)
Medical Checkup Follow-up Visit with Immunization Administration
Medical Checkup Follow-up Visit with TB Skin Test (TST)
Medical Nutrition Counseling (CCP Only)
Orthotic and Prosthetic Services (CCP Only)
Postpartum Depression Screening During an Infant THSteps Checkup
Private Duty Nurses (CCP Only)
THSteps New Patient, Immunization Without Counseling no Referral and by an NP
THSteps Established Patient Exception to Periodicity and Referral, Immunizations with Counseling, and by a Physician
THSteps Established Patient and Referral, Tuberculin Skin Test (TST), and Physical Examination by a Physician
THSteps Preventive Visit Checkup with Immunization and Vaccine Administration

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APPENDIX A. THSTEPS FORMS

A.1 Claim Forms

Providers must order CMS-1500 and American Dental Association (ADA) Dental Claims Forms from the vendor of their choice. Copies cannot be used. Claims filing instructions and examples of the claim forms are located in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Refer to: Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5.2, "CMS-1500 Claim Form (Paper) Billing" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.7, "American Dental Association (ADA) Dental Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

A.2 THSteps Medical Checkup Forms

The use of the child health clinical records is optional. These forms were developed to help providers document all components of the medical checkup. Unless required to be submitted to another program, one of the following forms of documentation must be included in the client's medical record: The completed screening tools with results, the completed questions to the tools within a provider-created medical record, and the results of the completed screening tools. Providers may be asked to provide the screening tool used to complete the screening. Texas Health Steps (THSteps) requires the following forms: Tuberculosis (TB) Questionnaire and the Texas Department of State Health Services (DSHS) State Laboratory forms. These forms can be downloaded from the THSteps website at https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers/ths-forms. The Parent Hearing Checklist and Lead Risk Questionnaire are optional forms. Lead poisoning screening questionnaires can be downloaded from the Texas Childhood Lead Poisoning Prevention Program (TX CLPPP) website at www.dshs.texas.gov/lead/providers.shtm.

Links to growth charts may be found on the THSteps website at https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers/ths-forms.

Form Number	Form Name
ECH-1	Child Health History Form
ECHR-5 Day	Discharge to 5 day Visit Child Health Record
ECHR-2 Week	2 Week Visit Child Health Record
ECHR-2 Month	2 Month Visit Child Health Record
ECHR-4 Month	4 Month Visit Child Health Record
ECHR-6 Month	6 Month Visit Child Health Record
ECHR-9 Month	9 Month Visit Child Health Record
ECHR-12 Month	12 Month Visit Child Health Record
ECHR-15 Month	15 Month Visit Child Health Record
ECHR-18 Month	18 Month Visit Child Health Record
ECHR-24 Month	24 Month Visit Child Health Record
ECHR-30 Month	30 Month Visit Child Health Record
ECHR-3 Year	3 Year Visit Child Health Record
ECHR-4 Year	4 Year Visit Child Health Record
ECHR-5 Year	5 Year Visit Child Health Record

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Form Number	Form Name
ECHR-6 Year	6 Year Visit Child Health Record
ECHR-7 Year	7 Year Visit Child Health Record
ECHR-8 Year	8 Year Visit Child Health Record
ECHR-9 Year	9 Year Visit Child Health Record
ECHR-10 Year	10 Year Visit Child Health Record
ECHR-11 Year	11 Year Visit Child Health Record
ECHR-12 Year	12 Year Visit Child Health Record
ECHR-13 Year	13 Year Visit Child Health Record
ECHR-14 Year	14 Year Visit Child Health Record
ECHR-15 Year	15 Year Visit Child Health Record
ECHR-16 Year	16 Year Visit Child Health Record
ECHR-17 Year	17 Year Visit Child Health Record
ECHR-18 Year	18 Year Visit Child Health Record
ECHR-19 Year	19 Year Visit Child Health Record
ECHR-20 Year	20 Year Visit Child Health Record
ECHR-19-20 Year	19 & 20 Year Visit Child Health Record
	Form Pb-110, Lead Risk Questionnaire
	TB Questionnaire

Providers should refer to sources such as *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (4th edition), located at www.brightfutures.org or the Guidelines for Adolescent Preventive Services (GAP) Implementation Materials located at brightfutures.aap.org/materials-and-tools/pages/default.aspx. For nutritional screening for all ages, refer to Bright Futures.

A.3 Laboratory Forms

For information on procedures for submission of laboratory forms, refer to the DSHS Laboratory Services Section's web page at www.dshs.texas.gov/lab/MRS_forms.shtm.

A.4 Guidelines for Tuberculosis Skin Testing

For information on procedures for tuberculosis skin testing, refer to the DSHS tuberculosis web page at www.dshs.texas.gov/idcu/disease/tb/.

A.5 Tuberculosis Screening and Guidelines

The screening tool for tuberculosis (TB) exposure risk is to be used annually to determine the need for tuberculin skin testing.

The questions in the screening tool are intended as a minimum screen. Follow-up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the client's community may need to be added.

The following applies for tuberculin screening and skin testing:

- If all the answers are unqualified negatives, the client is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is "Yes" or "I don't know," the client should be tuberculin skin tested.

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- In the case of the client for whom an answer in the past of "Yes" or "I don't know" prompted a skin test, which was negative, the skin test *may* not have to be repeated annually.
- The decision to administer a skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.
- Bacillus of Calmette and Guérin (BCG) vaccinated clients should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.
- Clients who have had a positive TB skin test in the past (whether treated or not), should be re-evaluated at least annually by a physician for signs and symptoms of TB.

Care of clients who are newly discovered to be tuberculin skin test positive includes:

- An evaluation for signs and symptoms of TB.
- A chest X-ray to rule out active disease.
- Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present.
- Referral for consultation by a pediatric TB specialist is recommended if active disease is present.
- A report to the local health authority for investigation to find the source of the infection.

Refer to: The TB screening tool on the THSteps website at www.txhealthsteps.com/tools-resources.

"Frequently Asked Questions About TB" on the DSHS website at www.dshs.texas.gov/idcu/disease/tb/faqs for information about assessing a child's risk of TB exposure, providers can refer to

The TVFC Provider Manual, Forms, & Resources web page on the DSHS website at www.dshs.texas.gov/immunize/tvfc/ProviderResources.shtm#forms for the Patient Eligibility Screening Record (Bilingual), Questions & Answers about TVFC, and additional information.

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APPENDIX B. IMMUNIZATIONS

B.1 Immunizations Overview

Clients who are 17 years of age and younger must be immunized according to the Recommended Childhood Immunization Schedule for the United States. If the immunizations are due as part of a Texas Health Steps (THSteps) medical checkup, the medical checkup provider is responsible for the administration of immunizations for clients who are birth through 20 years of age and may not refer clients to local health departments. The Department of State Health Services (DSHS) requires that immunizations be administered during the THSteps medical checkup, unless they are medically contraindicated or excluded from immunization for reasons of conscience, including a religious belief.

Providers, in both public and private sectors, are required by federal mandate to provide a Vaccine Information Statement (VIS) to the responsible adult accompanying a client for an immunization. These statements are specific to each vaccine and inform the responsible adult about the risks and benefits. It is important that providers use the most current VIS.

Providers interested in obtaining copies of current VISs and other immunization forms or literature may call the DSHS Immunization Branch at 1-512-458-7284. VISs may also be downloaded from the DSHS Immunization Branch website at www.dshs.texas.gov/immunizations/public/vis.

B.1.1 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) requires health-care providers to report to VAERS:

- Any adverse event listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the VAERS Table of Reportable Events that occurs within the specified time period after vaccination.

VAERS encourages providers to report vaccine administration errors and any adverse event that occurs after the administration of any vaccine licensed in the United States even if it is clear whether a vaccine caused the adverse event.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from vaers.hhs.gov/resources/infoproviders.html.

B.1.2 TVFC Versus Non-TVFC Vaccines/Toxoids

When single antigen vaccines/toxoids or comparable antigen vaccines/toxoids are available for distribution through the Texas Vaccines for Children (TVFC) Program, but the provider chooses to use a different Advisory Committee on Immunization Practices (ACIP)-recommended product, the vaccine/toxoid will not be reimbursed; however, the administration fee will be considered.

Note: *All administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with consent to a centralized immunization registry, known as ImmTrac2.*

Refer to: Subsection B.3.6, "How to Report Immunization Records to ImmTrac2, the Texas Immunization Registry" in this handbook.

B.1.3 Exemption from Immunization for School and Child-Care Facilities

Parents may obtain an exemption from immunization requirements for school and childcare entry for reasons of conscience or religious beliefs. An exemption is also available for clients who are medically contraindicated from receiving a vaccine. For more information on exemptions call 1-512-458-7284, or visit www.dshs.texas.gov/immunizations.

Refer to: Section 4, "THSteps Medical" in this handbook.

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B.2 Recommended Childhood Immunization Schedule

The Recommended Childhood Immunization Schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. This schedule was developed and approved by ACIP, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Some combination vaccines are available and may be used whenever any component of the combination is indicated and its other components are not contraindicated. Providers should consult the manufacturer's package insert for detailed recommendations.

Vaccines should be administered at the recommended ages. Any dose not given at the recommended age should be given as a catch-up immunization on any subsequent visit when indicated and feasible.

A current copy of the Recommended Childhood Immunization Schedule can be accessed at www.cdc.gov/vaccines/hcp/imz-schedules/child-schedule-vaccines.html.

Refer to: Recommended Childhood and Adolescent Immunization Schedule on the THSteps page of the TMHP website at www.tmhp.com.

B.3 General Recommendations

For information about vaccine administration, dosing, and contraindications, immunization providers should consult vaccine package inserts and the January 28, 2011, issue of the Center for Disease Control and Prevention *Morbidity and Mortality Weekly Report* (MMWR). For copies of the MMWR, contact the Immunization Branch at 1-512-458-7284.

B.3.1 How to Obtain Vaccines at No Cost to the Provider

TVFC provides routinely recommended ACIP vaccines for immunization of THSteps and other Medicaid- and TVFC-eligible clients free of charge to providers who are enrolled in TVFC. The local health department/district or DSHS regional office provides information on how to order, account for, and inventory vaccines. Local and public health departments that are not otherwise enrolled as a provider that is authorized to receive reimbursement for vaccine administration fees should enroll as a Comprehensive Care Program (CCP) provider. Monthly reports are required in order to receive state-purchased vaccines. Physicians who request and accept state-supplied vaccines must complete and sign the provider enrollment and profile forms annually. The provider may not charge Medicaid or the client for vaccines obtained from TVFC.

Additional information is available at www.dshs.texas.gov/immunizations.

B.3.2 Administrations and Immunizations

B.3.2.1 Administrations

The following administration procedure codes must be submitted in combination with an appropriate vaccine/toxoid procedure code:

Administration Procedure Code							
90460	90461	90471	90472	90473	90474	90480	M0201

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered. Documentation of counseling by the physician or other qualified health-care professional must be noted in the client's medical record.

Procedure codes 90471, 90472, 90473, and 90474 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

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Procedure code 90480 is a benefit for clients who are 6 months of age or older. Procedure code 90480 includes counseling and may only be reported with a COVID-19 vaccine procedure code.

Procedure code M0201 is a benefit for clients of any age. Procedure code M0201 may be reported, in addition to the vaccine and vaccine administration procedure codes when a pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine is administered inside a client's home.

Refer to: Subsection 4.3.12.3, "Immunizations" in this handbook for appropriate diagnosis codes for immunization administration.

B.3.3 Immunizations (Vaccine/Toxoids)

The following vaccine procedure codes are a benefit of Texas Medicaid and distributed by TVFC (does not include COVID-19, influenza, and RSV vaccines):

Procedure Codes	Age Range	Number of Recognized Components
90619	2 years of age or older	1
90620	10 years of age or older	1
90621	10 years of age or older	1
90623	10 years through 23 years of age	1
90624	10 through 23 years of age	1
90632	18 years of age or older	1
90633	Birth through 18 years of age	2
90647	6 weeks through 18 years of age	1
90648	6 weeks of age or older	1
90651	9 years through 45 years of age	1
90670	2 months of age or older	1
90671	6 weeks of age or older	1
90677	2 months of age or older	1
90680	Birth through 8 months of age	1
90681	Birth through 8 months of age	1
90696	4 years through 6 years of age	4
90697	Birth through 4 years of age	6
90698	Birth through 5 years of age	5
90700	Birth through 6 years of age	3
90702	Birth through 6 years of age	2
90707	1 year of age or older	3
90710	1 year through 12 years of age	4
90713	2 months of age or older	1
90714	7 years of age or older	2
90715	7 years of age or older	3
90716	1 year of age or older	1
90723	6 weeks through 6 years of age	5
90732	2 years of age or older	1
90734	2 months through 55 years of age	1
90743	11 years through 17 years of age	1

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Procedure Codes	Age Range	Number of Recognized Components
90744	Birth through 17 years of age	1
90746	18 years of age or older	1

Note: *A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

COVID-19 Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for COVID-19:

Procedure Codes	Age Range
91320	12 years of age or older
91322	12 years of age or older
91323	12 years of age or older

Because the ACIP frequently reviews the composition of COVID-19 vaccines and makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of COVID-19 vaccines that TVFC is distributing for clients who are birth through 18 years of age.

Procedure code 90480 must be used in conjunction with one of the vaccine procedure codes listed above for reimbursement of COVID-19 vaccine administration.

COVID-19 vaccine counseling (procedure code G0315) may be reimbursed for clients who are birth through 20 years of age.

Procedure code G0315 will be denied if billed on the same day by the same provider as procedure code 90480.

Procedure code G0315 is limited to once per day, by the same provider, and three per rolling year by any provider.

Influenza Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for influenza:

Procedure Codes	Age Range
90655	6 months through 35 months of age
90656	6 months of age or older
90657	6 months through 35 months of age
90658	6 months of age or older
90660	2 years through 49 years of age
90661	6 months of age or older
90672	2 years through 49 years of age
90673	18 years of age or older
90674	6 months of age or older
90682	18 years of age or older
90685	6 months through 35 months of age
90686	6 months of age or older

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Procedure Codes	Age Range
90687	6 months through 35 months of age
90688	6 months of age or older
90756	6 months of age or older

Refer to: Subsection 4.5.4, "Vaccine Reimbursement" in this handbook for additional information about influenza.

The following vaccine procedure codes are a benefit of Texas Medicaid and are not distributed by TVFC:

Procedure Codes	Age Range	Number of Recognized Components
90476	19 years through 50 years of age	1
90477	19 years through 50 years of age	1
90581	19 years through 65 years of age	1
90585	All ages	1
90586	All ages	1
90589	19 years of age or older	1
90593	12 years of age or older	1
90611	18 years of age or older	1
90625	19 years through 64 years of age	1
90626	19 years of age or older	1
90627	19 years of age or older	1
90636	19 years of age or older	2
90675	All ages	1
90684	19 years of age or older	1
90690	19 years of age or older	1
90691	19 years of age or older	1
90717	19 years of age or older	1
90738	19 years of age or older	1
90739	18 years of age or older	1
90740	20 years of age or older	1
90747	20 years of age or older	1
90758	18 years of age or older	2
90759	18 years of age or older	1
J9030	All ages	1

Providers may use the state-defined modifier U1 in addition to the associated administered vaccine procedure code for clients who are birth through 18 years of age and the vaccine was unavailable through TVFC.

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Modifier	Description
U1	State-defined modifier: Vaccines/toxoids privately purchased by provider when TVFC vaccine/toxoid is unavailable

Note: *"Unavailable" is defined as a new vaccine approved by ACIP that has not been negotiated or added to a TVFC contract, funding for new vaccine that has not been established by TVFC, or national supply or distribution issues. Providers will be informed if a vaccine meets the definition of 'not available' from TVFC and when the provider's privately purchased vaccine may be billed with modifier U1.*

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine inventory, or for clients who are 19 through 20 years of age.

B.3.4 Respiratory Syncytial Virus (RSV)

Because the ACIP reviews the composition of certain seasonal vaccines annually and frequently makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the RSV vaccines and RSV monoclonal antibodies that TVFC is distributing for clients who are birth through 18 years of age for the current RSV season.

Vaccine administration (procedure code 90460 or 90471) must be used in conjunction with RSV vaccine (procedure code 90678) for reimbursement of RSV vaccine administration.

RSV vaccine (procedure code 90678) may be administered to clients who are 10 years of age or older.

RSV monoclonal antibody nirsevimab (procedure codes 90380 and 90381) may be administered to clients who are birth through 19 months of age and are limited to two per lifetime.

RSV monoclonal antibody clesrovimab (procedure code 90382) may be administered to clients who are birth through 7 months of age and are limited to one per lifetime.

RSV monoclonal antibody administration (procedure codes 96380 and 96381) must be used in conjunction with one of the monoclonal antibody procedure codes (90380, 90381, or 90382) for reimbursement of RSV monoclonal antibody administration.

B.3.5 Requirements for TVFC Providers

By enrolling, public and private providers agree to:

- Screen patients for TVFC eligibility at all immunization encounters, and administer TVFC-purchased vaccines only to clients who are 18 years of age and younger who meet one or more of the following criteria:
  - Is an American Indian or Alaska Native.
  - Is enrolled in Medicaid.
  - Has no health insurance.
  - Is underinsured: clients who have other health insurance but the coverage does not include vaccines, clients whose insurance covers only selected vaccines (TVFC-eligible for noncovered vaccines only), clients whose insurance capitates vaccine coverage at a certain amount (once that coverage amount is reached, these clients are categorized as underinsured).
  - Is a client who receives benefits from the Children's Health Insurance Program (CHIP) and the provider bills CHIP for the administration fee.

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- Maintain all records related to the TVFC program, including parent, guardian, or authorized representative's responses to screening for patient's eligibility for at least five years. If requested, the provider will make such records available to DSHS, the local health department authority, or the U.S. Department of Health and Human Services (HHS).
- Comply with the appropriate vaccination schedule, dosage, and contraindications, as established by ACIP, unless (a) in making a medical judgment in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas law, including laws relating to religious and medical exemptions.
- Provide VISs to the responsible adult, parent, or guardian, and maintain records in accordance with the NCVIA which include reporting clinically significant adverse events to VAERS. Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)
- Not charge for vaccines supplied by DSHS and administered to a client who is eligible for TVFC.
- Charge a vaccine administration fee to Texas Medicaid but not impose a charge for the administration of the vaccine in any amount higher than the maximum administration fee established by DSHS (providers may charge a vaccine administration fee to Medicaid, but not a fee for the vaccine). Medicaid clients cannot be charged any out-of-pocket expense for the vaccine or the administration of the vaccine.
- Not deny administration of a TVFC vaccine to a client because of the inability of the client's parent or guardian/individual of record to pay an administration fee.
- Comply with the state's requirements for ordering vaccines and other requirements as described by DSHS, and operate within the TVFC program in a manner intended to avoid fraud, waste, and abuse.
- Allow DSHS (or its contractors) to conduct scheduled and unannounced storage and handling visits.

The provider or the state may terminate the agreement at any time for failure to comply with the requirements listed above. If the agreement is terminated for any reason, the provider agrees to properly return any unused vaccine.

B.3.6 How to Report Immunization Records to ImmTrac2, the Texas Immunization Registry

Texas law requires all medical providers and payors to report *all immunizations* administered to clients who are 17 years of age and younger, to ImmTrac2, the Texas immunization registry operated by DSHS (Texas Health and Safety Code §§161.007-161.009). Providers must report all immunization information within 30 days of administration of the vaccine, and payors must report within 30 days of receipt of data elements from a provider. Prior to reporting immunizations to ImmTrac2, providers must first register for registry participation and access.

ImmTrac2 is a centralized repository of immunization histories for clients of all ages and is a free service and benefit available to all Texans. Registry information is confidential, and by law, may be released only to:

- The client or client's parent, legal guardian, or managing conservator.
- The client's physician, school, or licensed child-care facility in which the client is enrolled.
- Public health districts or local health departments.
- The insurance company, health maintenance organization, or other organization that pays for the provision of the client's health-care benefits.
- A health-care provider authorized to administer a vaccine.

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- A state agency that has legal custody of the client.

ImmTrac2 offers two methods for reporting immunizations to DSHS: direct internet entry into ImmTrac2's internet application and electronic data transfer (import).

B.3.6.1 Direct Internet Entry

This method allows providers to access and review clients' immunization histories prior to administering vaccines. Providers then update their client's immunization record directly into the ImmTrac2 web application after administering vaccines to the patient.

B.3.6.2 Electronic Data Transfer (Import)

This method allows providers to report immunizations from an electronic medical record (EMR) software application by extract file for import into ImmTrac2. Providers may still have access to the ImmTrac2 web application to access and review their clients' immunization histories before administering any vaccines.

Regardless of reporting option selected, all providers must first register for ImmTrac2 access and receive login credentials from ImmTrac2 Customer Support. To register for ImmTrac2 access, providers may obtain and complete an ImmTrac2 Registration Packet (for providers and schools) from immtrac.dshs.texas.gov/TXPRD/enrollProviderEntry.do?action=newOrg or request it from ImmTrac2 Customer Support at 1-800-348-9158.

B.3.6.3 Obtaining Parental Consent for Registry Participation

Before including a client's immunization information in ImmTrac2, DSHS must verify that written consent for registry participation has been granted by the client's parent, legal guardian, or managing conservator. Most parents grant consent for ImmTrac2 participation during the birth certificate registration process. Written parental consent for ImmTrac2 participation applies to all past, present, and future immunizations. Texas law also permits a parent, managing conservator, or guardian to withdraw consent for ImmTrac2 participation at any time.

Providers may offer parents the opportunity to grant consent for their child's participation in ImmTrac2 using the pre-filled, ImmTrac2-generated Immunization Registry (ImmTrac2) Consent Form or the manual version (#C-7) of this form, also available from the ImmTrac2 application. Providers should retain the consent form and affirm parental consent through ImmTrac2 to establish the client's ImmTrac2 record and report all immunizations administered and add any historical immunization information to the client's record. Entering administered immunizations and historical immunization information to the client's record constitutes "reporting" to ImmTrac2 as required by current Texas law.

B.4 Texas Vaccines for Children Program Packet

Refer to: The DSHS website for TVFC information at www.dshs.texas.gov/immunizations/what-we-do/programs.

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APPENDIX C. LEAD SCREENING

C.1 Blood Lead Screening Procedures and Follow-up Testing

For all children enrolled in Texas Health Steps (THSteps) blood lead testing is mandatory when they are 12 months of age and 24 months of age, or whenever they receive their first checkup after these ages if blood testing was not completed (up to and including the 6-year checkup). Lead-risk assessment should be done at all other checkups through age 6, and may be performed using Form PB 110, Lead Risk Questionnaire. A "yes" or "don't know" answer to any question on the questionnaire indicates that a blood lead test should be administered. All blood lead levels in clients who are birth through 14 years of age must be reported to the Department of State Health Services (DSHS). Reports should include all information as required on the Texas Child Blood Lead Level Report Form F09-11709, which is available at https://www.dshs.texas.gov/blood-lead-surveillance-group/for-providers or by calling 1-800-588-1248. Information related to blood lead screening and reporting for clients who are 15 years of age or older is available on the DSHS Blood Lead Surveillance Branch's website at www.dshs.texas.gov/lead.

C.2 Symptoms of Lead Poisoning

Children who have EBLLs in the range of 3.5–45µg/dL may be asymptomatic, although impairment of neurodevelopment may become evident as they get older. Very high lead levels may cause colic, constipation, anorexia, or vomiting. Children with venous blood lead levels (BLLs) over 44µg/dL are eligible for medical intervention. However, it is important not to equate the absence of symptoms with the absence of toxicity.

C.3 Measuring Blood Lead Levels

A blood lead test is the only definitive method to detect exposure. BLLs are measured as micrograms of lead per deciliter of whole blood (µg/dL). In Texas, a BLL requires medical case management and follow-up testing if the level is greater than or equal to 3.5 µg/dL.

Blood lead tests, in order of occurrence:

- Screening test—A blood lead test that indicates whether a client may have an EBLL. This test must be sent to the DSHS lab, or may be done using point-of-care technology in the provider's office.
- Diagnostic test—A venous blood lead test that is performed within recommended guidelines to determine the status of a client who has previously had an EBLL on a screening test (See subsection C.5, "Lead Poisoning Prevention Educational Materials and Forms" in this handbook for a link to form Pb-109 and recommended guidelines).
- Follow-up test—A venous blood lead test to monitor the status of a client with a previously elevated diagnostic test for lead.

> ***Note:*** *A follow-up test is not related to the THSteps follow-up visit. A visit to monitor a child with EBLL would be submitted as an acute care evaluation and management (E/M) visit.*

Providers are responsible for conducting a diagnostic test when a screening test finds a lead level of 3.5 µg/dL or greater. Blood for a screening test may be drawn from a venous or capillary site. A venous blood draw is strongly recommended and preferred. To order venous sample supplies from the DSHS Laboratory, call 1-888-963-7111, Ext. 7661.

> ***Note:*** *The capillary lead screen analysis is subject to a false positive result from skin lead contamination during collection. A soap and water wash of the patient's hands or feet and the collector's hands (or the wearing of gloves) must be performed to minimize the chance of contamination. Alcohol cleansing alone is not sufficient.*

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If the screening test is 3.5 µg/dL or above, recalling a client for a diagnostic sample may be billed as a THSteps follow-up visit. If the screening test was rejected due to clotting, insufficient quantities, or perceived contamination, the provider must repeat the sample as a diagnostic test. Again, the provider may bill the visit and analysis as an E/M visit. Providers can submit the specimen to the DSHS Clinical Chemistry Laboratory using the appropriate DSHS Laboratory Specimen Submission form (the same way as for all other THSteps laboratory blood specimens). If the initial blood lead test is collected as part of a THSteps medical checkup, it must either be sent to the DSHS lab or performed in the provider's office using point-of-care. The diagnostic and follow-up test for the same client may be sent to a private laboratory.

Refer to: Pb-109: *Reference for Blood Lead Retesting and Medical Case Management* on the DSHS website for interpretation of laboratory test results and guidelines for follow-up for clients with elevated blood lead levels.

Subsection 4.3.12.6.8, "Required Laboratory Tests Related to Medical Checkups" in this handbook.

Subsection 4.3.10, "Newborn Examination" in this handbook.

Providers can find more information about the medical and environmental management of lead-poisoned children on the DSHS Texas Childhood Lead Poisoning Prevention Program (TX CLPPP) website at www.dshs.texas.gov/lead or by calling 1-800-588-1248.

C.4 Environmental Lead Investigation Services

C.4.1 Enrollment

State and local health departments that employ or contract certified lead risk assessors must be enrolled with Texas Medicaid as a THSteps provider to perform environmental lead investigation (ELI) services.

- State and local health departments that are currently enrolled in Texas Medicaid must complete the THSteps Provider Enrollment Application.
- State and local health departments that are not currently enrolled in Texas Medicaid must complete the Texas Medicaid Provider Enrollment Application and the THSteps Provider Enrollment Application.

C.4.1.1 Services, Benefits, Limitations, and Prior Authorization

ELI services must be billed with procedure code T1029, which is restricted to the following diagnosis codes:

Diagnosis Codes							
T560X1A	T560X1D	T560X1S	T560X2A	T560X2D	T560X2S	T560X3A	T560X3D
T560X3S	T560X4A	T560X4D	T560X4S	Z77011			

Texas Medicaid may only reimburse a state or local health department for the certified lead risk assessor's time and activities during an onsite investigation of a client's home or primary residence. Laboratory analysis of environmental substances (e.g., water, paint, or soil) is not a benefit of Texas Medicaid.

Children who have confirmed and persistent EBLLs may require an ELI to determine the source of the lead exposure. An ELI is completed in a client's home or primary residence by a certified lead risk assessor to determine whether a lead hazard exists and, if so, whether the lead source could be the cause of the EBLL.

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C.4.1.2 Requesting an Environmental Lead Investigation

For the purpose of requesting an ELI, a health-care provider is a physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) who conducts blood lead tests for a THSteps client. Health-care providers may submit a request for an ELI after a blood lead test has been conducted and there is evidence of persistent and confirmed EBLLs for the client. An EBLL is defined as a BLL of 10µg/dL or higher.

An ELI may be considered medically necessary if the results of the most recent blood lead test indicate any of the following:

- A venous BLL result of 10µg/dL to 19µg/dL from two separate specimens conducted at least 12 weeks apart
- A venous BLL result of 20µg/dL or greater from one specimen

Note: *The ELI must be requested as soon as possible and no later than 30 days after obtaining the most recent BLL that indicates medical necessity. The health-care provider must maintain in the client's medical record the ELI request and the documentation of the BLL that indicates medical necessity.*

The health-care provider can request an ELI by completing Form Pb-101 "Environmental Lead Investigation Request" and submitting it to the TX CLPPP. TX CLPPP will review the request and determine whether the criteria for an ELI have been met. If an ELI request meets the TX CLPPP criteria, TX CLPPP sends a referral for an ELI to a state or local health department that is enrolled as a THSteps provider so that it can be assigned to a certified lead risk assessor. A certified lead risk assessor conducts an ELI using a completed Pb-103 Texas Elevated Blood Lead Level Investigation Questionnaire (all pages).

An ELI can be performed under one of the following circumstances:

- No previous investigation of the current home or primary residence has been performed.
- There is a change in the client's current home or primary residence.

If a previous investigation of the current home or primary residence has been performed and there has been a change in the client's residential environment, TX CLPPP will determine whether the criteria have been met for an additional ELI.

C.4.1.3 Prior Authorization

Prior Authorization is not required for ELI services.

C.4.2 Documentation Requirements

The state or local health department that is responsible for conducting the investigation must maintain the following documentation in the client's medical record:

- The TX CLPPP fax transmittal cover sheet that refers the ELI request to the local health department. The cover sheet must include:
  - The site to be assessed.
  - A statement that identifies the site as the client's primary place of residence.
- A completed Form Pb-101: Environmental Lead Investigation Request (two pages) that includes the:
  - Name of the referring health-care provider.
  - BLLs that indicate medical necessity.
  - Client's diagnosis.
- A completed Form Pb-103: Elevated Blood Lead Level Investigation Questionnaire (all pages) that includes the:

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- Date and location of the investigation.
- Name of the client who received the investigation.
- Identifying information and signature of the certified lead risk assessor who conducted the investigation. The person listed as the assessor must be the same person who signs the report.

Note: *Forms Pb-101 and Pb-103 are located on the TX CLPPP website at https://www.dshs.texas.gov/blood-lead-surveillance-group/for-providers/forms.*

C.4.3 Claims Filing and Reimbursement

C.4.3.1 Claims Filing

ELI services must be submitted to Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic format or on the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

The following documentation must be submitted with the claim:

- The TX CLPPP fax transmittal cover sheet that refers the ELI request to the state or local health department. The cover sheet must include:
  - The site to be assessed.
  - A statement that identifies the site as the client's primary place of residence.
- A completed Form Pb-101: Environmental Lead Investigation Request.
- The first and last page of Form Pb-103: Elevated Blood Lead Level Investigation Questionnaire, which has been completed by the lead risk assessor.

An ELI is subject to retrospective review and may be recouped if the documentation maintained by the health-care and ELI providers does not support medical necessity.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

C.4.3.2 Managed Care Clients

ELI services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's managed care organization (MCO).

C.4.3.3 Reimbursement

Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

C.5 Lead Poisoning Prevention Educational Materials and Forms

Providers may download lead poisoning prevention education materials and forms from the Texas CLPPP website at www.dshs.texas.gov/lead.

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The following table lists materials available to providers for download:

Lead Poisoning Prevention Materials	
1-26	Protect Your Children From Lead Poisoning (English and Spanish)
1-307	Keep Lead at Bay (English and Spanish)
1-308	Consuming Lead-Free (English and Spanish)
1-311	How Lead Affects Your Child's Health (English and Spanish)
1-313	Getting a Good Specimen (Poster)
1-315	A Guide for Cleaning Lead-Safe (English and Spanish)
09-13410	Pica and Pregnancy (English and Spanish)
Pb-101	Request for Environmental Investigation
Pb-102	Follow-up of Initial Elevated Blood Lead Level
Pb-103	Elevated Blood Lead Level Investigation Questionnaire
Pb-104	Physician Checklist for Parent Education Topics
Pb-109	Reference for Blood Lead Retesting and Medical Case Management
Pb-110	Lead Risk Questionnaire (English and Spanish)

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APPENDIX D. TEXAS HEALTH STEPS STATUTORY STATE REQUIREMENTS

D.1 Legislative Requirements

Several specific legislative requirements affect Texas Health Steps (THSteps) and the provider's participation in Texas Medicaid. The legislation includes, but is not limited to, those included in this Appendix.

D.2 Texas Health Steps (THSteps) Program

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is mandated by Title XIX of the Social Security Act. EPSDT is a program of prevention, diagnosis, and treatment for Medicaid-eligible clients who are birth through 20 years of age.

In Texas, EPSDT is known as THSteps. The Texas Department of State Health Services (DSHS), by authorization of Texas Department of Health and Human Services (HHSC), operates and administers the outreach and informing, medical and dental checkup, dental treatment utilization components of this program. State authority is found in Title 26 Texas Administrative Code (TAC), Part 1, Chapter 256, Subchapter A, Rule §256.1.

D.3 Communicable Disease Reporting

Diagnosis of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are reportable conditions under 25 TAC, Chapter 97, Subchapter F. Providers must report confirmed diagnosis of STDs as required by 25 TAC §§97.132-134.

D.4 Early Childhood Intervention (ECI) Referrals

All health-care professionals are required by federal and state regulations to refer children who are birth through 35 months of age to the Texas HHS ECI program as soon as possible, but no longer than 7 days after identifying a disability or suspected delay in development.

Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

To refer families for services, providers should use the ECI referral form available on the HHS ECI website at https://www.hhs.texas.gov/sites/default/files/documents/services/disability/eci/eci-referral-form-icd-10.pdf. Providers may also refer families for services by calling their local ECI program or the Health and Human Services Office of the Ombudsman at 1-877-787-8999, select a language, and then select Option 3. The Ombudsman staff will ask for your ZIP code, county, or city and provide the name and number of the local ECI program. Callers that are deaf or hard of hearing may use the relay option of their choice or dial 7-1-1 to connect with Relay Texas.

To facilitate referrals for ECI services an optional form is available on the HHS ECI website at https://www.hhs.texas.gov/services/disability/early-childhood-intervention-services/make-a-referral-eci.

For additional ECI information, providers can visit the HHS ECI website at www.hhs.texas.gov/services/disability/early-childhood-intervention-services. Persons who are deaf or hard of hearing may use the relay option of their choice or dial 7-1-1 to connect with Relay Texas.

D.5 Parental Accompaniment

Texas Human Resource Code (HRC) §§32.024(s)-(2) requires that, as a condition for provider reimbursement, a client who is 14 years of age or younger be accompanied by the client's parent, legal guardian, or other authorized adult during medical and dental checkups and dental treatment. The authorized adult can be the client's relative. DSHS implemented this requirement through rules found in 26 TAC §256.2 (Definitions) and 26 TAC §256.6 (THSteps Provider Responsibilities).

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The DSHS rules require that the parent, legal guardian, or authorized adult accompany the client to the checkup, and that the parent, legal guardian, or authorized adult must wait for the client while the checkup, treatment, or service takes place.

Providers will not be required to submit documentation to TMHP to verify compliance with this policy in order for TMHP to process claims. By submitting the claim for reimbursement, the provider acknowledges compliance with all Medicaid requirements. Additional assurances are not necessary.

Exception: *School health clinics, Head Start programs, and childcare facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement in the health care of the client and obtains written consent for the services. The consent from the client's parent or guardian must have been received within the one-year period before the date on which the services are provided and must not have been revoked.*

Refer to: HRC §§32.024(s)-(s-1) and 26 TAC §256.2 and §256.6.

D.6 Newborn Blood Screening

The Health and Safety Code (HSC), Chapter 33, Section §33.011, implemented by the rules found at 25 TAC, Part 1, Chapter 37, Subchapter D, requires testing of all newborns. A current list of disorders can be found at www.dshs.texas.gov/newborn/screened_disorders.shtm.

This testing is the responsibility of the physician who is attending a newborn client (defined as up to 30 days of age by rule in 25 TAC, Chapter 37, Subchapter D, §37.52) or the person who is attending the delivery of a newborn client who is not attended by a physician to screen for the disorders within 24 to 48 hours of birth.

All infants must be tested a second time at 1 to 2 weeks of age. If there is any doubt that a client who is 12 months of age or younger was properly tested, the provider should submit a blood sample with the appropriate DSHS Form NBS3 to the DSHS Newborn Screening Laboratory.

D.7 Abuse and Neglect

D.7.1 Requirements for Reporting Abuse or Neglect

Providers are required to report abuse or neglect as outlined in subsection 1.7, "Provider Responsibilities" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Additionally, the General Appropriations Act, Article II, Rider 23 under DSHS, and Rider 13 under HHSC, of S.B. 1, 79th Legislative Regular Session, 2007, require that DSHS and HHSC distribute or provide appropriated funds only to recipients who show good faith efforts to comply with all child abuse and reporting requirements set forth in the Texas Family Code (TFC), Chapter 261, relating to investigations of reports of child abuse and neglect.

D.7.2 Procedures for Reporting Abuse or Neglect

Professionals, as defined in TFC §261.101 (b), are required to report abuse or neglect no later than the 48th hour after the hour in which the professional first has cause to believe the client has been or may be abused or is the victim of the offense of indecency with a child.

Nonprofessionals shall immediately make a report when the nonprofessional has cause to believe that the client's physical or mental health or welfare has been adversely affected by abuse.

A report must be made regardless of whether the provider staff suspects that a report may have previously been made. Reports of abuse or indecency with a child should be made to one of the following:

- Texas Department of Family and Protective Services (DFPS), if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (DFPS Texas Abuse Hotline, 1-800-252-5400, 24 hours a day, 7 days a week).

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- Call the DFPS Texas Abuse Hotline if:
  - You believe your situation requires action in less than 24 hours.
  - You prefer to remain anonymous.
  - You have insufficient data to complete the required information on the report.
  - You do not want an email to confirm your report.

  Note: *Providers can also report nonemergency abuse online at www.txabusehotline.org.*
- Any local or state law enforcement agency or the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred.
- The agency designated by the court to be responsible for the protection of children.

The law requires that the report include the following:

- Name and address of the minor, if known.
- Name and address of the minor's parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known.
- Any other pertinent information concerning the alleged or suspected abuse, if known.

A provider may not reveal whether the client has been tested or diagnosed with HIV or acquired immunodeficiency syndrome (AIDS). If the minor's identity is unknown (e.g., the minor is at the provider's office to receive testing for HIV or an STD anonymously), no report is required.

D.7.2.1 Staff Training on Reporting Abuse and Neglect

All providers shall develop training for all staff on the policies and procedures in regard to reporting child abuse, including sexual abuse and neglect. New staff shall receive this training as part of their initial training or orientation.

Training shall be documented. As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

Several specific legislative requirements affect THSteps and the provider's participation in Texas Medicaid. The legislation includes, but is not limited to those included in this appendix.

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APPENDIX E. HEARING SCREENING INFORMATION

E.1 Texas Early Hearing Detection and Intervention (TEHDI) Process

The following processes for early hearing detection and intervention are addressed in this section:

- Birth screen
- Outpatient rescreen
- Evaluation using Texas Pediatric Protocol for Audiology
- Referral to an Early Childhood Intervention (ECI) program
- Periodic monitoring by the physician or medical home

Refer to: The *1-3-6 Month Practitioner's Guide* on the DSHS website.

E.1.1 Birth Screen

The hearing screen at birth will be either screening auditory brainstem response (ABR) or transient or distortion product otoacoustic emissions (OAE). The following items apply:

- A newborn's hearing is screened at the birth facility. If a newborn does not pass the screen, hearing is rescreened before discharge.
- The birth facility reports results to the Department of State Health Services (DSHS) using the web-based eScreener Plus (eSP™) system.
- The newborn's family and physician/medical home receive a written report of the hearing screen outcome.
- If a newborn passes the screen, the physician monitors hearing as part of well child checkups.
- If a newborn does not pass the second screen, a referral is made to a local resource who is experienced with the pediatric population for outpatient rescreen.

E.1.2 Outpatient Rescreen

If an outpatient rescreen is necessary, either ABR or OAE will be used. The following items apply:

- The physician/medical home receives the written report of results from the birth facility.
- The screener/physician reports results to the DSHS contractor, OZ Systems, using the web-based eSP™ system, by calling 1-866-427-5768 or faxing 1-817-385-3939.
- If the newborn passes the outpatient rescreen, the physician monitors hearing as part of well child checkups.
- If a newborn does not pass the outpatient rescreen, a referral is made to an audiologist for evaluation using the Texas Pediatric Protocol for Evaluation. Visit www.dshs.texas.gov/tehdi for more information.
- Hearing services for clients who are birth through 20 years of age are administered through the Texas Medicaid hearing services benefit. Clients may use the Online Provider Lookup (OPL) to locate a Texas Medicaid provider who provides hearing services for children (clients who are birth through 20 years of age).

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E.1.3 Evaluation using Texas Pediatric Protocol for Audiology

These evaluations will include a diagnostic ABR and, if not previously done, a diagnostic OAE will be performed to determine cochlear involvement. The following items apply:

- Audiologists use equipment norms for newborns, preferably ones that they have collected on their equipment.
- Protocols include air and bone conduction testing using tone burst ABR, as well as click ABR, so the amplification may be appropriately fit.
- The physician/medical home receives results and makes the referral to ECI using the web-based eSP™ system or by using the ECI program search web page at citysearch.hhsc.state.tx.us.
- The physician/medical home monitors the child. See the *Journal of Early Hearing Detection and Intervention 2019 Position Statement* at "Year 2019 JCIH Position Statement" (usu.edu).
- The audiologist reports results to the DSHS contractor as noted above and makes the referral to ECI.
- Fitting of hearing aids by an audiologist when appropriate.
- Continued audiological assessment and monitoring as needed (usually monitor each three months for the first year of hearing aid use).

E.1.4 Referral to an ECI Program

The client will be referred to an ECI program by an audiologist or physician as soon as possible, but no longer than 7 days of identification of hearing loss as required by law. The following items apply:

- Service coordination provided by ECI.
- ECI will refer to the Local Education Agency (LEA) for auditory impairment (AI) services as outlined in the *Memorandum of Understanding between TEA and HHS ECI.*
- An evaluation and Individual Family Service Plan (IFSP) will occur within 45 days of referral to ECI.
- ECI services are available to clients birth through 35 months of age when determined by an IFSP.
- ECI and LEA will coordinate transition services upon the child's third birthday.

E.1.5 Periodic Monitoring by the Physician or Medical Home

The physician/medical home will continue to monitor the client periodically and may consult or use the following:

- Providers may refer to the Joint Committee on Infant Hearing (JCIH) 2007 Position Statement for suggested monitoring protocols at publications.aap.org/pediatrics/article/120/4/898/71218/Year-2007-Position-Statement-Principles-and?autologincheck=redirected.
- Deaf education and other special education services available from birth through 20 years of age when determined by an individualized education program.

E.2 JCIH 2007 Position Statement

The JCIH 2007 Position Statement is available on the JCIH website at www.jcih.org/posstatemts.htm. The 2007 Position Statement lists the indicators that are associated with permanent congenital, delayed-onset or progressive hearing loss in childhood.

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APPENDIX F. TEXAS HEALTH STEPS QUICK REFERENCE GUIDE

The Texas Health Steps Quick Reference Guide (THSteps-QRG) is available on the TMHP website.

APPENDIX G. AMERICAN ACADEMY OF PEDIATRIC DENTISTRY PERIODICITY GUIDELINES

The American Academy of Pediatric Dentistry (AAPD) periodicity guidelines are available on the AAPD website at www.aapd.org.

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CLINICS AND OTHER OUTPATIENT FACILITY SERVICES HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human Services

CLINICS AND OTHER OUTPATIENT FACILITY SERVICES HANDBOOK

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1 General Information

This information is intended for birthing centers, Federally Qualified Health Centers (FQHCs), local health departments, maternity service clinics, renal dialysis facilities, Rural Health Clinics (RHCs) and tuberculosis (TB) clinics. This handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers. This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Texas Medicaid Managed Care Handbook*. Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook*.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

1.1 National Drug Codes (NDC)

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

1.2 Revenue Codes for UB-04 Submissions

Claims that are submitted on the CMS-1450 UB-04 paper claim form or electronic equivalent by non-hospital facility or other non-hospital providers must be submitted with a revenue code for correct processing.

If the non-hospital provider is required to submit a procedure code for reimbursement, the provider must include the procedure code and an appropriate corresponding revenue code on the same detail, even if the chosen revenue code does not require a procedure code for claims processing.

Refer to: Subsection 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for a list of revenue codes that do and do not require procedure codes.

1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The services were FQHC, RHC, THSteps, or some renal dialysis services.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.

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- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Birthing Center

2.1 Provider Enrollment

A birthing center is a place, facility, or institution where a woman is scheduled to give birth following a normal, uncomplicated (low-risk) pregnancy. This term does not include a hospital, an ambulatory surgical center, or the residence of the woman giving birth.

A birthing center must be licensed as a birthing center by the Department of State Health Services (DSHS) and meet the minimum standards as required by the Texas Health and Safety Code, Chapter 244.010. To enroll in Texas Medicaid, a birthing center must be licensed to provide a level of service commensurate with the professional services of a doctor of medicine (MD), doctor of osteopathy (DO), certified nurse-midwife (CNM), or licensed midwife (LM) who acts as birth attendant. Texas Medicaid may reimburse birthing center providers only for those services that the attending physician or CNM determines to be reasonable and necessary for the care of the mother or newborn child.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Birthing centers are encouraged to refer clients for Texas Health Steps (THSteps) services.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information on setting up referral procedures for family planning services.

The HHSC website a www.healthytexaswomen.org for information about family planning and the locations of family planning clinics receiving HHSC Family Planning Program funding from HHSC.

Subsection 7.2.1.3, "Laboratory Tests" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about required human immunodeficiency virus (HIV) testing for pregnant women.

2.2 Services, Benefits, Limitations, and Prior Authorization

Birthing centers may only be reimbursed by Texas Medicaid for their facility labor and delivery services using the following procedure codes:

Service	Procedure Code
Delivery	59409
Labor only	S4005

Note: *Deliveries at a facility licensed as a birthing center by DSHS must be billed with procedure code 59409.*

If the client is discharged prior to delivery, procedure code S4005 may be billed by the facility for labor services only.

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Refer to: Subsection 9.2.35, "Immunization Guidelines and Administration" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information about immunization administration.

2.2.1 Newborn Hearing Screening

The Texas Health and Safety Code, Chapter 47, requires birthing centers to offer all newborns a hearing screening as a part of the obstetrical care at delivery.

Refer to: Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the newborn hearing screening.

Subsection 2.2.2.3, "Abnormal Hearing Screening Results" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about abnormal hearing screens.

2.2.2 Newborn Eligibility Process

If the mother of the newborn is eligible for Medicaid, the newborn may be assigned his or her own Medicaid number. The birthing center must complete form GN.4, "Birthing Center Report (Newborn Child or Children) (Form 7484)" to provide information about each child born to a mother who is eligible for Medicaid.

Refer to: Hospital Report (Newborn Child or Children) (Form 7484) on the TMHP website at www.tmhp.com.

If the newborn's name is known, the name must be on the form. The use of "Baby Boy" or "Baby Girl" delays the assignment of a number.

The form must be completed by the birthing center no later than five days after the child's birth. Birthing centers that submit the birth certificate information using the HHSC, Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth software and the HHSC Form 7484 receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers that are involved in the care of the newborn.

Additional information about obtaining a newborn Medicaid identification number can be found on the agency website at www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs-services/medicaid-pregnant-women-chip-perinatal. Providers may also call 1-888-963-7111, Ext. 7368 or 1-512-458-7368 for additional information or comments about this process.

Upon receipt of a completed 7484 form, DSHS verifies the mother's eligibility and, within ten days of the receipt, sends notification letters to the hospital or birthing center, attending physician (if identified), mother, and caseworker. The notice includes the child's Medicaid identification number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification card (Your Texas Benefits Medicaid card) to the client.

The attending physician's notification letter is sent to the address on file (by license number) at the Texas Medical Board. This address must be kept current to ensure timely notification. Physicians must submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

2.2.3 Prior Authorization

Prior authorization is not required for services rendered in birthing centers.

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2.2.4 Services Rendered in the Birthing Center Setting

Maternity clinic, physician, CNM, LM, nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) providers who render prenatal or family planning services in the birthing center setting must submit separate claims.

Refer to: Section 4, "Obstetric Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about birthing center providers.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered.

Birthing center services are subject to retrospective review and recoupment if documentation does not support the service billed.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Claims for birthing center services must be submitted to Texas Medicaid & Healthcare Partnership (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.

When completing a CMS-1500 paper claim form, providers must include all required information on the claim, as TMHP does not key any information from attachments. Superbills or itemized statements are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement

Birthing centers are reimbursed in accordance with 1 TAC §355.8181. See the applicable fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. The Centers for Medicare & Medicaid Services (CMS) NCCI and medically unlikely edits (MUE) guidelines can be found in the NCCI Policy and Medicaid Claims Processing manuals, which are available on the CMS NCCI web page. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

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In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

3 Comprehensive Health Center (CHC)

CHCs or physician-operated clinics are funded by federal grants. To apply for participation in Texas Medicaid, they must be certified and participate as health centers under Medicare (Title XVIII).

CHC claims are paid according to each center's encounter rates as established by CMS. Medicaid payments to CHCs are limited to Medicare deductible or coinsurance according to current guidelines. CHC providers that supply laboratory services in an office setting must comply with the rules and regulations for the Clinical Laboratory Improvement Amendments (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

"Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Section 4, "Federally Qualified Health Center (FQHC)" in this handbook.

Section 8, "Rural Health Clinic" in this handbook.

4 Federally Qualified Health Center (FQHC)

4.1 Enrollment

To enroll in Texas Medicaid, an FQHC must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services (HHS) to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. The CMS has granted a waiver for the Medicare prerequisite at the time of initial enrollment of FQHC parents and satellites. FQHC look-alikes are *not* required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers.

Refer to: Subsection 4.3.2.1, "Medicare Crossover Claims Pricing" in this handbook.

A copy of the Public Health Service's Notice of Grant Award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to TMHP Provider Enrollment annually.

FQHCs are required to notify TMHP of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing Texas Medicaid for FQHC services must also be approved by the United States Department of Health and Human Services Health Resources and Services Administration (HRSA). For accounting purposes, centers may elect to enroll the HRSA-approved satellites using a Federally Qualified Satellite (FQS) provider identifier that ties back to the parent FQHC National Provider Identifier (NPI) and tax ID number (TIN). This procedure allows for the parent FQHC to have one provider agreement and one cost report that combines all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to submit claims to Texas Medicaid directly, the center must have a separate NPI from the parent FQHC and will be required to file a separate cost report.

All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care

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services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

FQHC providers do not need to apply for a separate physician or agency number to provide family planning services.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

FQHCs must identify and attest to all contractual agreements for those medical services in which the FQHC is receiving Prospective Payment System (PPS) reimbursement. This is a mandate from the 2012 to 2013 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 78).

The attestation shall be made using the Federally Qualified Health Center Affiliation Affidavit, which is available on the TMHP website at www.tmhp.com.

4.1.1 Initial Cost Reporting

New FQHCs must file a projected cost report within 90 days of their designation as an FQHC to establish an initial payment rate. The cost report will contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. The FQHC must file a cost report within five months of the end of the FQHC's initial fiscal year. The cost settlement must be completed within 11 months of the receipt of a cost report. The cost per visit rate established by the cost settlement process will be the base rate. Any subsequent increases will be calculated as provided herein.

FQHC providers are required to submit a copy of their Medicare-audited cost report for the provider's fiscal year within 30 days of receipt from Medicare to:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

A new FQHC location established by an existing FQHC participating in Texas Medicaid will receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

4.1.2 Services, Benefits, Limitations, and Prior Authorization

The services listed in the following tables may be reimbursed using the FQHC's NPI. Any additional physician services must be submitted for reimbursement using the physician's NPI. Hospital services are not considered for reimbursement to FQHC providers, and cannot be billed using the facility provider number assigned to the FQHC.

General Medical Services									
T1015									
General medical services must be submitted using one of the appropriate modifiers AH, AJ, AM, SA, TD, TE, TH, U1, U2, or U7.									

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FQHC Encounter Services							
G0466	G0467	G0468	G0469	G0470			

Adult Preventative Care									
99385	99386	99387	99395	99396	99397				
Adult preventative care must be submitted with diagnosis codes Z0000, Z0001, Z01411, and Z01419.									

Case Management
G9012
Comprehensive visit must be submitted using modifiers U2 and U5. **Follow-up face-to-face visit must be submitted using modifiers TS and U5.** **Follow-up telephone visit must be submitted using modifier TS.**

Family Planning Services									
99202	99203	99204	99205	99211	99212	99213	99214	99215	J7296
J7297	J7298	J7300	J7301	J7307					
Annual family planning examination must be submitted with modifier FP.									

Mental Health Services									
90791	90792	90832	90833*	90834	90836*	90837	90838*	90846	90847
90853	90899	96116	96130	96132	96136				
*** Procedures cannot be performed by Psychologist. Mental health services must be submitted using one of the appropriate modifiers AH, AJ, AM, U1, or U2.**									

THSteps Dental Services									
D0120	D0140	D0145	D0150	D0160	D0170	D0180	D0330	D0340	D0350
D0367	D0470	D1110	D1120	D1208	D1351	D1510	D1516	D1517	D1520
D1526	D1527	D1551	D1552	D1553	D1575	D2140	D2150	D2160	D2161
D2330	D2331	D2332	D2335	D2390	D2391	D2392	D2393	D2394	D2750
D2751	D2791	D2792	D2930	D2931	D2932	D2933	D2934	D2940	D2950
D2954	D2971	D3220	D3230	D3240	D3310	D3320	D3330	D3346	D3347
D3348	D3351	D3352	D3353	D4277	D4278	D4283	D4285	D4341	D4355
D5211	D5212	D5630	D5640	D5650	D5660	D5670	D5671	D5720	D5721
D5740	D5741	D5760	D5761	D5992	D5993	D6049	D6549	D7140	D7210
D7220	D7230	D7250	D7270	D7286	D7510	D7550	D7910	D7961	D7962
D7970	D7971	D7997	D7999	D8010	D8020	D8070	D8080	D8210	D8220
D8660	D8670	D8680	D9110	D9211	D9212	D9223	D9224	D9225	D9230
D9243	D9244	D9245	D9246	D9247	D9930	D9944	D9974	D9994	D9995
D9999									
Procedure codes D8210, D8220, and D8080 must be submitted with Diagnostic Procedure Code (DPC) remarks codes for correct claims processing.									

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THSteps Medical Services									
99211	99381	99382	99383	99384	99385	99391	99392	99393	99394
99395	96160	96161							
THSteps medical services must be submitted using modifier EP in addition to one of the appropriate modifiers AM, SA, or U7.									

Note: *Procedure codes 96160 and 96161 are a benefit for Texas Medicaid clients who are 12 through 18 years of age and is limited to once per calendar year, any provider. Only one procedure code (96160 or 96161) may be reimbursed for the mental health screening per client per calendar year based on the description of the procedure code and the service rendered.*

Vision Care Services									
92002	92004	92012	92014	92015	92020	92025	92060	92065	92081
92082	92083	92100	92201	92202	92230	92235	92240	92242	92250
92260	92265	92270	92273	92274	92285	92286	92287	95060	95930
95933	S0620	S0621							

Copayments									
CP001	CP002	CP005	CP006						

Refer to: Subsection 6.3.5, "Modifiers" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for a definition of modifiers.

Section 3, "Texas Health Steps (THSteps) Dental" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 2, "Healthy Texas Women (HTW) Program Overview" in the *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "Vision Care Professionals" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 9.2.60.4.2, "Preventive Care Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 8.8.2.2, "HMO Copayments" in "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for information about HMO copayments.

The *Health and Human Services Commission Family Planning Program Services Handbook* (*Vol. 2, Provider Handbooks*).

Medicaid coverage is limited to FQHC services that are covered by Texas Medicaid and are reasonable and medically necessary. When furnished to a client of the FQHC, medically necessary services include the following:

- CNM services
- Clinical psychologist services
- Licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), and other mental health services

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- Dental services
- NP services
- Other ambulatory services included in Medicaid such as family planning, THSteps, and maternity service clinic (MSC)
- PA services
- Physician services
- Services and supplies necessary for services that would be covered otherwise, if furnished by a physician or a physician service
- Vision care services
- Visiting nurse services to a homebound individual, in the case of those FQHCs located in areas with a shortage of home health agencies

Types of FQHC visits are defined in 1 TAC §355.8261. A visit is a face-to-face encounter between an FQHC client and a physician, PA, NP, CNM, visiting nurse, qualified clinical psychologist, LCSW, LMFT, LPC, other health-care professional for mental health services, dentist, dental hygienist, or optometrist. Encounters that take place on the same day at a single location with more than one health-care professional or multiple encounters with the same health-care professional constitute a single visit, except where one of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The FQHC client has a medical visit and an other health visit such as a qualified clinical psychologist, LCSW, LMFT, LPC, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a THSteps medical checkup.

All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. They are not billable as a separate encounter.

Registered nurses may not be the sole provider of a medical checkup in an FQHC. If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be used. These procedure codes are informational only, and are not payable.

To be reimbursed for Case Management for Children and Pregnant Women, an FQHC must be approved as a case management services provider by the DSHS Case Management Branch.

An annual family planning examination is allowed once per state fiscal year (September 1 through August 31), per client, per provider. An FQHC may be reimbursed for up to three family planning encounters per client, per year, regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters, an annual family planning examination, or intrauterine devices.

Family planning services must be submitted with the most appropriate evaluation and management (E/M) procedure code and one of the following family planning diagnosis codes:

Family Planning Diagnosis Codes							
Z30011	Z30013	Z30014	Z30018	Z3002	Z3009	Z302	Z3040
Z3041	Z3042	Z30430	Z30431	Z30432	Z30433	Z3049	Z308
Z309	Z9851	Z9852					

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Procedure code 58300 must be submitted on the same claim as J7296, J7297, J7298, J7300, and J7301. Procedure code 58300 will process as informational only. Only the annual family planning examination requires modifier FP. All other family planning visits do not require the FP modifier. Claims filed incorrectly may be denied.

Laboratory and radiology services or the services of a licensed vocational nurse (LVN), registered nurse (RN), nutritionist, or dietitian are *not* considered an encounter, because they are incidental to an encounter with one of the previously-mentioned payable health-care professionals. Providers should continue to include the cost associated with these services on their cost report (they are allowable but do not constitute an encounter).

Per federal regulations, the provider cannot submit claims to Medicaid or bill the client for vaccines obtained from the Texas Vaccine for Children (TVFC) Program.

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

4.1.3 After-Hours Care

After-hours care for FQHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday. After-hours care provided by FQHCs does not require a referral.

4.1.4 Prior Authorization

Prior authorization or authorization may be required for FQHC services. Refer to the individual sections referenced in subsection 4.1.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

4.1.5 Referral Requirements

Texas Medicaid fee-for-service limited clients, are allowed to choose any enrolled family planning provider.

4.2 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered. All services provided are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

4.3 Claims Filing and Reimbursement

4.3.1 Claims Information

All services (except for family planning, THSteps medical, THSteps dental, copayments, vision, mental health services, and case management for high-risk pregnant women and infants) provided during an encounter must be submitted for reimbursement using procedure code T1015. All services provided that are incidental to the encounter must be included in the total charge for the encounter and are not billable as a separate encounter. For example, if an office visit was provided at a charge of $30 and a lab test for $15, the center would submit a claim to TMHP for procedure code T1015 for $45 and would be reimbursed at the center's encounter rate.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA are not reimbursed for laboratory services.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

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To obtain the encounter rate when submitting claims for family planning services that are provided under Title XIX or HTW, FQHCs must use the most appropriate E/M procedure code, or procedure code J7296, J7297, J7298, J7300, and J7301, or J7307 with a family planning diagnosis code. Providers must use procedure code J7296, J7297, J7298, J7300, J7301, or J7307 if the visit is for the insertion of an intrauterine device (IUD) or implantable contraceptive capsule. These procedure codes must be submitted in conjunction with the most appropriate informational procedure codes for services that were rendered. Procedure codes J7296, J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an IUD or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program. Providers must use modifier FP only to submit claims for the annual family planning examination.

If an employed physician of an FQHC provides a service in the hospital (e.g., a delivery), the service may be billed using the physician provider number if the terms of the FQHC and physician agreement indicate this occurrence. Physicians must be enrolled in Medicaid separately from the FQHC facility. Physicians are not allowed to bill through their FQHC group number for hospital services. The services will be reimbursed at the physician fee-for-service (FFS) fee schedule rate. The costs that are associated with these physician services must be excluded from the FQHC's cost report and will not be considered during the FQHC cost settlement or encounter rate setting process.

Services rendered in the (inpatient or outpatient) hospital setting are not considered a reimbursable FQHC encounter and are not payable to the FQHC. FQHC services for clients who have only Medicaid must be submitted to TMHP in approved electronic format or on a UB-04 CMS-1450, CMS-1500, or 2017 paper claim form. Providers may purchase UB-04 CMS-1450 or CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a UB-04 CMS-1450 or CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The ADA Dental Claim Form can be downloaded at www.ada.org.

The 2017 Claim Form can be found in the Forms section of this manual.

Refer to: 2017 Claim Form on the TMHP website at www.tmhp.com.

"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Section 12, "Forms" in this handbook.

Claims must be filed as follows:

Services	Claim Form
THSteps medical services	UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format
Family planning claims filed by FQHC providers who have contracted with HHSC	2017 Claim Form or approved electronic format
Family planning claims filed by FQHC providers not contracted with HHSC	UB-04 CMS-1450 or 2017 paper claim form or approved electronic format

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Services	Claim Form
THSteps dental services	American Dental Association (ADA) Dental Claim Form or approved electronic format
Case Management for Children and Pregnant Women services	UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format

When filing for a client who has Medicare and Medicaid coverage, providers must file on the same claim form that was filed with Medicare.

Services provided by a health-care professional require one of the following modifiers with procedure code T1015, to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, U1, U2, or U7.

- If more than one health-care professional is seen during the encounter, the modifier must indicate the primary contact. The primary contact is defined as the health-care professional who spends the greatest amount of time with the client during that encounter.
- If the encounter is for antepartum care or postpartum care, the modifier TH must be indicated on the claim in addition to any other appropriate modifier.
- If the antepartum or postpartum care is provided by a CNM, the modifier SA must be indicated on the claim in addition to any other appropriate modifiers.

Use modifier TD or TE for home health services provided in areas with a shortage of home health agencies.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

The Claim Form Examples page of the TMHP website at www.tmhp.com.

The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

The *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*).

4.3.2 Reimbursement

FQHCs are reimbursed provider-specific prospective payment system encounter rates in accordance with 1 TAC §355.8261.

FQHCs are exempt from the mandated rate reductions except for HHSC Family Planning services.

Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 2.3, "Reimbursement Reductions" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

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4.3.2.1 Medicare Crossover Claims Pricing

For Medicare Part B cost sharing obligations, all deductible obligations will be reimbursed at 100 percent of the deductible amount owed, even if the cost sharing comparison results in a lower payment. For all other cost sharing obligations (including Medicare Part A, B, and C), the cost sharing comparison is performed according to current guidelines.

For FQHC Medicare crossover claims, Texas Medicaid will reimburse the lesser of the following:

- The coinsurance and full deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service. If this amount is less than the deductible, then the full deductible is reimbursed instead.

If the Medicare payment is equal to, or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid will not make a payment for coinsurance.

The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

4.3.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

5 Local Health Department

Local Health Department (LHD) providers may be reimbursed for Medicaid services within their scope of practice.

The types of services LHD providers may render include, but are not limited to, the following:

- Dental
- Family planning
- Immunizations
- Laboratory
- Radiology
- Screening and treatment for sexually transmitted infections and infectious diseases
- Vaccines

LHD providers can refer to the applicable static Fee Schedules on the TMHP website at www.tmhp.com for a complete list of services that may be reimbursed to LHD providers.

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6 Maternity Service Clinic (MSC)

MSCs are limited provider clinics that are unrelated to a hospital and that only provide maternity services. An MSC will be reimbursed for antepartum care and/or postpartum care visits only. Hemoglobin, hematocrit and urinalysis procedures are included in the charge for antepartum care and not separately reimbursed. Services other than antepartum and postpartum care visits will be denied.

Refer to: Section 7, "Maternity Service Clinics (MSC)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

7 Renal Dialysis Facility

7.1 Enrollment

To enroll in Texas Medicaid, a renal dialysis facility must be Medicare-certified in the state where it is located. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information.

7.2 Services, Benefits, Limitations, and Prior Authorization

Renal dialysis is a benefit of Texas Medicaid for the following acute kidney injury (AKI) or end stage renal disease (ESRD) diagnosis codes:

Diagnosis Codes							
N170	N171	N172	N178	N179	N181	N182	N1830
N1831	N1832	N184	N185	N186	N189	N990	T795XXA
T795XXD	T795XXS						

All of the services, except for ultrafiltration (revenue code B-881), are diagnosis-restricted to the diagnoses in the above table.

Refer to: Subsection 9.2.51, "Organ/Tissue Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.2.5, "Organ and Tissue Transplant Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for information on organ transplant and facility services.

Dialysis treatments are a benefit for clients in an inpatient or outpatient hospital or a renal dialysis facility according to the guidelines for outpatient maintenance dialysis approved through CMS. Dialysis treatments may also be a benefit in the client's home. Outpatient dialysis includes:

- Staff-assisted dialysis performed by the staff of the center or facility.
- Self-dialysis performed by a client with or without professional assistance (the client must have completed an appropriate course of training).
- Home dialysis performed by an appropriately trained client (and the client's caregiver) at home.
- Dialysis furnished in a facility on an outpatient basis at an approved renal dialysis facility.

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7.2.1 Physician Supervision

Physician reimbursement for supervision of ESRD clients on dialysis is based on a monthly capitation payment (MCP) that is calculated by Medicare. The MCP is a comprehensive payment that covers all of the physician services that are associated with the continuing medical management of a maintenance dialysis client for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all places of service except inpatient hospital.

Physician supervision of outpatient ESRD dialysis includes services that are rendered by the attending physician during the course of an office visit which any of the following occur:

- Routine monitoring of dialysis
- Treatment or follow-up of complications of dialysis, including:
  - Evaluation of related diagnostic tests and procedures
  - Services that are involved in the prescription of therapy for illnesses that are unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts

The following physician services are a benefit for physician supervision of outpatient ESRD dialysis services:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970

Physician services (procedure codes 90935, 90937, 90945, and 90947) are a benefit for hemodialysis or other dialysis procedures and are restricted to diagnosis codes T795XXA, T795XXD, and T795XXS.

Procedure codes 90935, 90937, 90945, and 90947 are a benefit for:

- ESRD or non-ESRD services in the inpatient setting when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of dialysis procedure. These codes are not payable for a cursory visit by the physician. Hospital visit procedure codes must be used for a cursory visit.
- Non-ESRD services when provided by a physician, nurse practitioner, clinical nurse specialist, or physician assistant in an office or outpatient setting.

Only one of the following procedure codes 90935, 90937, 90945, or 90947 may be reimbursed per day by any provider.

If the physician sees the client only when the client is not dialyzing, the physician must submit the appropriate hospital visit procedure code. The inpatient dialysis procedure code must not be submitted for payment.

Providers must use one of the following procedure codes to submit claims for services when the client:

- Is not on home dialysis.
- Has had a complete assessment visit during the calendar month.
- Has received a full month of ESRD related services

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

When a full calendar month of ESRD-related services are submitted for clients on home dialysis, providers must use procedure code 90963, 90964, 90965, or 90966.

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Providers must submit claims with procedure code 90967, 90968, 90969, or 90970 if ESRD-related services are provided for less than a full month, per day, under the following conditions:

- Partial month during which a client who is not on home dialysis received one or more face-to-face visits but did not receive a complete assessment.
- A client who is 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 a client.
- Client received a kidney transplant.

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When submitting claims for these procedure codes, providers must indicate the dates of service on which supervision was provided.

Procedure codes 90967, 90968, 90969, and 90970 will be denied if they are submitted with dates of service in the same calendar month by any provider as the following procedure codes:

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

Only one of the procedure codes in the previous table will be reimbursed per calendar month by any provider.

The following services may be provided in conjunction with physician supervision of outpatient ESRD dialysis but are considered nonroutine and may be submitted for reimbursement separately.

- Declotting of shunts when performed by the physician.
- Physician services to inpatients.

If one of the following occurs:

- A client is hospitalized during a calendar month of ESRD-related services before a complete assessment is performed.
- The client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment.

Then the physician must submit both of the following:

- Procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision.
- The appropriate hospital evaluation and management code for individual services provided on the days during which the client was hospitalized.

If a client has a complete assessment in the month during which the client is hospitalized, one of the following procedure codes must be submitted for the month of supervision:

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

The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.

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- Dialysis at an outpatient facility other than the usual dialysis setting for a client of a physician who bills the MCP. The physician must submit procedure code 90967, 90968, 90969, or 90970 for each date on which supervision is provided. The physician may not submit claims for days that the client dialyzed elsewhere.
- 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. Physicians may submit claims 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.

Inpatient services that are provided to a hospitalized client for whom the physician has agreed to submit monthly claims, may be reimbursed in one of the following ways:

- The physician may elect to continue monthly billing, in which case the physician may not bill for individual services that were provided to the hospitalized client.
- The physician may reduce the monthly amount submitted by 1/30th for each day of hospitalization and may charge fees for individual services that were provided on the hospitalized days.
- The physician may submit a claim for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the client during the course of the dialysis.

Clients may receive dialysis at an outpatient facility other than the client's usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly amount submitted for reimbursement by 1/30th for each day the client is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client's renal condition may be reimbursed on a fee-for-service basis. The physician must provide medical documentation with the claim that identifies how the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the MCP for physician supervision rendered to maintenance facility clients.

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

For some medical situations in which ESRD clients cannot obtain their regularly scheduled dialysis treatment at a certified ESRD facility, Texas Medicaid will allow for non-routine dialysis treatments furnished in the outpatient department of a hospital that does not have a certified dialysis facility.

Unscheduled dialysis for clients may be a benefit for one of the following reasons:

- Dialysis was performed following, or in connection with, a vascular access procedure.
- Dialysis was performed following treatment for an unrelated medical emergency (e.g., a client goes to the emergency room and, as a result, misses a regularly scheduled dialysis treatment that cannot be rescheduled).
- Emergency dialysis was performed for clients who would otherwise have to be admitted as inpatient in order for the hospital to receive payment.

Providers must submit claims using procedure code G0257 with revenue code 880 in order to receive payment for unscheduled outpatient dialysis.

Procedure code G0257 will be limited to once per week, same procedure, any provider. Procedure code G0527 will be denied if not submitted with revenue code 880, same day, same claim, same provider.

Procedure code G0257 is limited to diagnosis codes N185 and N186.

Texas Medicaid will provide a single payment to reimburse unscheduled or emergency dialysis treatments furnished to ESRD clients in the outpatient department of a hospital that does not have a certified ESRD facility.

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Reimbursement for procedure code G0257 is limited to the same services included in consolidated billing. Providers will not be reimbursed for individual services related to dialysis.

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.

Other outpatient hospital services are only reimbursed if they are not related to the dialysis services and are determined to be medically necessary with supporting documentation.

7.2.2 Renal Dialysis Facilities - Consolidated Billing

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. The facility's charge must not include the charge for the physician's routine supervision.

One of the following revenue codes must be billed for the dialysis facility to receive the composite rate payment:

Revenue Code – Renal Dialysis Composite	Limitations
821	3 per week
831	3 per week
841	Hemodialysis (HD) – equivalent sessions
851	HD – equivalent sessions

The composite rate includes all of the following necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in the facility:

Procedure Codes – Durable Medical Equipment ESRD Supply							
36000	36430	36591	36593	49421	71045	71046	71047
71048	93005	93040	93041	A4215	A4216	A4217	A4218
A4244	A4245	A4246	A4247	A4248	A4450	A4452	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	A4728	A4730	A4736	A4737	A4740	A4750	A4755
A4760	A4765	A4766	A4770	A4771	A4772	A4773	A4774
A4802	A4860	A4870	A4890	A4911	A4913	A4918	A4927
A4928	A4929	A4930	A4931	A4932	A6204	A6215	A6216
A6250	A6260	A6402	E0210	E0424	E0431	E0434	E0439
E0441	E0442	E0443	E0444	E0447	E1500	E1510	E1520
E1530	E1540	E1550	1560	E1570	E1575	E1580	E1590
E1592	E1594	E1600	E1610	E1615	E1620	E1625	E1630
E1632	E1634	E1635	E1636	E1637	E1639	E1699	

DME ESRD supply (procedure code E1629) for necessary equipment, supplies, and services for the client receiving dialysis in the home are excluded from the composite rate and will be paid separately.

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Laboratory testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for the following routine laboratory tests are included in the facility's composite rate billed to Medicaid regardless of where tests were processed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by the renal dialysis facility unless they are an inclusive test.

Procedure Codes – Labs Subject to ESRD Consolidated Billing							
80047^	80048^	80051^	80053^	80069^	80076	82040^	82108
82306	82310^	82330^	82374^	82379	82435^	82565^	82570^
82575	82607	82610	82652	82668	82728	82746	83540
83550	83735	83970	84075^	84100	84132^	84134	84155^
84157	84295^	84466	84520^	84540	84545	85014^	85018^
85025^	85027	85041	85044	85045	85046	85048	86704
86705	86706	87040	87070	87071	87073	87075	87076
87077	87081	87340	87341	87467	G0306	G0307	G0499
QW^ Modifier							

All drugs and biologicals used for the treatment of ESRD or AKI (unless specified otherwise) are included in the composite rate payment and are not paid separately, the following drugs are included:

Procedure Codes									
A4216	A4217	A4802	J0360	J0604	J0612	J0613	J0616	J0618	J0620
J0630	J0670	J0878	J0884	J0892	J0895	J0899	J0945	J1160	J1200
J1205	J1240	J1265	J1270	J1643	J1644	J1720	J1740	J1750	J1800
J1938	J1955	J2151	J2360	J2430	J2501	J2720	J2795	J2993	J2997
J3265	J3373	J3410	J3420	J3480	J3489	J7030	J7040	J7042	J7050
J7060	J7070	J7120	J7131	Q0163					

The following drugs used for the treatment of ESRD are excluded from the composite rate and will be paid separately:

Procedure Codes – Drugs Not Subject to ESRD Consolidated Billing									
J0879	J0882	J1439	J1756	J2916	Q4081	Q5105			

In addition to the diagnosis codes listed in the table of section 6.2, "Services, Benefits, Limitations, and Prior Authorization," procedure code J0879 is restricted to diagnosis code L2989, and procedure code Q5105 is restricted to diagnosis code D631.

Other drugs and biologicals furnished by an ESRD facility that are not used for the treatment of ESRD may be billed separately.

The ordering physician must maintain documentation in the client's medical record to support medical necessity.

Maintenance for Hemodialysis, IPD, CAPD, and CCPD

End Stage Renal Disease facilities furnishing dialysis treatments in-facility are paid for up to three treatments per week. ESRD facilities treating patients at home, regardless of modality, receive payment for three hemodialysis equivalent treatments per week.

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Maintenance intermittent peritoneal dialysis (IPD) is usually performed in sessions of 10 to 12 hours duration, three times per week. However, it is sometimes performed in fewer sessions of longer duration. If more than three sessions occur in one week, the provider must supply documentation of medical necessity with the claim.

For clients undergoing CAPD or CCPD in the home, the number of days of peritoneal dialysis, regardless of dialysate exchanges performed each day, is converted to hemodialysis-equivalent sessions. This is accomplished by dividing the number of days of peritoneal dialysis by 7 and multiplying the result by 3.

For clients undergoing CAPD or CCPD in the home, the number of days of peritoneal dialysis regardless of dialysate exchange performed each day will be 14 per 31 days.

A combination of HD, IPD, CAPD, and CCPD dialysis treatments are limited to 14 sessions within 31 days for any provider. If more than 14 sessions are needed, the provider must supply documentation of medical necessity with the claim. Documentation can include but is not limited to medical records, physicians' notes, and lab results. Records must clearly show why extra sessions are medically required.

The ordering physician must maintain documentation supporting medical necessity in the client's medical record.

7.2.3 Ultrafiltration

A separate ultrafiltration treatment to remove the excess fluid may be covered.

Ultrafiltration is performed on a day other than the day of a dialysis treatment. The dialysis facility must document in the medical record why the ultrafiltration could not have been performed at the time of dialysis treatment. Ultrafiltration performed on the same day as the dialysis treatment, is not separately reimbursed.

Ultrafiltration may be reimbursed using revenue code 881 up to a maximum of 3 times per week.

7.2.4 Home Dialysis Items and Services

Texas Medicaid utilizes Medicare's composite rate reimbursement system, consolidated billing. Under this reimbursement system, the dialysis facility must assume responsibility for providing all home dialysis equipment, supplies, and home support services.

One of the following revenue codes must be billed for the dialysis facility to receive the composite rate payment for clients that are treated in the home:

Revenue Code	Limitations
821	3 per week
831	3 per week
841	Hemodialysis (HD) – equivalent sessions
851	HD – equivalent sessions

Support services are included in the composite rate. Support services specifically applicable to home clients include, but are not limited to:

- Periodic monitoring of a client's adaptation to home dialysis and performance of dialysis, including provisions for visits to the home or the facility.
- Visits by trained personnel for the client with a qualified social worker and a qualified dietitian, made in accordance with a plan prepared and periodically reviewed by a professional team, which includes the physician.
- Individual unscheduled visits to a facility made on an as-needed basis; (e.g., assistance with difficult access situations).

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- ESRD-related laboratory tests covered under the composite rate.
- Providing, installing, repairing, testing, and maintaining home dialysis equipment, including appropriate water testing and treatment.
- Ordering of supplies on an ongoing basis.
- A record keeping system that assures continuity of care.
- Support services specifically applicable to chronic ambulatory peritoneal dialysis (CAPD) also include, but are not limited to:
  - Changing the connecting tube and administration set.
  - Monitoring the client's performance of CAPD, assuring that it is done correctly, and reviewing proper techniques with the client or informing the client of modifications to apparatus or technique.
  - Documenting whether the client has or has had peritonitis that requires physician intervention or hospitalization (unless there is evidence of peritonitis, a culture for peritonitis is not necessary).
  - Inspecting the catheter site.

Routine laboratory services listed in the table of section 6.2.2, Renal Dialysis - Consolidated Billing are included in the composite rate and are not reimbursed separately.

Equipment and supplies are listed in the table of section 6.2.2, Renal Dialysis - Consolidated Billing are included in the composite rate and are not reimbursed separately.

Installation and repair of home hemodialysis machines are not a benefit of Texas Medicaid. Home modifications for use of medical equipment are not a benefit of Texas Medicaid.

Clients may have a one month reserve of supplies available for use. Renal dialysis services beyond these limitations may be considered for clients who are 20 years of age and younger through the Comprehensive Care Program (CCP) with prior authorization.

7.2.5 Facility Revenue Codes

Under consolidated billing, the following services are a benefit for renal dialysis centers:

Service	Revenue Code	Description
Maintenance	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
Training	829	Hemodialysis (outpatient/home)–other
	839	Peritoneal Dialysis (outpatient/home)–other
	849	CAPD (outpatient/home)–other
	859	CCPD (outpatient/home)–other
Miscellaneous	881	Miscellaneous dialysis–ultrafiltration

Renal dialysis facilities should not use a HCPCS/CPT code when submitting a claim with a revenue code.

The facility charge must not include the charge for the physician's routine supervision.

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7.2.6 Training for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycle Peritoneal Dialysis (CCPD), and Chronic Ambulatory Peritoneal Dialysis (CAPD)

Most self-dialysis training for hemodialysis, IPD, CCPD, and CAPD is provided in an outpatient setting. Dialysis training provided in an inpatient setting will be reimbursed at the same rate as the facility's outpatient training rate.

Reimbursement for hemodialysis, IPD, CCPD, and CAPD training services and supplies provided by the dialysis facility includes personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine dialysis laboratory tests.

It may be necessary to supplement the patient's dialysis during CAPD training with intermittent peritoneal dialysis or hemodialysis because the client has not mastered the CAPD technique.

Training is limited to once per day. The composite rate will be denied as part of dialysis training when submitted for the same date of service.

The following revenue codes may be reimbursed for dialysis training:

Revenue Code	Limitations
829	18 sessions per lifetime
839	18 sessions per lifetime
849	18 sessions per lifetime
859	18 sessions per lifetime

Revenue codes 829, 839, 849, and 859 are limited to one per day, any procedure, any provider.

7.2.7 Laboratory and Radiology Services

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Laboratory and radiology testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for routine laboratory and radiology tests in tables of section 6.2.2 Renal Dialysis - Consolidated Billing are included in the facility's composite rate submitted to Texas Medicaid regardless of where tests were processed.

7.2.7.1 Hematopoietic Injections

Medicaid reimbursement is allowed for hematopoietic injections that are administered to clients who have anemia that is associated with chronic renal failure.

Providers must submit the client's most recent dated hemoglobin or hematocrit levels in the comments section of the claim form when billing with procedure code Q4081. Frequency and quantity limitations apply.

Refer to: The *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about benefit and limitation criteria.

7.2.7.2 Blood Transfusions

Whole blood (procedure codes P9010 and P9011) for transfusions may be reimbursed separately to dialysis facilities when medically indicated for a Medicaid eligible client.

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7.2.8 Telemedicine and Telehealth Services

Certain telemedicine and telehealth services may be provided for ESRD clients if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interactions, such as an in-person visit.

Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided.

The following ESRD dialysis services are authorized for telemedicine and telehealth delivery using synchronous audiovisual technology:

Procedure Codes							
90951	90952	90954	90955	90957	90958	90960	90961

Services provided by synchronous audio-visual technology must be billed using modifier 95.

During a Declaration of State of Disaster, the Texas Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

7.2.9 Vaccine Services for Renal Dialysis Facilities

The following procedure codes may be reimbursed to renal dialysis facility providers:

Category	Procedure Codes
COVID-19 vaccine	91320, 91322
Hepatitis B immune globulin	90371, J1571, J1573
Hepatitis B vaccine for immunocompromised/ dialysis patients	90740, 90747
Influenza vaccine	90653, 90655, 90656, 90657, 90658, 90661, 90662, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90756
Pneumococcal vaccine	90670, 90671, 90677, 90684, 90732
Vaccine administration	90460, 90471, 90472, 90480
Vaccine counseling	G0315

7.2.10 Prior Authorization

Prior authorization is not required for renal dialysis services. Prior authorization must be obtained for transplant-related services provided to clients who are not eligible for Medicare and are eligible only for Medicaid.

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7.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including renal dialysis services. Renal dialysis services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement. All physicians', renal dialysis centers', and medical suppliers' supporting documentation is subject to retrospective review.

7.4 Claims Filing and Reimbursement

7.4.1 Claims Information

Renal dialysis facility services must be submitted to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a UB-04 CMS-1450 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.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Reminder: *The original onset date must be included on the claim form to prevent claim denial. The original onset date must be the same date entered on Form CMS-2728 sent to the Social Security office.*

7.4.2 Reimbursement

Renal dialysis facilities are reimbursed according to composite rates, which are based on the CMS-specified calculations and the Texas Medicaid Reimbursement Methodology (TMRM). Texas Medicaid may reimburse for dialysis services by consolidated billing as defined by CMS.

All required items and services included under the composite rate must be made available by the facility, either directly or under arrangements, for each client.

Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Refer to: Section 2.2, "Fee-for-Service Reimbursement Methodology" for more information about reimbursement.

7.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

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7.5 Medicare and Medicaid

Medicaid coverage of a renal dialysis client who may be eligible for Medicare coverage begins with the original onset date of the dialysis treatments and may continue for a period of three months. During this period, Medicare eligibility is reviewed through the Health and Human Services Commission (HHSC). If HHSC determines that the client is Medicare-eligible, Medicaid coverage begins with the original onset date and continues until Medicare coverage begins.

If HHSC determines that the client is not eligible for Medicare, Medicaid coverage of eligible clients begins with the original onset date and continues as long as the dialysis treatments are medically necessary and the client is eligible for Medicaid. The date of onset is the date of the first dialysis treatment and does not change even if the client sees another provider.

Medicare eligibility usually begins after a three-month waiting period has been served. Medicare eligibility begins before the waiting period has expired if the individual receives a transplant or participates in a self-dialysis training program during the waiting period.

7.5.1 Facility Providers

Texas Medicaid pays the Medicare coinsurance less 5 percent and full Medicare deductible for Medicare crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers.

Texas Medicaid processes ESRD Medicare claims using the Part B Immunosuppressive Drug (Part B-ID) benefit for the reimbursement of immunosuppressive drugs for ESRD Medicare clients who have lost Part A and Part B Medicare coverage.

7.5.2 Physician Providers

The five percent reduction does not apply to physician-billed services. Nephrologists that are enrolled in Texas Medicaid as physician providers may be reimbursed according to the current payment guidelines.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for additional information about Medicare coinsurance and deductible reimbursement for professional and outpatient services.

8 Rural Health Clinic

8.1 Enrollment

To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. An NPI is issued to the RHC after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation. An RHC can also apply for enrollment as a family planning agency.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA are not reimbursed for laboratory services.

8.1.1 Initial Cost Reporting

New RHCs must file a projected cost report within 90 days of their designation as an RHC to establish an initial payment rate. The cost report will contain the RHC's reasonable costs anticipated to be incurred during the RHC's first full fiscal year. The projected cost report must contain a minimum of six months of information. The RHC must file a cost report within five months of the end of the RHC's initial fiscal year. The cost settlement must be completed within six months of the receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases or decreases shall be calculated as provided herein. A new RHC location established by an

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existing RHC participating in Texas Medicaid will receive the same effective rate as the RHC establishing the new location. An RHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

Providers must submit initial cost reports to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Providers can refer to 1 TAC §355.8101 for more information about reimbursement.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

8.2 Services, Benefits, Limitations, and Prior Authorization

8.2.1 Services Rendered by the RHC Facility Provider

General services and copayments are billed using the RHC's NPI. All other services billed using the RHC's NPI are processed as informational only.

Important: *If an RHC facility provider submits a claim for THSteps and Family Planning services, the services will process as informational only and will not be reimbursed.*

The following services are benefits of Texas Medicaid when provided in an RHC:

- Physician services
- Services and supplies furnished as incidental to physician services
- Services provided by an NP, CNM, LCSW, LMFT, LPC, or a PA's services
- Services and supplies furnished as incidental to the NP's or PA's services
- Visiting nurse services on a part-time or intermittent basis to homebound clients in areas determined to have a shortage of home health agencies (A homebound client is someone who is permanently or temporarily confined to his place of residence, not including a hospital or skilled nursing facility (SNF), because of a medical condition.)

When an RHC bills for visiting nurse services, the written plan of treatment to be used for the visiting nurse must be developed by the RHC supervising physician. It must be approved and ordered by the client's treating physician if different from the supervising physician. The plan of treatment must be reviewed and approved by the supervising physician of the clinic at least every 60 days.

A *visit* is a face-to-face encounter between an RHC client and a physician, PA, NP, CNM, visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The RHC client has a medical visit and an *other* health visit.

An *other* health visit includes, but is not limited to, a face-to-face encounter between an RHC client and an LCSW, LMFT, or LPC.

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For freestanding RHCs, all laboratory services provided in the RHC's laboratory are included in the encounter. This includes the basic laboratory tests as well as any other laboratory tests provided in the RHC laboratory. Consequently, there is no separate billing for laboratory services. However, if the RHC laboratory becomes a certified Medicare laboratory with its own supplier number, and enrolls in Medicaid as an independent laboratory, all laboratory tests (except the basic laboratory tests) performed for RHC and non-RHC clients can be billed to Medicaid. The claim must be filed under their independent laboratory NPI and using the appropriate HCPCS codes.

Refer to: The Medicare website at www.cms.gov for more information about Medicare RHC laboratory requirements.

8.2.1.1 Encounter Rates

An encounter rate may be reimbursed to the RHC facility only for the following services:

General Medical Services (encounter may be reimbursed to the RHC facility only)
T1015
General medical services must be submitted using one of the appropriate modifiers AJ, AM, SA, TD, TE, U1, U2, or U7. Adult preventative care must be submitted with diagnosis codes Z0000, Z0001, Z01411, and Z01419.

Note: *If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to clarify the service that was performed.*

8.2.1.2 Medicaid Fee-for-Service Reimbursement Rates

The following copayments may be reimbursed to RHC providers billing under their own NPI, and are reimbursed at the Medicaid fee-for-service rate.

Copayments									
CP001	CP002	CP005	CP006						

8.2.1.3 Freestanding Rural Health Clinic Services

The following services cannot be reimbursed to freestanding RHCs using only the RHC NPI. Use of the RHC NPI for billing these services causes claims to be processed as informational only. Services in any of these categories must be billed using the professional (non-RHC) NPI and the appropriate benefit code:

- THSteps medical checkups, which includes immunizations
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)

These services must be billed with an AM, SA, or U7 modifier.

Physician supplies are not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits. Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician NPI.

Exception: *If later in the same day the client suffers an additional illness or injury requiring diagnosis or treatment, the clinic may submit a claim for a second visit.*

Freestanding RHCs submit an all-inclusive encounter for services provided. All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. A claim for these services may not be submitted as a separate encounter.

If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be identified on the claim. These procedure codes are informational only, and are not payable.

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All services provided during a freestanding RHC encounter must be submitted using procedure code T1015. The total submitted amount should be the combined charges for all services provided during that encounter.

One of the following modifiers must be reported with procedure code T1015 to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, U1, U2, or U7. If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to designate the health-care professional providing the service.

Reminder: *The primary initial contact is defined as "the health-care professional who spends the greatest amount of time with the client during that encounter."*

If more than one health-care professional is seen during the encounter, the modifier (if appropriate) must indicate the primary contact. For example, if an NP or a PA performs an antepartum exam, modifiers SA or U7, and TH, must be entered. A maximum of two modifiers may be reported with each encounter.

Providers who render services in an RHC setting for THSteps Medical services or Family Planning services may be reimbursed an encounter rate.

THSteps Medical Services

RHC facility providers may be reimbursed for THSteps medical services using their RHC NPI with the appropriate benefit code.

If the appropriate benefit code is not included, the service will process as informational only and will not be reimbursed.

THSteps Medical Services									
99381	99382	99383	99384	99385	99391	99392	99393	99394	99395
THSteps medical services must be billed using one of the following modifiers: AM, SA, or U7.									

8.2.1.4 Family Planning Services

RHC facility providers may be reimbursed for family planning services using their RHC NPI with the appropriate benefit code.

If the appropriate benefit code is not included, the service will process as informational only and will not be reimbursed.

Family planning services must be submitted with the most appropriate evaluation and management (E/M) procedure code and the most appropriate family planning diagnosis code:

Family Planning Services*									
99202	99203	99204	99205	99211	99212	99213	99214	99215	J7296
J7297	J7298	J7300	J7301	J7307					
*** Family planning services performed in the RHC setting must be billed with the appropriate modifier: AM, SA, or U7.**									

RHC providers may receive an encounter rate when submitting claims with procedure code T1015, in addition to a flat "add on" fee for the Long-Acting Reversible Contraception (LARC) procedure codes listed above.

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Refer to: Subsection 4.1.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

Subsection 6.3.5, "Modifiers" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for a definition of modifiers.

Section 9, "Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 8.8.2.2, "HMO Copayments" in "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for information about HMO copayments.

Subsection 9.2.60.4.2, "Preventive Care Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

8.2.2 Services Rendered by Non-RHC Providers In An RHC Setting

Non-RHC providers (i.e., physicians and non-physician practitioners) submitting claims for THSteps and Family Planning services in the RHC setting must use their own NPI and the appropriate benefit code.

The following services, when rendered in an RHC setting by a non-RHC provider, will process as an encounter and will be reimbursed to the non-RHC provider as an encounter rate equivalent to the host facility:

- THSteps medical services
- Family planning services

Non-RHC providers rendering services in an RHC setting must use the appropriate national place of service (72) in order for claims to process as encounters.

8.2.3 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate. One of the following modifiers must be submitted for general medical services: AH, AJ, AM, SA, TD, TE, U1, U2, or U7.

The following services must be submitted using the National Provider Identifier (NPI) and the appropriate benefit code:

- THSteps medical checkups
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations provided in hospital-based RHCs

Note: *Refer to the tables in the above sections for procedure codes.*

These services must be submitted with an AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the PPS reimbursement methodology.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be submitted using the individual or group physician NPI. Hospital-based RHCs must submit claims for pneumococcal and influenza vaccines as non-RHC services, under their hospital NPI.

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8.2.3.1 After-Hours Care

After-hours care for RHCs is defined as care provided on weekends, federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday.

8.3 Prior Authorization

Prior authorization or authorization is not required for RHC services.

8.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including RHC services. RHC services are subject to retrospective review and recoupment if documentation does not support the service billed.

8.4.1 Record Retention

Freestanding RHCs must retain their records for a minimum of six years. Hospital-based RHCs must retain their records for a minimum of ten years.

8.5 Claims Filing and Reimbursement

8.5.1 Claims Information

General services and copayments are billed using the RHC's NPI. For all other services, providers must submit claims using their NPI and the appropriate benefit code.

Refer to: Subsection 9.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

Place of service 72 must be used on all claims when billing for services other than general medical. Benefit code EP1 must be used on claims for THSteps medical services.

Freestanding and hospital-based RHC services must be submitted to TMHP in an approved electronic format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

8.5.2 Reimbursement

Freestanding and hospital-based RHCs are reimbursed provider-specific per visit rates calculated in accordance with 1 TAC §355.8101. Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

8.5.2.1 Medicare Crossover Claims Pricing

For Medicare Part B cost sharing obligations, all deductible obligations will be reimbursed at 100 percent of the deductible amount owed, even if the cost sharing comparison results in a lower payment. For all other cost sharing obligations (including Medicare Part A, B, and C), the cost sharing comparison is performed according to current guidelines.

For RHC Medicare crossover claims, Texas Medicaid will reimburse the lesser of the following:

- The coinsurance and full deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service. If this amount is less than the deductible, then the full deductible is reimbursed instead.

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If the Medicare payment is equal to, or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid will not make a payment for coinsurance.

The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

8.5.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

9 Tuberculosis Services

TB clinics must be enrolled in Texas Medicaid and provide services in accordance with 1 TAC, §354.1371.

9.1 Enrollment

To enroll in Texas Medicaid as a tuberculosis (TB) clinic, the applicant must:

- Be a facility that is not an administrative, organizational, or financial part of a hospital.
- Be organizationally structured and operated to provide outpatient clinical care TB services and perform public health response TB activities.
- Have a letter verifying their TB services from the Texas Department of Health Services (DSHS) Tuberculosis and Hansen's Disease Section (TB Section). Examples of eligible TB clinics include local health departments funded by DSHS as a provider of TB clinic services.
- Employ or have a formal arrangement with a licensed physician (MD or DO) who assumes professional responsibility for the services provided to the clinic's clients.

Providers of TB-related clinic services must complete a provider application from the Texas Department of State Health Services (TX DSHS) Tuberculosis (TB) and Hansen's Disease Unit (TB Unit). Per Texas DSHS policy, TB clinics must develop and operate under a set of written policies and procedures that specify the criteria for licensed and non-licensed staff to provide services. The policies and procedures must include the following:

- The personnel file requirements for staff who provide directly observed therapy (DOT).
- The training and supervision that are required for outreach workers to be considered qualified to perform the assigned services.
- The written delegation protocol for services that are not performed by a physician, advanced practice registered nurse (APRN), or PA.
- The documentation that is required for all client encounters.

Once approved by DSHS, providers of TB-related clinic services are eligible to enroll using the Provider Enrollment and Management System (PEMS).

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Providers must obtain a group or individual NPI through the National Plan and Provider Enumeration System (NPPES). Providers that list additional (satellite) clinics in the DSHS TB Unit provider application will receive a different NPI for each location from NPPES. Enrollment as a Medicaid provider is not complete until enrollment has been finalized through PEMS.

The effective date for participation is the date an approved provider application with the TB Unit is established.

To receive a TB Unit provider application form or provider supplement, send a request to the following email address: tb.feedback@dshs.texas.gov

Providers can access the TB application online through the following link: TBMedicaidApplication.pdf

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures related to the TMHP Medicaid enrollment applications.

9.1.1 Managed Care Program Enrollment

TB clinics do not need to enroll with the Medicaid managed care health plans. All services provided by TB clinics are submitted to TMHP for all Medicaid clients, including Medicaid managed care clients.

9.2 Services, Benefits, Limitations, and Prior Authorization

The level of service provided varies depending on whether the services are delivered by a nonphysician or physician and if medications are prescribed.

9.2.1 TB-Related Clinic Services

The following services may be performed by a physician, APRN, or PA in the TB clinic:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

A physician's presence is not required to perform procedure code 99211; however, the physician must provide direct supervision by being present in the clinic and immediately available to furnish assistance and direction at the time service is provided.

Before TB treatment can be initiated, an initial screening (procedure code T1023) by an RN, LPN, or LVN, or a new patient physician E/M visit (procedure code 99202, 99203, 99204, or 99205) must be performed. If the treatment is initiated by a nursing screening, a new patient physician E/M visit must be completed within 90 days, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

Following the initial new patient physician E/M visit, an established patient physician E/M visit (procedure code 99212, 99213, 99214, or 99215) must be billed every 90 days throughout the course of treatment, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

Clients with latent TB infection, including those in a high-risk group (children who are 4 years of age and younger, those who are immunocompromised, and clients who are HIV-positive), and those with active TB disease, must be seen by a physician every 90 days throughout the course of treatment.

A physician must evaluate each client with active TB disease or LTBI prior to discharge from TB treatment.

Procedure codes H0033, T1002, T1003, and T1023 may be provided under established clinic protocols.

The initial TB screening (procedure code T1023), performed by an RN, LPN, or LVN includes, but is not limited to the following:

- Brief mental and physical assessment

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- Exposure history
- Referral for lab or X-ray per protocol
- Referral for social or other medical services
- Other assessment

Procedure code T1023 may be reimbursed prior to the client being seen by a physician, and no more often than once per 12 months. One RN or LVN/LPN (procedure codes T1023, T1002, and T1003) service may be reimbursed per day, per client, when physician services are not performed.

Subsequent nursing services (Procedure code T1002 and T1003) may be a benefit when not provided the same day as a physician E/M visit.

Reimbursement for DOT services (procedure code H0033) provided in the clinic or other places of service, excluding inpatient hospitals, SNFs, intermediate care facilities (ICFs), outpatient hospitals, independent laboratories, birthing centers, and extended care facilities will be limited to one per day, and a maximum of five per week, per client, throughout the course of treatment.

Procedure codes T1002 and T1003 are limited to a maximum of eight 15-minute units per day, per client.

- Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day.
- If the total number of minutes of nursing services per procedure code is less than 8 minutes for a calendar day, then no unit of service can be billed for that day. The minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.
- If more than 1 unit of service is billed, every unit except the last must be for the complete 15 minutes, with the last unit being no less than 8 minutes of nursing service.
- Time spent in contact investigations in not reimbursable.

Reimbursement for new client examinations (procedure code 99202, 99203, 99204, and 99205) are limited to new clients who have not received services in the same clinic for a period of three years.

One established E/M service may be reimbursed per day, per client, same provider.

Refer to: Subsection 9.2.60.1.1, "New and Established Patient Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about established patient E/M services.

9.2.2 Ancillary Services

The following ancillary TB services are a benefit of Texas Medicaid:

Procedure Codes									
71045	71046	71047	71048	81025*	86580	86701^	86703	89220	96365
96366	96367	96368	96374	96375	99000	99001	J0278	J1834	J1956
J2020**	J2280**	J3000**							
*** CLIA waived test** **^ Must be billed with QW modifier** **** Must be billed with KX modifier when oral formulation is not appropriate for the client**									

Procedure code 99000 is limited to specimens transported from the office setting.

Procedure code 99001 is limited to specimens transported from any setting except the office.

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Certain injectable TB medications (procedure codes J2020, J2280, and J3000), which also have an oral formulation, must be billed with modifier KX to indicate that the oral formulation is not appropriate for the client.

All drugs for which Medicaid is billed must have been purchased by the TB clinic. In the event that the clinic received the drug at no cost through DSHS or another source, it cannot be billed to Texas Medicaid. All medication claims are subject to retrospective review.

Lab-handling charges (procedure codes 99000 and 99001) is limited to one per day for each client unless specimens are sent to two or more different laboratories. If specimens are sent to two or more different laboratories, the information must be documented on the claim.

Handling or conveyance of a specimen from the patient in the clinic to a laboratory (procedure code 99000) will be reimbursed only when submitted with one of the following professional or nursing services performed on the same date of service. Prior authorization is not required for procedure code 99000 or 99001.

Procedure Codes									
99202	99203	99204	99205	99211	99212	99213	99214	99215	T1002
T1003*	T1023								
* Reimbursed for individual or group TB clinics for services rendered in the home or other setting.									

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The TMHP website Required CLIA Lab Certifications web page at www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

9.2.3 Prior Authorization

Prior authorization is not required for TB-related services.

9.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including TB services. TB services are subject to retrospective review and recoupment if documentation does not support the service billed.

9.4 Provider Responsibilities

If approved to submit claims as a TB clinic under Texas Medicaid, the provider must adhere to the following requirements:

- Be a facility that is not an administrative, organizational, or financial part of a hospital, but is organized and operated to provide medical care to outpatients.
- Comply with all applicable federal, state, and local laws and regulations.
- Employ or have a contract or formal arrangement with a licensed physician (M.D. or D.O.) who is responsible for providing medical direction and supervision over all services provided to the clinic's clients. To meet this requirement, a physician must see the client at least once every 90 days to prescribe the type of care provided and, if the services are not limited by the prescription, periodically review the need for continued care.
- Adhere to the guidelines issued by HHSC, under the authority of the Texas Health and Safety Code, and ensure that services are consistent with the recommendations of the American Thoracic Society and the Centers for Disease Control and Prevention (CDC). For more information, visit the website at www.cdc.gov/tb/index.html.

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- Maintain complete and accurate medical records of each recipient's care and treatment and accurately document all services provided and the medical necessity for the services.
- Ensure that services provided to each client are commensurate with the client's medical needs based on the client's assessment or evaluation, diagnostic studies, plan of care, and physician direction. These services must be documented in the client's medical records.
- Be enrolled and approved for participation in Texas Medicaid.
- Sign a written provider agreement with HHSC or its designee. By signing the agreement, the provider of TB-related clinic services agrees to comply with the terms of the agreement and all requirements of Texas Medicaid including regulations, rules, handbooks, standards, and guidelines published by HHSC or its designee.
- Submit claims for services covered by Texas Medicaid in the manner and format prescribed by HHSC or its designee.
- Be organized and operated to provide TB-related services, which include, but are not limited to, the covered services as indicated in subsection 9.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.
- Not provide services within an SNF, ICF, or intermediate care facility for persons with intellectual disability (ICF-ID)

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information.

9.5 Claims Filing and Reimbursement

9.5.1 Claims Information

TB-related clinic services must use benefit code TB1 on all claims and authorization requests. All TB-related clinic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply them. 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.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

9.5.1.1 Managed Care Clients

TB-related services are carved out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients, but are administered by TMHP and not the client's MCO.

9.5.2 Reimbursement

The Medicaid reimbursement rates for TB clinics are calculated in accordance with 1 TAC §355.8085.

X-ray services are reimbursed in accordance with 1 TAC §355.8085 and are listed in the current physician fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules

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include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

9.5.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the *Texas Medicaid Provider Procedures Manual*. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

10 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
American Dental Association (ADA) Dental Claim Filing Instructions	Subsection 6.7, "American Dental Association (ADA) Dental Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
Tuberculosis Screening and Guidelines	Subsection A.5, "Tuberculosis Screening and Guidelines" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

11 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

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12 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Federally Qualified Health Center Affiliation Affidavit
Hospital Report (Newborn Child or Children) (Form 7484)

13 Claim Form Examples

Claim Form Examples
Birthing Center
2017 Claim Form
Family Planning Services for Hospitals, FQHCs
FQHC Encounter (T1015)
FQHC Follow-Up
Renal Dialysis Facility CAPD Training
Renal Dialysis Facility CAPD/CCPD
Renal Dialysis CMS-1500 Example
Rural Health Clinic Freestanding
Rural Health Clinic Freestanding (Immunization)
Rural Health Clinic Hospital-Based
Tuberculosis

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Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

November 2026

TEXAS
Health and Human Services

DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND NUTRITIONAL PRODUCTS

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1 General Information

The information in this handbook is intended for Texas Medicaid durable medical equipment (DME) supplier and medical supply company providers. This handbook provides information about the Texas Medicaid benefits, policies, and procedures that are applicable to these providers.

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Texas Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.7.1.2, "Reporting Child Abuse or Neglect" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay, and are related to the inpatient hospital admission, will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

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2 Texas Medicaid (Title XIX) Home Health Services

2.1 Enrollment

All DME providers must be Medicare-certified before applying for enrollment in Texas Medicaid.

Providers that render custom DME wheeled mobility systems to Texas Medicaid clients must enroll in Texas Medicaid as a specialized/custom wheeled mobility group provider and must have at least one qualified rehabilitation professional (QRP) performing provider.

Certified QRP providers must enroll in Texas Medicaid as performing providers under DME provider groups.

To enroll in Texas Medicaid as a QRP performing provider, individual professionals must be certified by the National Registry of Rehabilitation Technology Suppliers (NRRTS) or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) and must enroll as a performing provider under a Specialized /Custom Wheeled Mobility group.

Providers can use the online Provider Enrollment and Management System (PEMS) tool to enroll electronically through the TMHP website at www.tmhp.com.

Providers may request prior authorization for home health services by contacting:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

2.1.1 Pending Agency Certification

DME providers that submit claims before the enrollment process is complete or without prior authorization for services issued by the TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is the date on which all Medicaid provider enrollment forms have been received and approved by TMHP.

Upon the receipt of notice of Medicaid enrollment, the supplier must contact the TMHP Home Health Services Prior Authorization Department before rendering to a Medicaid client, services that require a prior authorization number. Prior authorization cannot be issued before Medicaid enrollment has been completed. Regular prior authorization procedures are followed at that time.

Providers must not submit home health services claims for payment until they have received their Medicaid certification and a prior authorization number has been assigned.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

2.1.2 Surety Bond Requirements

All newly enrolling and re-enrolling durable medical equipment (DME) providers must, as a condition of enrollment and continued participation into Texas Medicaid, obtain a surety bond that complies with Title 1, Texas Administrative Code (TAC) §352.15.

Important: *Surety bonds obtained for the purpose of accreditation in the Medicare program, which lists the Centers for Medicare & Medicaid Services (CMS) as obligee, do not fulfill the surety bond requirement for Texas Medicaid.*

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The surety bond submitted to Texas Medicaid must meet the following requirements:

- A bond in an amount of no less than $50,000 must be provided for each enrolled location.

  Note: *Only one surety bond is required if the provider has multiple Medicaid DME provider numbers related to the same location. For example, if the provider has an enrollment record for DME and an enrollment record for Specialized Custom Wheeled Mobility all for the same practice location, only one surety bond is required.*

- The bond must be submitted on the State of Texas Medicaid Provider Surety Bond Form. No other form will be accepted. The use of this form designates the Health and Human Services Commission (HHSC) as the sole obligee of the bond. Instructions are included with the form.
- The bond must be issued for a term of 12 months. Bonds for longer or shorter terms are not acceptable.
- The bond must be in effect on the date that the provider enrollment application is submitted to TMHP for consideration. The effective date stated on the bond must be:
  - No later than the date that the provider enrollment application is submitted.
  - No earlier than 12 months before the date that the provider enrollment application is submitted.
- The bond must be a continuous bond. A continuous bond remains in full force and effect from term to term unless the bond is canceled.

Important: *An annual bond that specifies effective and expiration dates for the bond, is not acceptable.*

At the time of enrollment or re-enrollment, providers must submit the surety bond form with original signatures and a copy of the Power of Attorney document from the surety company that issued the bond.

Note: *Surety companies may refer to Texas Department of Insurance (TDI) file #9212562912 or TDI link #132456 when filing the bond.*

2.1.2.1 Proof of Continuation

DME providers must maintain a current surety bond to continue participation in Texas Medicaid. Each year, providers must submit documentation that shows proof of continuation of the bond for a new 12-month term. The document may be submitted on the surety bond company's form and must include the following components:

- Bond number
- Principal's name, address, and Tax ID or National Provider Identifier (NPI)
- Surety's company name and address
- Date of the original bond
- New "good through" date

To avoid losing Medicaid enrollment status, providers must submit the proof of continuation to the TMHP Provider Enrollment before the expiration date of the bond that is currently on file. The completed proof of continuation document must include the original signatures of the authorized corporate representative of the DME provider (principal), and the attorney-in-fact of the surety company. Providers may submit a copy of the proof of continuation (i.e., scan, FAX, photocopy) pending the submission of the original document.

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Submission Information

The surety bond can be submitted using the Provider Enrollment and Management System (PEMS).

2.2 Services, Benefits, Limitations and Prior Authorization

Home health services include home health skilled nursing (SN), home health aide (HHA), physical therapy (PT) and occupational therapy (OT) services; DME; and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about therapy services.

The *Home Health Nursing and Private Duty Nursing Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about nursing services.

2.2.1 Home Health Services

The benefit period for home health professional services is up to 60 days with a current plan of care (POC). For all DME and medical supplies with or without prior authorization requirements, providers must complete a Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form except as outlined in subsection 2.2.12, "Diabetic Equipment and Supplies" in this handbook. In chronic and stable situations, the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form is valid for up to, but no more than, 6 months from the date of the physician or allowed practitioner's signature on the form, unless otherwise noted in this handbook. If necessary, DME and supplies that are ordered on a Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form may be prior authorized for up to 6 months with medical necessity determination. Because Medicaid clients have a one-month eligibility period, providers must bill for a one month supply at a time, even though prior authorization may be granted for up to 6 months. This extended prior authorization period begins on the date that clients receive their first prior-authorized home health service. Texas Medicaid allows additional DME or supplies that have been determined to be medically necessary and have been prior authorized by TMHP Home Health Services Prior Authorization Department. Durable medical equipment providers must retain all orders; copies of completed, signed, and dated Title XIX forms; delivery slips; and corresponding invoices for all supplies provided to a client. Durable medical equipment providers must disclose these records to HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

2.2.1.1 Client Eligibility

Home health clients do not have to be homebound to qualify for services.

To qualify for home health services, the Medicaid client must be eligible on the DOS and must:

- Have a medical need for home health professional services, DME, or supplies that is documented in the client's POC and considered a benefit under home health services.
- Receive services that meet the client's existing medical needs and can be safely provided in the client's home.
- Receive prior authorization from TMHP for most home health professional services, DME, and medical supplies.

Unless otherwise noted in this handbook, certain DME/supplies may be obtained without prior authorization. Durable medical equipment providers must retain a copy of the completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form that has been reviewed, signed, and dated by the treating physician or allowed practitioner for these clients.

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Refer to: Subsection A.12.3, "Automated Inquiry System (AIS)" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

"Section 6: Claims Filing" (*Vol. 1, General Information*) for more information on clients who are 20 years of age and younger.

2.2.1.2 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date on which the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

For services provided to fee-for-service Medicaid clients during the client's retroactive eligibility period (i.e., the period from the effective date to the add date), prior authorization must be obtained within 95 days of the client's add date and before a claim for those services is submitted to TMHP. For services provided on or after the client's add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible and strongly encouraged to verify client eligibility frequently. Eligibility can be verified electronically by checking:

- TexMedConnect.
- The Medicaid Client Portal for Providers.

Additionally, providers can verify eligibility through AIS. To use the AIS, call the TMHP Contact Center at 800-925-9126 and select option 1.

If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: "Section 4: Client Eligibility" (*Vol. 1, General Information*).

2.2.1.3 Prior Authorization

Prior authorization must be obtained for some supplies and most DME from TMHP within three business days of the DOS. Although durable medical equipment providers may supply some DME and medical supplies to a client without prior authorization, they must still retain a copy of the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form that has Section B completed, signed, and dated by the client's attending physician or allowed practitioner, unless otherwise noted in this handbook.

The following prior authorization requests can be submitted on the TMHP website at www.tmhp.com:

- External Insulin Pump
- Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form
- Home Health Services POC
- Statement for Initial Wound Therapy System In-Home Use
- Statement for Recertification of Wound Therapy System In-Home Use
- Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (Attachments will be sent separately due to size and detailed information)

Refer to: Subsection 5.5.1, "Prior Authorization Requests Through the TMHP Website" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information, including mandatory documentation requirements.

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If a client's primary coverage is private insurance and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will pay only the coinsurance or deductible according to current payment guidelines. If Medicare denied the service, then Medicaid prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare's final disposition. The Medicare Remittance Advice Notice (MRAN) containing Medicare's final disposition must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the DOS.

The provider must contact the TMHP Home Health Services Prior Authorization Department within three business days of the DOS to obtain prior authorization for DME and medical supplies.

If inadequate or incomplete information is provided or medical necessity is lacking, the provider will be asked to furnish any required or additional documentation so that a decision about the request can be made. Because the documentation must often be obtained from the client's physician, providers have two weeks to submit the requested documentation. If the additional documentation is received within the two-week period, prior authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks after the request for the documentation, prior authorization is not considered before the date on which the additional documentation is received. It is the DME supplier's responsibility to contact the physician or allowed practitioner to obtain the requested additional documentation. The physician or allowed practitioner must maintain documentation of medical necessity in the client's record.

TMHP Home Health Services toll-free number is 1-800-925-8957.

Refer to: Subsection 2.2.2.2, "Prior Authorization" in this handbook for DME prior authorization information.

Subsection 2.3.1, "Medicaid Relationship to Medicare" in this handbook.

Client eligibility for Medicaid is for one month at a time. Providers should verify their client's eligibility every month. Prior authorization does not guarantee payment.

2.2.2 Durable Medical Equipment (DME) and Supplies

Texas Medicaid defines DME as:

Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician or allowed practitioner for use in the home, and required to correct or ameliorate a client's disability, condition, or illness.

Since there is no single authority, such as a federal agency, that confers the official status of "DME" on any device or product, HHSC retains the right to make such determinations with regard to Texas Medicaid DME benefits. DME provided by Texas Medicaid must either have a well-established history of efficacy, or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a Medicaid-eligible medical condition or functional disability.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or clinical nurse specialist (CNS).*

Requested DME may be a benefit when it meets the Medicaid definition of DME. The majority of DME and expendable supplies are covered home health services. If a service cannot be provided for a client who is 20 years of age or younger through home health services, these services may be covered through CCP if they are determined to be medically necessary.

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed for the requested equipment or supply must be met.

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- The requested equipment or supply must be medically necessary, and Federal Financial Participation (FFP) must be available.
- The client's health status would be compromised without the requested equipment or supply.
- The requested equipment or supplies must be safe for use in the home.
- The client must be seen by a physician or allowed practitioner no more than 6 months prior to the start of service.

For any purchased DME, the DME provider and the client must sign the DME Certification and Receipt Form that is available on the TMHP website at www.tmhp.com before the claim is submitted for payment. The client's signature on the certification form verifies that the DME is the property of the client. The certification form must include:

- The date that the client received the DME
- The name of the item
- The name of the separate receiver/monitor if applicable
- The printed name of the client or primary caregiver
- The printed name of the provider
- The signature of the client or primary caregiver
- The signature of the provider

The provider must maintain a completed copy of the certification form in the client's record.

The completed, signed, and dated DME Certification and Receipt Form must be submitted to TMHP for claims and appeals for DME that meet or exceed a billed amount of $2,500.00. The form must also be submitted when multiple items that meet or exceed a total billed amount of $2,500.00 are billed for the same DOS. The form is required in addition to obtaining prior authorization, when applicable.

If the DME Certification and Receipt Form is not submitted to TMHP, the claim payment or appeal will be reviewed and will be eligible for recoupment. Incomplete forms will be returned to the provider for correction and resubmission.

TMHP will contact clients that received DME that meets or exceeds a billed amount of $2,500.00 to verify that services were rendered. If the delivery of the equipment cannot be verified by the client, the claim payment will be eligible for recoupment.

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form prescribing the DME and/or supplies must be signed and dated by a physician or an allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician or an allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To document the item and date of delivery for all DME that is provided to a client, DME providers must also retain the following documentation:

- All delivery slips
- Corresponding invoices
- The completed, signed, and dated DME Certification and Receipt Form

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DME providers must disclose this documentation to HHSC or its designee upon request.

The DME must be used for medical or therapeutic purposes, and supplied through an enrolled DME provider in compliance with the client's POC.

These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

> ***Note:*** *All purchased equipment must be new upon delivery to client. Used equipment may be utilized for lease, but when purchased, must be replaced with new equipment.*

HHSC/TMHP reserves the right to request the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form or Addendum to Home Health Services (Title XIX) DME/ Medical Supplies Prescribing Provider Order Form at any time.

To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department. To complete the prior authorization process electronically, the DME provider must submit the prior authorization requirements through any approved electronic methods.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or an allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the DME.

DME must meet the following requirements to qualify for reimbursement under Home Health Services:

- The client received the equipment as prescribed by the physician or allowed practitioner.
- The equipment has been properly fitted to the client or meets the client's needs.
- The client, the parent or guardian of the client, or the primary caregiver of the client, has received training and instruction regarding the equipment's proper use and maintenance.

DME must:

Be medically necessary due to illness or injury or to improve the functioning of a body part, as documented by the physician or allowed practitioner in the client's POC or the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form.

Be prior authorized by the TMHP Home Health Services Prior Authorization Department for rental or purchase of most equipment. Some equipment does not require prior authorization. Prior authorization for equipment rental can be issued for up to six months based on diagnosis and medical necessity. If an extension is needed, requests can be made up to 60 days before the start of the new prior authorization period with a new Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form.

- Meet the client's existing medical and treatment needs.
- Be considered safe for use in the home.
- Be provided through an enrolled DME provider or supplier.

> ***Note:*** *Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

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DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase unless there has been a significant change in the client's condition, as documented by the physician or allowed practitioner familiar with the client. All adjustments and modifications within the first six months after delivery are considered part of the purchase price.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

All DME purchased for a client becomes the Medicaid client's property upon receipt of the item. This property includes equipment delivered which will not be prior authorized or reimbursed in the following instances:

- Equipment delivered to the client before the physician or allowed practitioner signature date on the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form.
- Equipment delivered more than three business days before obtaining prior authorization from the TMHP Home Health Services Prior Authorization Department and meets the criteria for purchase.

Additional criteria:

- A determination as to whether the equipment will be rented, purchased, replaced, repaired, or modified will be made by HHSC or its designee based on the client's needs, duration of use, and age of the equipment.
- Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment.
- Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.
- If a DME/medical supply provider is unable to deliver a prior authorized piece of equipment or supply, the provider should allow the client the option of obtaining the equipment or supplies from another provider.

Items or services are reimbursed at the lesser of:

- The provider's billed charges
- The published fee determined by HHSC
- Manual pricing as determined by HHSC based on one of the following:
  - The manufacturer's suggested retail price (MSRP) less 18 percent
  - The provider's documented invoice cost

If an item is manually priced, providers must submit documentation of one of the following for consideration of purchase or rental with the appropriate procedure codes:

- The MSRP or average wholesale price (AWP), whichever is applicable
- The provider's documented invoice cost

> ***Note:*** *Handwritten alterations (crossing out of information or changing values) of the invoice render the invoice invalid.*

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2.2.2.1 Modifications, Adjustments, and Repairs

Modifications are the replacement of components because of changes in the client's condition, not replacement because the component is no longer functioning as designed. All modifications and adjustments within the first six months after delivery are considered part of the purchase price.

Modifications to custom equipment may be prior authorized should a change occur in the client's needs, capabilities, or physical and mental status which cannot be anticipated.

Documentation must include the following:

- All projected changes in the client's mobility needs
- The date of purchase, and serial number of the current equipment
- The cost of purchasing new equipment versus modifying the current equipment

All modifications, adjustments, and repairs to a wheeled mobility system within the first six months after delivery are considered part of the purchase price. An exception is made for the push-rim activated power assist wheelchair (PAPAW) system, which may be considered for prior authorization with a new seating assessment form within the first six months after fitting and delivery.

Adjustments do not require supplies. Adjustments made within the first six months after delivery will not be prior authorized. A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months following delivery.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Repairs require the replacement of components that are no longer functional. Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

A DME repair will be considered based on the age of the item and cost to repair it.

A request for repair of DME must include an itemized estimated cost list from the vendor or DME provider of the repairs. Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.

Repairs will not be prior authorized in situations where the equipment has been abused or neglected by the client, client's family, or caregiver. Routine maintenance of rental equipment is the provider's responsibility. For clients requiring wheelchair repairs only, the date last seen by a physician or an allowed practitioner does not need to be filled in on the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. Rental of a wheeled mobility system during the time of repair should be offered at the time of equipment pick-up, if appropriate.

2.2.2.1.1 Accessories

Equipment accessories including, but not limited to, pressure support cushions, may be prior authorized with documentation of medical necessity.

2.2.2.2 Prior Authorization

Prior authorization is required for most DME and supplies provided through Home Health Services. These services include accessories, modifications, adjustments, and repairs for the equipment.

Providers must submit a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form to the TMHP Home Health Services Prior Authorization Department.

Unless otherwise noted in this handbook, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME) or Medical Supplies Prescribing Provider Order Form prescribing the DME or supplies must be signed and dated by a physician or allowed practitioner and by the representative of the DME/Medical Supply provider familiar with the client before requesting prior authorization for all DME equipment and supplies. A current signature and date is valid for no more than 90 days prior to

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the date of the requested prior authorization or the initiation of service. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and numerical quantities for services requested.

A copy of the completed, signed, and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must be maintained by the DME provider. The ordering physician or allowed practitioner must maintain the completed, originally signed, and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form in the client's medical record.

To complete the prior authorization process by paper, the provider must fax or mail the completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form to the Home Health Services Prior Authorization Department and retain a copy of the completed, signed, and dated form in the client's medical record at the provider's place of business.

To complete the prior authorization process electronically, the provider must submit the prior authorization requirements through any approved electronic methods and retain a copy of the completed, signed, and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form in the client's medical record at the provider's place of business.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

Retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested services.

The date last seen by the physician or an allowed practitioner must be within the past six months. The physician or allowed practitioner's signature on the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form is only valid for 90 days before the initiation of services. The requesting provider may be asked for additional information to clarify or complete the request.

Providers must obtain prior authorization within three business days of providing the service by calling the TMHP Home Health Services Prior Authorization Department or faxing the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form.

To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization, the physician or allowed practitioner must provide correct and complete information supporting the medical necessity of the equipment or supplies requested and is subject to retrospective review, including:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status.
- Diagnosis or condition causing the impairment resulting in a need for the equipment or supplies requested.

Purchased DME is anticipated to last a minimum of five years, unless otherwise noted, and may be considered for replacement when the time has passed or the equipment is no longer functional or repairable. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

Prior authorization for equipment replacement is considered within five years of equipment purchase when one of the following occurs:

- There has been a significant change in the client's condition such that the current equipment no longer meets the client's needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.

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Replacement of equipment is also considered when loss or irreparable damage has occurred. The following must be submitted with the prior authorization request:

- A copy of the police or fire report, when appropriate
- A statement about the measures to be taken in order to prevent reoccurrence

Payment may be prior authorized for repair of purchased DME. Maintenance of rental equipment (including repairs) is the supplier's responsibility. The toll-free number for the TMHP Home Health Services Prior Authorization Department is 1-800-925-8957. Requests for repairs must include the cost estimate, reasons for repairs, age of equipment, and serial number.

2.2.3 Home Health DME and Supplies Exceptional Circumstances Provision

The Home Health Durable Medical Equipment (DME) and Supplies Exceptional Circumstances provision is made available in accordance with Title 42 Code of Federal Regulations (CFR) §440.70 and Title 1 Texas Administrative Code (TAC) §354.1039. Under the Exceptional Circumstances provision, Texas Medicaid is obligated to consider coverage of medically necessary DME and supplies that are not currently listed as benefits of Texas Medicaid for clients who are 21 years of age or older.

2.2.3.1 Prior Authorization Requests for Home Health DME and Supplies under the Exceptional Circumstances Provision

All Exceptional Circumstances DME and supplies must be prior authorized. The Home Health DME and Supplies Exceptional Circumstances provision is not an available process to pursue for clients who receive prior authorization denials for medical necessity or technical reasons (e.g., missing essential fields, incomplete documentation). Clients that have been denied prior authorization under these circumstances may appeal the decision through the regular fair hearing process.

To request prior authorization for home health DME and supplies under the Exceptional Circumstances provision, providers must submit a written notice to TMHP. The written notice must include:

- Completed copies of all of the necessary forms for the requested home health DME or supplies, such as the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form, Special Medical Prior Authorization (SMPA) Request Form, Prior Authorization Request for Oxygen Therapy Devices and Supplies, Wound Care Equipment and Supplies Order Form etc. The forms must be signed and dated by the prescribing physician or allowed practitioner along with a cover letter indicating the forms are being submitted under the Home Health DME and Supplies Exceptional Circumstances provision.
- The client's specific diagnosis, medical needs and the reasons why they can only be met by the requested home health DME or supply.
- A clear, concise description of the requested DME or supply.
- The manufacturer's suggested retail price (MSRP) for the requested DME or supply or an invoice documenting the provider's cost.
- Letters of Medical Necessity (LOMN) from the client's prescribing physician or allowed practitioner and other clinical professionals, as appropriate, documenting the alternative measures and alternative DME or supplies that have been tried and have failed to meet the client's medical needs, or have been ruled out and an explanation of why they have failed or have been ruled out.

Important: *TMHP may request additional supporting documentation after reviewing the initial request.*

2.2.3.2 Reimbursement and Billing

TMHP will only consider reimbursement for home health DME and supplies under the Exceptional Circumstances provision if:

- Providers request DME and supplies using the most appropriate procedure code available.

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- TMHP approves the prior authorization request.

2.2.4 Medical Supplies

Medical supplies are benefits of the Home Health Services Program if they meet the following criteria:

- Unless otherwise noted in this handbook, the representative of the DME/medical supply provider and a physician or allowed practitioner who is familiar with the client must sign and date a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form that prescribes the DME or supplies before requesting prior authorization for the DME or supplies. A current signature and date is valid for no more than 90 days prior to the date of the requested prior authorization or the initiation of service. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and numerical quantities for the services requested.
- The provider must contact TMHP within three business days of providing the supplies to the client and obtain prior authorization, if required.
- The durable medical equipment provider must keep all completed copies of the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Forms on file. The ordering physician or allowed practitioner must maintain copies of the completed, originally signed, and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Forms in their records.
- Providers must retain individual delivery slips or invoices for each DOS that documents the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. Documentation of delivery must include one of the following:
  - Delivery slip or corresponding invoice signed and dated by client or caregiver, or
  - A dated carrier tracking document with shipping date and delivery date as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or corresponding invoice.
  - If using a third-party distributor, delivery confirmation from the third-party distributor and corresponding tracking number from the third-party distributor's carrier.
- The dated delivery slip or invoice must include the client's full name, the address to which supplies were delivered, and an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client and the corresponding tracking number from the carrier. This document could also include prices, shipping weights, shipping charges, or other descriptions.
- All claims submitted for medical supplies must include the same quantities or units that are documented on the delivery slip or corresponding invoice and on the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. They must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 300 diapers is delivered, the delivery slip or corresponding invoice and the claim must reflect that 300 diapers were delivered and not that one package was delivered. Diaper wipes are measured as boxes or packages. If one box of 200 wipes is delivered, the delivery slip or invoice and the claim must reflect that one box was delivered and not that 200 individual wipes were delivered. There must be one dated delivery slip or invoice for each claim submitted for each client. All claims submitted for medical supplies must reflect either one business day before or one business day after the date of service as documented on the delivery slip or corresponding invoice and the

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same time frame covered by the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. The DME Certification and Receipt Form is still required for all equipment delivered.

Note: *These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*

- The ordering physician or allowed practitioner must document medical supplies as medically necessary in the client's POC or on a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form.

HHSC/TMHP reserves the right to request the signed and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form at any time.

Note: *Client eligibility can change monthly. Providers are responsible for verifying eligibility before providing supplies.*

The DOS is the date on which supplies are delivered to the client or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date. The provider must maintain the signed and dated records supporting documentation that an item was not billed before delivery. These records are subject to retrospective review.

Refer to: Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form on the TMHP website at www.tmhp.com.

Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form Instructions on the TMHP website at www.tmhp.com.

Subsection 2.8, "Durable Medical Equipment (DME) Supplier (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for specific information about certain DME and medical supplies.

Subsection 2.2.1.1, "Client Eligibility" in this handbook.

2.2.4.1 Supply Procedure Codes

When submitting supplies on the CMS-1500 claim form, itemize the supplies, including quantities, and also provide the Healthcare Common Procedure Coding System (HCPCS) national procedure codes.

Refer to: Subsection 6.3.3, "Procedure Coding" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about HCPCS procedure codes.

2.2.4.2 Prior Authorization

TMHP must prior authorize most medical supplies. They must be used for medical or therapeutic purposes, and supplied through an enrolled DME provider in compliance with the client's POC.

Some medical supplies may be obtained without prior authorization; however, the provider must retain a copy of the completed POC or Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form in the client's file. Unless otherwise noted in this handbook, a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form for medical supplies not requiring prior authorization may be valid for a maximum of six months, unless the physician or allowed practitioner indicates the duration of need is less. If the physician or allowed practitioner indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form is required at the end of the determined duration of need.

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For a list of DME/medical supplies that do not require prior authorization, providers can refer to subsection 2.2.30, "Procedure Codes That Do Not Require Prior Authorization" in this handbook.

Clients with ongoing needs may receive up to six months of prior authorizations for some expendable medical supplies under Home Health Services when requested on a Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. Providers may deliver medical supplies as ordered on a Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form for up to six months from the date of the physician or allowed practitioner's signature. In these instances, a review of the supplies requested by the physician or allowed practitioner familiar with the client's condition, and a new Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form is required for each new prior authorization request. Requests for prior authorization can be made up to 60 days before the start of the new prior authorization period. Professional Home Health Services prior authorization requests require a review by the physician or allowed practitioner familiar with the client's condition and a physician or allowed practitioner signature every 60 days when requested on a POC.

Note: *These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

2.2.4.3 Cancelling a Prior Authorization

The client has the right to choose his DME/medical supply provider and change providers. If the client changes providers, TMHP must receive a change of provider letter with a new Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. The client must sign and date the letter, which must include the name of the previous provider and the effective date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form.

2.2.5 Augmentative Communication Device (ACD) System

An ACD system, also known as an augmentative and alternative communication (AAC) device system, allows a client with an expressive speech language disorder to electronically represent vocabulary and express thoughts or ideas in order to meet the client's functional speech needs.

Digitized speech devices and synthesized speech devices are benefits of Texas Medicaid Title XIX Home Health Services.

A digitized speech device, sometimes referred to as a "whole message" speech output device, uses words or phrases that have been recorded by someone other than the ACD system user for playback upon command by the ACD system user.

Providers must use procedure codes E2500, E2502, E2504, and E2506 when billing for a digitized speech device.

A synthesized speech device uses technology that translates a user's input into device-generated speech using algorithms representing linguistic rules. Users of synthesized speech ACD systems are not limited to prerecorded messages, but can independently create messages as their communication needs dictate. Some synthesized speech devices require the user to make physical contact with a keyboard, touch screen, or other display containing letters.

Providers must use procedure code E2508 when billing for a synthesized speech device.

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Other synthesized devices allow for multiple methods of message formulation and multiple methods of device access. Multiple methods of message formulation must include message selection by two or more of the following methods:

- Letters
- Words
- Pictures
- Symbols

Multiple methods of access must include the capability to access the device by direct physical contact with a keyboard or touch screen and one or more of the following indirect selection techniques:

- Joystick/switches
- Head mouse
- Optical head pointer
- Light pointer
- Infrared pointer
- Scanning device
- Morse code

Note: *ACD systems that do not meet the criteria through Title XIX Home Health Services may be considered for clients who are birth through 20 years of age under CCP.*

Providers must use procedure code E2510 when billing for other synthesized speech devices.

Items included in the reimbursement for an ACD system and not reimbursed separately include, but are not limited to, the following:

- ACD
- Basic, essential software (except for software purchased specifically to enable a client-owned computer or personal digital assistant [PDA] to function as an ACD system)
- Batteries
- Battery charger
- Power supplies
- Interface cables
- Interconnects
- Sensors
- Moisture guard
- Alternating current (A/C) or other adapters
- Adequate memory to allow for system expansion within a three-year timeframe
- All basic operational training necessary to instruct the client and family/caregivers in the use of the ACD system
- Manufacturer's warranty

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2.2.5.1 ACD System Accessories

Accessories are a benefit of Texas Medicaid if the criteria for ACD system prior authorization are met and the medical necessity for each accessory is clearly documented in the speech language pathologist (SLP) evaluation.

All accessories necessary for proper use of an ACD system, including those necessary for the potential growth and expansion of the ACD system (such as a memory card), must be included in the initial prescription/Title XIX form. The following accessories for an ACD system may be covered:

- Access devices for an ACD system include, but are not limited to, devices that enable selection of letters, words, or symbols by direct or indirect selection techniques such as optical head pointers, joysticks, and ACD scanning devices.
- Gross motor access devices, such as switches and buttons, may be considered for clients with poor fine motor and head control.
- Fine motor, head control access devices, such as laser or infrared pointers, may be considered for clients with poor hand control and good head control.

Mounting systems are devices necessary to place the ACD system, switches and other access devices within the reach of the client. Mounting devices may be considered for reimbursement when used to attach an ACD system or access device to a wheelchair or table.

A request for prior authorization of a wheelchair mounting device must include the manufacturer name, model, and purchase date of the wheelchair. One additional mounting device, separate from the one included in the system, may be considered for prior authorization for the same client.

Providers must use procedure codes E2512 and E2599 when billing for ACD system accessories.

2.2.5.1.1 Carrying Case

Carrying cases may be considered for separate reimbursement with supporting documentation of medical necessity.

Providers must use procedure code E2599 and modifier U1 when billing for the carrying case. Carrying cases are limited to one every three years.

Carrying cases may be considered for prior authorization. The prior authorization request must include the make, model, and purchase date of the ACD system.

2.2.5.1.2 Non-warranty Repairs

Non-warranty repairs of an ACD system may be considered for prior authorization using procedure code V5336 with documentation from the manufacturer explaining why the repair is not covered by the warranty.

2.2.5.1.3 Trial Period

In order to ensure the client's needs are met in the most cost effective manner and to ascertain the most appropriate system and access device for the client, the ACD system is prior authorized for purchase only after the client has completed a three-month trial period that includes experience with the requested system.

The ACD system for the trial period may be obtained through the rental, the school setting, or another setting determined by the licensed SLP.

In the situation where an ACD system is not available for rental and the client has recent documented experience with the requested ACD system, purchase can be considered.

A trial period is not required when replacing an existing ACD system, unless the client's needs have changed and another ACD system or access device is being considered.

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2.2.5.1.4 Rental

Prior authorization may be provided for rental during this trial period. All components necessary for use of the device, such as access devices, mounting devices, and lap trays, must be evaluated during this trial period.

2.2.5.1.5 Purchase

Purchase of an ACD system may be considered for prior authorization when all of the following ACD system criteria are met:

- The evaluation/re-evaluation includes documentation that the client has had sufficient experience with the requested ACD system through trial, rental, school, or another setting. When the SLP has confirmed the appropriateness of a specific device for the client, the trial/rental period may be cancelled.
- A Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form listing the prescribed ACD system, access device, and accessories (such as a mounting device) must be completed, signed, and dated by the physician or allowed practitioner.

ACD systems, equipment, and accessories that have been purchased are anticipated to last a minimum of three years.

2.2.5.1.6 Replacement

Prior authorization for replacement may be considered within three years of purchase when one of the following occurs:

- There has been a significant change in the client's condition such that the current device no longer meets his or her communication needs.
- The ACD system is no longer functional and either cannot be repaired or it is not cost effective to repair.
- Three years have passed and the equipment is no longer repairable.

Note: *Replacements for clients who are birth through 20 years of age that do not meet the criteria above may be considered through CCP.*

2.2.5.1.7 Software

Computer software that enables a client's computer or PDA to function as an ACD system may be covered as an ACD system. Providers must use procedure code E2511 when billing for a speech generating software. Requests for ACD software may be considered for prior authorization if the software is more cost effective than an ACD system.

If an ACD system is more cost effective than adapting the client's computer or PDA, an ACD system may be prior authorized instead of the ACD software.

Laptop or desktop computers, PDAs, or other devices that are not dedicated ACD systems are not a benefit of Texas Medicaid, because they do not meet the definition of DME.

2.2.5.2 Non-Covered ACD System Items

Noncovered items that are not necessary to operate the system and are unrelated to the ACD system or software components are not benefits of Texas Medicaid. These items include, but are not limited to:

- Printer
- Wireless Internet access devices

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Specialized evaluations required for the provision of new complex rehabilitation technology, such as augmentative communication devices, require physical in-person presence of the rendering provider.

Note: *For clients who are 21 years of age or older, requests for ACD systems that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

2.2.5.3 Prior Authorization

Prior authorization is required for ACD systems provided through Home Health Services. The prior authorization also includes all related accessories and supplies. The physician or allowed practitioner must provide information supporting the medical necessity of the equipment or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition and any other medical diagnoses or conditions, including the client's overall physical and cognitive limitations.
- Diagnosis or condition causing the impairment of speech.

Prior authorization for an ACD system and accessories (rental or purchase) must be requested using the following information:

- Medical diagnosis and how it relates to the client's communication needs.
- Any significant medical information pertinent to ACD system use.
- Limitations of the client's current communication abilities, systems, and devices.
- Statement as to why the prescribed ACD system is the most effective, including a comparison of benefits using other alternatives.
- Complete description of the ACD system with all accessories, components, mounting devices, or modifications necessary for client use (must include manufacturer's name, model number, and retail price).
- Documentation that the client is mentally, emotionally, and physically capable of operating the device.
- An evaluation and assessment must be conducted by a licensed SLP in conjunction with other disciplines, such as physical or occupational therapies. The prescribing provider must base the prescription on the professional evaluation and assessment.

The prior authorization request must include the specifications for the ACD system, all component accessories necessary for the proper use of the ACD, and all necessary therapies or training. It is recommended that the preliminary evaluation for an ACD system include the involvement of an occupational therapist or physical therapist to address the client's seating/postural needs and the motor skills required to utilize the ACD system.

The prescribing provider familiar with the client must review the SLP evaluation of the client's cognitive and language abilities and base the prescription and treatment plan on the SLP's recommendations.

An evaluation and assessment by a licensed SLP must be signed and dated before the date on the physician or allowed practitioner's prescription or the Title XIX form and include the following information:

- Documentation of medical necessity for an ACD system, including a formal written evaluation performed by a licensed SLP.
- Medical status or condition and medical diagnoses underlying the client's expressive speech-language disorder that justifies the need for an ACD system.

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- Current expressive speech-language disorder, including the type, severity, anticipated course, and present language skills.
- Description of the practical limitations of the client's current aided and unaided modes of communication.
- Other forms of therapy or intervention that have been considered and ruled out.
- Rationale for the recommended ACD system and each accessory, including a statement as to why the recommended device is the most appropriate and least costly alternative for the client and how the recommended system will benefit the client.
- Documentation that the client possesses the cognitive and physical abilities to use the recommended system.
- Comprehensive description of how the ACD system will be integrated into the client's everyday life, including home, school, or work.
- Treatment plan that includes training in the basic operation of the recommended ACD system necessary to ensure optimal use by the client (if appropriate, the client's caregiver) and a therapy schedule for the client to gain proficiency in using the ACD system.
- Description of the client's speech-language goals and how the recommended ACD system will assist the client in achieving these goals.
- Description of the anticipated changes, modifications, or upgrades with projected time frames of the ACD system necessary to meet the client's short- and long-term speech-language needs.
- Identification of the assistance or support needed by, and available to, the client to use and maintain the ACD system.
- Statement that the licensed SLP is financially independent of the ACD system manufacturer/vendor.
- Speech- and language- skills assessment that includes the prognosis for speech or written communication.
- Interactional/behavioral and social abilities.
- Capabilities, including intellectual, postural, sensory (visual and auditory), and physical status.
- Motivation to communicate.
- Residential, vocational, and educational setting.
- Alternative ACD system considered with comparison of capabilities.
- Ability to meet projected communication needs, growth potential, and length of time it will meet the client's needs.

2.2.6 Bath and Bathroom Equipment

Bath and bathroom equipment is DME that is included in a treatment protocol, serves as a therapeutic agent for life and health maintenance, and is required to treat an identified medical condition. Bath and bathroom equipment may be considered for reimbursement for those clients who have physical limitations that do not allow for bathing, showering, or bathroom use without assistive equipment.

Bath seats are not considered for clients who are younger than 1 year of age or weighing less than 30 pounds.

Note: *For clients who are 21 years of age or older, requests for bath and bathroom equipment that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

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Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

2.2.6.1 Hand-Held Shower Wand

A hand-held shower wand with attachments may be considered for prior authorization only if the client currently owns or meets the criteria for a bath or shower chair, tub stool or bench, or tub transfer bench. Prior authorization of a hand-held shower wand includes all attachments and accessories. Providers must use procedure code E1399 when billing for a hand-held shower wand. Hand-held shower wands with attachments are limited to one every five years.

2.2.6.2 Bath Equipment

2.2.6.2.1 Bath or Shower Chairs, Tub Stool or Bench, Tub Transfer Bench

A bath or shower chair is a stationary or mobile seat with or without upper body or head support used to support a client who is unable to stand or sit independently in the shower or tub.

Bath/shower chairs are grouped into three levels of design to assist the client based on their physical condition and mobility status:

- Level 1- standard bath or shower chair is defined as stationary equipment.
- Level 2 - intermediate bath or shower chair is defined as mobile equipment with or without a commode cut out.
- Level 3 - complex bath or shower chair is defined as custom equipment (either stationary or mobile) with or without a commode cut out.

A tub stool or bench is a stationary seat or bench used to support a client who is unable to stand or sit independently in the shower or tub.

A tub transfer bench is a stationary bench that sits in the tub and extends outside the tub. It is used to support a client who is unable to stand or sit independently in the shower or tub and allows the client to scoot or slide over the side of the tub.

Bath or shower chairs, tub stools or benches, and tub transfers are limited to one every five years.

A custom bath or shower chair may be considered for prior authorization only if the client does not also have any type of commode chair.

Level 1 Group

A Level 1 device may be considered if the client:

- Is either unable to stand independently or is unstable while standing, or
- Is unable to independently enter or exit the shower or tub due to limited functional use of the upper or lower extremities, and
- Maintains the ability to ambulate short distances (with or without assistive device), or
- Has a condition that is defined as a short-term disability without a concomitant long-term disability (including, but not limited to postoperative status).

Providers must use procedure code E0240 without a modifier when billing for Level 1 group bath or shower chairs.

Level 2 Group

A Level 2 device may be considered if the client:

- Has good upper body stability, and
- Has impaired functional ambulation, including, but not limited to, lower body paralysis, osteoarthritis, or

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- Is nonambulatory.

The client must have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers.

Providers must use procedure code E0240 and modifier TF (Intermediate Level) when billing for Level 2 group bath or shower chairs.

Level 3 Group

A Level 3 device may be considered if the client requires:

- Trunk or head or neck support, or
- Positioning to accommodate conditions, including, but not limited to, spasticity, or frequent and uncontrolled seizures.

Providers must use procedure code E0240 and modifier TG (Complex/high Level) when billing for Level 3 group bath/shower chairs.

A bath or shower chair may be prior authorized for clients who meet the Level 1, 2, or 3 criteria. A Level 3 custom bath or shower chair may be prior authorized only if the client does not also have any type of commode chair. A Level 3 mobile bath or shower chair may be considered for clients who have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers.

A tub stool or bench may be prior authorized for clients who meet the Level 1 criteria. Providers must use procedure code E0245 when billing for a tub stool or bench.

A tub transfer bench may be considered for clients who meet the Level 1 or 2 criteria. Providers must use procedure code E0247 when billing for a tub transfer bench.

A heavy duty tub transfer bench may be considered for clients who meet the Level 1 or 2 criteria and who weigh more than 200 pounds. Providers must use procedure code E0248 when billing for a heavy duty tub transfer bench.

2.2.6.3 Bathroom Equipment

2.2.6.3.1 Non-fixed Toilet Rail, Bathtub Rail Attachment, and Raised Toilet Seat

Nonfixed toilet rails are limited to two every five years. A bathtub rail is limited to one every five years.

Raised toilet seats are limited to one every five years. Nonfixed toilet rails and bathtub rail attachments may be considered for prior authorization for a client who has decreased functional mobility and is unable to safely self-toilet or self-bathe without assistive equipment. Raised toilet seats do not require prior authorization. Providers must use procedure code E0243 when billing for non-fixed toilet rails, procedure code E0244 when billing for raised toilet seats, and procedure code E0246 when billing for bathtub rails.

2.2.6.3.2 Toilet Seat Lifts

A toilet seat lift mechanism is designed for the top of the toilet to assist lifting the body from a sitting position to a standing position.

A toilet seat lift mechanism must be prior authorized. To qualify for prior authorization, clients must meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The toilet seat lift mechanism must be a part of the physician or allowed practitioner's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.

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- The client must be completely incapable of standing up from a regular armchair or any chair in the client's home.

The client's difficulty or incapability of getting up from a chair is not sufficient justification for a toilet seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

Prior authorization will be given for either mechanical or powered toilet assist devices, not for both. If a client already owns one or more mechanical toilet-assist devices, a powered toilet seat lift mechanism will not be prior authorized unless there has been a documented change in the client's condition such that the client can no longer use the mechanical equipment.

Toilet seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and effectively assist a client in standing up and sitting down without other assistance. A toilet seat lift operated by a spring release mechanism with a sudden, catapult-like motion that jolts the client from a seated to a standing position is not a benefit of Texas Medicaid.

Providers must use procedure code E0172 when billing for a toilet seat lift mechanism. A toilet seat lift mechanism is limited to one purchase very five years.

2.2.6.3.3 Commode Chairs and Foot Rests

Commode chairs, foot rests, and replacement commode pails or pans may be considered as benefits, depending on the client's level of need. The client must meet the criteria for the level of commode chair or foot rest requested.

A commode chair with or without a foot rest may be considered a benefit for the client who also has a stationary bath chair without a commode cutout.

Documentation must support medical necessity for a customized commode chair or the addition of attachments to a standard commode chair.

Level 1: Stationary Commode Chair

A Level 1 commode chair is defined as a stationary commode chair with fixed or removable attachments to support the arms.

A stationary commode chair with fixed or removable arms may be considered for prior authorization when the client has a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

Providers must use procedure code E0163 or E0165 when billing for a stationary and mobile commode chair.

Level 2: Mobile Commode Chair

A Level 2 commode chair is defined as a mobile commode chair with fixed or removable attachments to support the arms.

A mobile commode chair with fixed or removable arms may be considered for prior authorization when the following criteria are met:

- In addition to meeting the criteria for a Level 1 commode chair, the client must be on a bowel program and require a combination commode or bath chair for performing the bowel program and bathing after.
- A mobile commode chair will be considered for reimbursement with prior authorization only if the client does not also have any type of bath chair. If the client meets the criteria for a stationary bath chair, prior authorization of a stationary chair may be considered.

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Level 3: Custom Commode Chair

A Level 3 commode chair is defined as a custom commode chair with all of the following characteristics:

- Is stationary or mobile
- Has fixed or removable attachments to support the arms, head, neck, or trunk.

A custom stationary or mobile commode chair with fixed or removable arms and head, neck, and/or trunk support attachments may be considered for prior authorization when the following criteria are met:

- In addition to meeting the criteria for a Level 1 or 2 commode chair, the client must have a medical condition that results in an inability to support their head, neck, or trunk without assistance.
- A mobile custom commode chair may be considered for reimbursement only if the client does not also have any type of bath chair.

Providers must use procedure code E0163 or E0165 with modifier TG when billing for a custom stationary or mobile commode chair.

Extra-wide and Heavy-Duty Commode Chair

An extra-wide, heavy-duty commode chair is defined as one with a width greater than or equal to 23 inches, and capable of supporting a client who weighs 300 pounds or more.

An extra-wide or heavy-duty commode chair may be considered for prior authorization when the client meets the criteria for a Level 1, 2, or 3 commode chair and weigh 300 pounds or more.

Providers must use procedure code E0168 and the appropriate modifiers when billing for an extra-wide or heavy-duty commode chair. Use modifier TF when billing for a mobile extra-wide, heavy-duty commode chair. Use modifier TG when billing for a custom extra-wide, heavy-duty commode chair.

Commode Chair With Integrated Seat Lift

A commode chair with integrated seat lift is designed to assist lifting the body from a sitting position to a standing position.

A commode chair with integrated seat lift mechanism for top of the commode must be prior authorized for clients who meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The client must be completely incapable of standing up from a regular toilet, commode, or any chair in their home.
- The commode chair with integrated seat lift must be a part of the physician or allowed practitioner's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate independently for a short distance of no more than ten feet.

  Note: *The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.*

Providers must use procedure code E0170 or E0171 when billing for a commode chair with integrated seat lift. The purchase of a commode chair with integrated seat lift is limited to one every five years.

Replacement Commode Pail or Pan

Replacement commode pails or pans are a benefit through Title XIX Home Health Services and are limited to one per year. Additional quantities may be considered for prior authorization with documentation of medical necessity.

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Providers must use procedure code E0167 when billing for a commode pail or pan.

Foot Rest

A foot rest is used to support feet during use of the commode chair.

A foot rest may be considered for prior authorization if the client meets the criteria for a Level 1, 2, or 3 commode chair and the foot rest is necessary to support contractures of the lower extremities of clients who are paraplegic or quadriplegic.

Providers must use procedure code E0175 when billing for a foot rest.

2.2.6.3.4 Portable Sitz Bath

Portable sitz baths that fit over commode seats are limited to 1 per 180 days for clients requiring any of the following:

- Cleaning, irrigation, or pain relief of a perianal wound.
- Relief of pain associated with the pelvic area (hemorrhoids, bladder, vaginal infections, prostate infections, herpes, testicle disorders).
- Muscle toning for bowel and bladder incontinence.

Providers must use procedure codes E0160 or E0161 when billing for portable sitz baths.

2.2.6.3.5 Bath Lifts

The purchase of a bath lift is limited to one every five years. The rental of a bath lift is limited to one per month.

The two types of bath lifts that are considered for reimbursement include:

- An outside the tub bath lift which is a portable transfer system used to move a nonambulatory client a short distance from bed or chair to bath and is designed to accommodate the smaller space. This type of lift is either hydraulic or electric and consists of a base with wheels or casters and a sling which can transfer the client in and out of the bath.
- An inside the tub bath lift is a portable transfer system used to lower and raise a nonambulatory client into and out of the bath tub. This type of lift is either hydraulic or electric and consists of a base which adheres to the tub surface using suction cups and a seat that will lower and raise the client into and out of the tub.

Providers must use procedure code E0625 with the appropriate modifier (U1, U2, or U3) if necessary when billing for a bath lift.

The bath lift must be free standing, it cannot be attached to the floor, walls, or ceiling. Home adaptation for use of medical equipment is not a benefit of Home Health Services.

A hydraulic bath lift is for a client who is unable to assist in their own transfers and is operated by the weight or pressure of a liquid.

An electric bath lift is operated by electricity and may be considered when a hydraulic lift will not meet the client's needs.

A bath lift is not a benefit for the convenience of a caregiver.

There are four levels of bath lifts:

- Level 1 - an outside the tub bath lift (hydraulic or electric) and must accommodate a client weighing up to 300 pounds. Providers must use procedure code E0625 when billing for the purchase of a Level 1 bath lift.

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- Level 2 - an in-tub bath lift (hydraulic or electric) and must accommodate a client weighing up to 300 pounds. Providers must use procedure code E0625 and the U1 modifier when billing for the purchase of a Level 2 bath lift.
- Level 3 - a bariatric lift (hydraulic or electric, out of tub type) designed to lift a client weighing greater than 300 pounds. Providers must use procedure code E0625 and the U2 modifier when billing for the purchase of a Level 3 bath lift.
- Level 4 - a bariatric lift (hydraulic or electric, in tub type) designed to lift a client weighing greater than 300 pounds. Providers must use procedure code E0625 and the U3 modifier when billing for the purchase of a Level 4 bath lift.

A bath lift may be considered for prior authorization if the client:

- Has an inability to transfer to the bathtub or shower independently using assistive devices (including, but not limited to, a cane, walker, bathtub rails).
- Requires maximum assistance by the caregiver to transfer to the bathtub or shower.
- Has bathroom and tub or shower that meets the manufacturer's recommended depth, width, and height for safe bath lift installation and operation.

Providers must use procedure code E0621 when billing for a lift sling. The purchase of a lift sling is limited to one every five years.

The following are payable procedure codes for bath and bathroom equipment:

Procedure Code	Maximum Limitation
E0160	2 per year
E0161	2 per year
E0163	1 every 5 years
E0165	1 every 5 years
E0167	1 per year
E0168	1 every 5 years
E0170	1 every 5 years
E0171	1 every 5 years
E0172	1 every 5 years
E0175	1 every 5 years
E0240	1 every 5 years
E0243	2 every 5 years
E0244	1 every 5 years
E0245	1 every 5 years
E0246	1 every 5 years
E0247	1 every 5 years
E0248	1 every 5 years
E0621	1 per 5 years
E0625	1 purchase every 5 years; 1-month rental
E0630	1 purchase every 5 years; 1 per month rental
E1399	1 every 5 years

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2.2.6.4 Prior Authorization

Except as otherwise indicated in this section, prior authorization is required for all bath and bathroom equipment and related supplies, including any accessories, modifications, adjustments, replacements and repairs to the equipment.

Bathroom and toilet lift rentals may be prior authorized during the period of repair up to a maximum of four months per lifetime, per client.

Prior authorization will not be considered for modifications, adjustments, or repairs to bath or bathroom equipment delivered to a client's home and then found to be inappropriate for the client's condition within the first six months after delivery. This applies unless there is a significant change in the client's condition that is documented by a physician or allowed practitioner familiar with the client.

2.2.6.5 Documentation Requirements

2.2.6.5.1 Bath and Bathroom Equipment

To request prior authorization for all bath or bathroom equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition, including the client's overall health status, any other medical needs, developmental level, and functional mobility skills and why regular bath or bathroom equipment will not meet the client's needs.
- The age, height, and weight of the client.
- Assessment of the client's home to ensure the requested equipment can be safely accommodated.
- Anticipated changes in the client's needs, including anticipated modifications or accessory needs and the growth potential of any custom shower and bath equipment.

2.2.6.5.2 Toilet Seat Lifts

In addition to the above documentation, the submitted documentation for a toilet seat lift must include an assessment completed by a physician, an allowed practitioner, physical therapist, or occupational therapist that includes all of the following:

- A description of the client's current level of function without the device
- An explanation why a nonmechanical toilet elevation device, such as toilet rails or elevated toilet seat, will not meet the client's needs
- Documentation that identifies how the toilet seat lift mechanism will improve the client's function
- A list of the mobility related activities of daily living (MRADLs) the client will be able to perform with the toilet seat lift mechanism that the client is unable to perform without the toilet seat lift mechanism and how the device will increase the client's independence
- The client's goals for use of the toilet seat lift mechanism

Supporting documentation must be kept in the client's record that all appropriate therapeutic modalities (e.g., medication or physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

2.2.7 Blood Pressure Devices (Manual and Automated)

Blood pressure devices are benefits in the home setting for self-monitoring when:

- The devices are medically necessary and appropriate.
- The devices are prescribed by a physician or allowed practitioner.

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A manual blood pressure device requires manual cuff inflation with real-time visualization of the results displayed on the manometer and does not require prior authorization for purchase when provided for one of the diagnosis codes listed in the table below. Providers must use procedure code A4660 when billing for a manual blood pressure device.

An automated blood pressure device inflates the cuff manually or automatically, displays the blood pressure results on a small screen, and does not require prior authorization for purchase when provided for one of the diagnosis codes listed in the table below. Providers must use procedure code A4670 when billing for an automated blood pressure device.

Repair of equipment may be considered with documentation of why the equipment needs repair. Providers must use procedure code A4660 when billing for the replacement of other components or repair of equipment.

Finger cuff automated blood pressure devices and ambulatory blood pressure devices for diagnostic purposes are not a benefit of Texas Medicaid.

2.2.7.1 * Prior Authorization

Procedure codes A4660 and A4670 do not require prior authorization if they are billed with one of the following diagnosis codes:

[Revised] Diagnosis Codes							
I10	I110	I119	I120	I129	I130	I1310	I1311
I132	I150	I151	I152	I158	I159	I160	I161
I169	I1A0	I219	I21A1	I21A9	I21B	I2601	I2602
I2603	I2604	I2609	I2690	I2692	I2693	I2694	I2695
I2696	I2699	I270	I271	I2720	I2721	I2722	I2723
I2724	I2729	I2781	I2782	I2783	I27840	I27841	I27848
I27849	I2789	I279	I340	I341	I342	I3481	I3489
I349	I350	I351	I352	I358	I359	I360	I361
I362	I368	I369	I370	I371	I372	I378	I379
I421	I422	I424	I425	I4281	I4289	I429	I43
I440	I441	I442	I4430	I4439	I444	I445	I4460
I4469	I447	I450	I4510	I4519	I452	I453	I454
I455	I456	I4581	I4589	I459	I4710	I4711	I4719
I4720	14722	I4729	I479	I480	I4811	I4819	I4820
I4821	I483	I484	I4891	I4892	I495	I501	I5020
I5021	I5022	I5023	I5030	I5031	I5032	I5033	I5040
I5041	I5042	I5043	I50810	I50811	I50812	I50813	I50814
I5082	I5083	I5084	I5089	I509	I5A	I950	I951
I952	I953	I9581	I9589	I959	N00A	N00B1	N00B2
N010	N011	N012	N013	N014	N015	N016	N017
N018	N01A	N02A	N02B1	N02B2	N02B3	N02B4	N02B5
N02B6	N02B9	N03A	N04A	N04B1	N04B2	N050	N051
N052	N053	N054	N055	N056	N057	N058	N059
N05A	N08	N130	N1330	N1339	N13721	N13722	N13729
N13731	N13732	N13739	N170	N171	N172	N178	N179

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[Revised] Diagnosis Codes							
N181	N182	N1830	N1831	N1832	N184	N185	N186
N189	N250	N2589	Q200	Q201	Q202	Q203	Q204
Q205	Q208	Q210	Q2110	Q2111	Q2112	Q2113	Q2114
Q2115	Q2116	Q2119	Q2120	Q2121	Q2122	Q2123	Q213
R001	T800XXA	T81718A	T8172XA	T82817A	T82855A	T82855D	T82855S
T82856A	T82856D	T82856S					

Manual and automated blood pressure devices should last at least one year and may be considered for replacement after one year has passed. If it is medically necessary to replace nonfunctional and irreparable equipment before one year has passed, providers can submit prior authorization requests with documentation of medical necessity that explains the need for the replacement.

Prior authorization is required in the following situations:

- Another blood pressure device is medically necessary within the same year. Replacement of equipment within the same year as the purchase requires prior authorization. If equipment must be replaced before the end of the anticipated lifespan, the provider must submit a copy of the police or fire report, when appropriate, and the measures that will be taken to prevent reoccurrence.
- The diagnosis code is not in the table above. If the diagnosis code is not one of those listed in the table above, providers must submit a request for the prior authorization of the initial or replacement device and must include all of the documentation necessary to support the medical necessity of the blood pressure device.

2.2.7.2 Hospital-Grade Blood Pressure Devices

Hospital-grade blood pressure devices and their components are benefits of CCP in the home setting for self-monitoring when the equipment is prescribed by a physician or an allowed practitioner. A hospital-grade blood pressure device includes memory for continuous recording, has an alarm system to notify the caregiver of abnormal readings, and is capable of frequent or continuous automatic blood pressure and heart rate monitoring with correction of motion artifact.

Documentation that supports medical necessity of the requested equipment, including the diagnosis, must be maintained in the client's medical record and is subject to retrospective review.

Refer to: Section 9.2.26.1, "Blood Pressure Monitoring" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about ambulatory blood pressure devices.

Providers must use procedure code A9279 with modifier U1 when billing for hospital-grade blood pressure devices.

Hospital-grade blood pressure devices that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or when the equipment is not functional and not repairable.

For clients who are birth through 11 months of age, the rental or purchase of a hospital-grade blood pressure device is a benefit when documentation supports medical necessity and includes an explanation of why the client cannot use a standard automated blood pressure device.

For clients who are 12 months of age and older, the rental or purchase of a hospital-grade blood pressure device is a benefit on a case-by-case basis. Supporting documentation of medical necessity must be provided.

The following indications are recognized by Texas Medicaid for hospital-grade blood pressure devices:

- Hypotension

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- Essential hypertension
- Hypertensive heart disease
- Hypertensive renal disease
- Myocardial infarction
- Pulmonary embolism
- Acute pulmonary heart disease
- Chronic pulmonary heart disease
- Valve disorders
- Cardiomyopathy
- Conduction disorders
- Cardiac dysrhythmias
- Heart failure
- Acute kidney failure
- Chronic kidney disease
- Hydronephrosis
- Vesicoureteral reflux with neuropathy
- Bulbus cordis anomalies and anomalies of cardiac septal closure
- Embolism
- Stenosis of either coronary artery stent or peripheral vascular stent

All rental costs of the hospital-grade blood pressure device apply toward the purchase price.

2.2.7.3 Components, Replacements, and Repairs

The following may be considered for reimbursement of blood pressure device replacement and repairs with prior authorization:

- Replacement of blood pressure cuffs (procedure code A4663)
- Replacement of other components (procedure code A4660)
- Repairs of the equipment (procedure code A4660)

2.2.7.4 Prior Authorization

Prior authorization is required for the rental or purchase of a hospital-grade blood pressure device. A determination will be made by HHSC or its designee as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of the equipment. Repairs and modifications can only be performed on purchased equipment.

Documentation of medical necessity for the hospital-grade blood pressure device must support the client's need for self-monitoring and address why an automated blood pressure device will not meet the client's needs. The documentation must include:

- All pertinent diagnoses.
- Initial evaluation.
- Symptoms.
- Duration of symptoms.

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- Any recent hospitalizations (within past 12 months).
- Comorbid conditions.
- How frequent or continuous self-monitoring will affect treatment.
- All pertinent laboratory and radiology results.
- Client's weight.
- A family or caregiver(s) who has an understanding of cause and effect and object permanence and who has agreed to accept the responsibility to be trained to use the hospital-grade monitor.

Prior authorization may be granted for a six-month rental period when the request is submitted with documentation of medical necessity supporting the client's need for self-monitoring and addressing why an automated blood pressure device will not meet the client's needs.

Recertification for an additional six-month period may be considered when the physician or allowed practitioner provides current documentation that supports the ongoing medical necessity for self-monitoring and confirms the client or family is compliant with its use.

A hospital-grade blood pressure device will not be considered for prior authorization of purchase until the client has completed a six-month trial period.

Purchase of a hospital-grade blood pressure device may be prior authorized when all of the following criteria are met:

- The client is 12 months of age or older.
- Documentation of medical necessity supports the client's need for ongoing self-monitoring and addresses why an automated blood pressure device will not meet the client's needs.

2.2.7.4.1 Components, Replacements, and Repairs

Replacement of blood pressure cuffs and other components may be considered for purchase with prior authorization and documentation of medical necessity that explains the need for the replacement.

Repair of equipment must be prior authorized when irreparable damage has occurred and documentation exists that supports the need for repair. Repair of equipment will be considered after the factory warranty has expired.

2.2.8 Bone Growth Stimulators

Internal and external bone growth (osteogenic) stimulators are a benefit of Texas Medicaid. Bone growth stimulators are a benefit for skeletally-mature individuals only.

Note: *Bone growth stimulators that do not meet criteria for coverage through Title XIX Home Health Services may be considered through Texas Health Steps—Comprehensive Care Program (THSteps-CCP) for clients who are birth through 20 years of age.*

Note: *For clients who are 21 years of age or older, requests for bone growth stimulators that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Electromagnetic bone growth stimulators promote healthy bone growth and repair by low intensity electrical stimulation. Electrical stimulation is provided by implanting low-voltage electrodes within the tissue surrounding the bone (internal) or by external placement of a device that transmits low-voltage currents through the soft tissue to the bone (external).

Ultrasonic bone growth stimulators promote healthy bone growth and repair through low-intensity, pulsed ultrasound waves.

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A noninvasive electrical bone growth stimulator (procedure codes E0747 and E0748) and noninvasive ultrasound bone growth stimulator (procedure code E0760) are benefits of Texas Medicaid for DME providers when provided in the home setting. An invasive electrical bone growth stimulator (procedure code E0749) is a benefit of Texas Medicaid for freestanding and hospital-based ambulatory surgical centers when provided in the outpatient setting.

Electrical and ultrasonic bone growth stimulator devices for the treatment of orthopedic and neurosurgical conditions are a benefit for Texas Medicaid clients when the client experiences nonunion of a fracture, requires an adjunct to spinal fusion surgery, or experiences congenital pseudarthrosis.

Nonunion is defined as a fractured bone that fails to heal completely. Diagnosis of nonunion is established when a minimum of six months has passed since the injury and the fracture site shows no progressive signs of healing for a minimum of three months and is not complicated by a synovial pseudoarthrosis. Serial radiographs must confirm that fracture healing has ceased for three months or longer before the client begins treatment with the bone growth stimulator.

2.2.8.1 Professional Services

Procedure codes 20974, 20975, and 20979 are a benefit of Texas Medicaid and limited to one per six months. During the six-month limitation period, a subsequent fracture that meets the above criteria for a bone growth stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

2.2.8.2 Prior Authorization Criteria and Documentation Requirements for Bone Growth Stimulators

Procedure codes E0747, E0748, E0749, and E0760 require prior authorization. Additional bone growth stimulators may be considered for prior authorization with documentation that supports treatment of a different fracture.

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form prescribing the DME and/or supplies must be signed and dated by a physician or an allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

A copy of the completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment or supplies prescribed and is subject to retrospective review. Either provider may be asked for additional information to clarify or complete a request for the bone growth stimulator.

2.2.8.2.1 Documentation for Noninvasive Electrical Bone Growth Stimulator

Documentation of one of the following is required for prior authorization of the external, electromagnetic bone stimulator (procedure code E0747):

- Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three or more months despite appropriate fracture care.
- Delayed unions of fractures of failed arthrodesis at high-risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures).

Documentation must also indicate all the following:

- Serial radiographs have confirmed that no progressive signs of healing have occurred.

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- The fractured gap is 1 cm or less.
- The individual can be adequately immobilized and is likely to comply with non-weight-bearing restrictions.

Documentation of one of the following is required for prior authorization of the external, electromagnetic bone stimulator for spinal application (procedure code E0748):

- One or more failed fusions.
- Grade II or worse spondylolisthesis.
- A multiple-level fusion with extensive bone grafting is required.
- Other risk factors for fusion failure are present, including gross obesity, degenerative osteoarthritis, severe spondylolisthesis, current smoking, previous fusion surgery, previous disc surgery, or gross instability.

2.2.8.2.2 Documentation for Invasive Electrical Bone Growth Stimulators

Documentation of one of the following is required for prior authorization of the surgically implanted bone growth stimulator (procedure code E0749):

- Nonunion of long bone fractures (i.e., clavicle, humerus, radius, ulna, femur, tibia, fibula, and metacarpal, metatarsal, carpal, and tarsal bones). Nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for three or more months prior to starting treatment with the bone growth stimulator. Serial radiographs must include a minimum of two sets of radiographs separated by a minimum of 90 days. Each set of radiographs must include multiple views of the fracture site.
- Failed fusion of a joint other than the spine when a minimum of three months has elapsed since the joint fusion was performed.
- Congenital pseudoarthrosis.
- An adjunct to spinal fusion surgery for patients at high risk for pseudoarthrosis due to previously failed spinal fusion at the same site.
- An adjunct to multiple-level fusion, which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc).

2.2.8.2.3 Documentation for Ultrasound Bone Growth Stimulator

Documentation of the following is required for prior authorization of the external, low-intensity ultrasound bone growth stimulator device (procedure code E0760):

- Nonunion of a fracture, other than the skull or vertebrae, in a skeletally mature person, which is documented by a minimum of two sets of radiographs that were:
  - Obtained prior to starting treatment with the bone growth stimulator.
  - Separated by a minimum of 90 days.
  - Taken with multiple views of the fracture site.
  - Accompanied by a written interpretation by a physician who states that there has been no clinically significant evidence of fracture healing between the two set of radiographs.
- Evidence of all of the following:
  - The fracture is not tumor related.
  - The fracture is not fresh (less than seven days), closed or grade I open, tibial diaphyseal fractures, or closed fractures of the distal radius (Colles fracture).

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2.2.8.3 Claims Reimbursement for Professional Services

Professional claims that are submitted for bone growth stimulation (procedure codes 20974, 20975, and 20979) may be reimbursed if the claim includes documentation of one of the following:

- Documentation of medical necessity as outlined in subsection 2.2.8.2, "Prior Authorization Criteria and Documentation Requirements for Bone Growth Stimulators" in this handbook.
- The corresponding bone growth stimulator device was submitted within 95 days of the date the bone growth stimulation procedure was performed.

The appropriate evaluation and management (E/M) procedure code must be billed for monitoring the effectiveness of bone growth stimulation treatment.

2.2.9 Breast Feeding Support Services

Refer to: Section 3, "Breastfeeding Support Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about breastfeeding support services.

2.2.10 Cochlear Implants

Cochlear implant services (procedure codes L8499, L8615, L8616, L8617, L8618, L8619, L8623, and L8624) may be reimbursed in the home setting to DME providers.

Refer to: Subsection 9.2.22, "Cochlear Implants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about cochlear implant services.

2.2.11 Continuous Passive Motion (CPM) Device

A CPM device is reimbursed on a daily basis and is limited to once per day. Reimbursement includes delivery, set-up and all supplies. Providers must use procedure code E0935 when billing for a CPM machine.

2.2.11.1 Prior Authorization

A CPM device may be considered for prior authorization through Home Health Services. Reimbursement for a CPM device is considered after joint surgery, such as knee replacement, when prescribed by a physician and submitted with clinical documentation of medical necessity and appropriateness.

2.2.12 Diabetic Equipment and Supplies

Diabetic equipment and supplies are a benefit through Title XIX Home Health Services and do not require prior authorization unless otherwise specified.

Note: *For clients who are 21 years of age or older, requests for diabetic equipment and supplies that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Diabetic equipment and supplies may be obtained through one of the following methods:

- A Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form
- A verbal or a detailed written order provided by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or a certified nurse midwife (CNM).

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2.2.12.1 Obtaining Equipment and Supplies Through a Title XIX Form

The completed Title XIX Form must be maintained by the dispensing provider and the prescribing physician or allowed practitioner in the client's medical record. The physician or allowed practitioner must maintain the original signed and dated copy of the Title XIX Form. The completed Title XIX Form is valid for a period up to six months from the physician or allowed practitioner's signature date.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

2.2.12.2 Obtaining Equipment and Supplies Through a Verbal or Detailed Written Order

If the dispensing provider does not have a detailed written order then a verbal order is required to be on file until the written order is received from the prescribing provider and before providing diabetic equipment and supplies. The prescribing provider's order may be a written, fax, electronic, or verbal order and must include:

- A description of the item(s).
- Make and model for a device.
- The client's name.
- The name of the physician or authorized prescribing provider.
- The date of the order.

A detailed written order must be received by the DME supplier within 90 days from the date of the prescribing provider's signature. The detailed written order for diabetic equipment and supplies is valid for six months from the date of the order or the date of the prescribing provider's signature, whichever is earlier, for initial orders, and from the start date of renewal orders. In the absence of a start date, then the authorized prescribing signature date will be the beginning date of service.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

A completed, detailed written order must be signed and dated by the authorized prescribing provider. The prescribing provider is required to retain a copy of the signed and dated detailed written order in the client's medical record. The DME provider must retain the original, faxed, photocopied, or electronic, signed and dated detailed written order in the client's medical record.

A completed detailed written order must contain all the following components:

- The client's name
- The date of the verbal order if different from the date the authorized prescribing provider signed the written order
- Description of item(s) to be provided, including make and model for a device
- Quantity to dispense (quantity required per day or month)
- Diagnosis code or description supporting the medical necessity

Before submitting a claim to Texas Medicaid, DME providers must have on file a detailed written order with the required information. No other documentation is required.

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Prior Authorization

Prior authorization, when necessary, may be considered with documentation of medical necessity, which must include one of the following:

- A completed Title XIX Form that has been signed and dated by the physician or an allowed practitioner who is familiar with the client. The make and model of a requested device must also be included on the Home Health Services Title XIX Form.
- Or all the following:
  - A completed and signed detailed written or verbal order.
  - A Title XIX Form with section A completed, along with the make and model information of the requested device.

Note: *Daily blood glucose logs are not required for prior authorization.*

2.2.12.3 Glucose Testing Equipment and Other Supplies

The prescribing provider must indicate on a completed, signed and dated Title XIX Form, or a signed and dated detailed written order how many times a day the client is required to test blood glucose or ketone levels when applicable (not all supplies are related to testing glucose or urine, e.g., batteries).

Glucose tablets or gel (procedure code A9150) may be considered with prior authorization when provided to a client with a diagnosis from the diagnosis code table below. Procedure code A9150 is limited to one per six months.

The procedure codes for the diabetic supplies listed in the following table do not require prior authorization, up to the quantities listed in the table, when provided to a client with a diagnosis from the diagnosis code table below. These limitations are not dependent on the client's use of insulin:

Procedure Code	Limitation
A4233	1 per 180 days
A4234	1 per 180 days
A4235	1 per 180 days
A4236	1 per 180 days
A4252	10 strips per month
A4256	2 per year
A4258	2 per year

Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require prior authorization up to the quantities listed when the supplies are provided to an insulin-dependent client with a valid diagnosis. If the client is insulin-dependent, providers must submit claims for these procedure codes with modifier U9:

Procedure Code	Limitation
A4253*	2 boxes per month
A4259	1 box per month
A9275*	2 per month
***A client may receive a combined total of two per calendar month of procedure codes A4253 and A9275, either two or one procedure code or one of each procedure code**	

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Non-Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require prior authorization up to the quantities listed when they are provided to a non-insulin-dependent client with a valid diagnosis. If the client is not insulin-dependent, providers must submit claims for these procedure codes with no modifier:

Procedure Code	Limitation
A4253*	1 box per month
A4259	1 box every 2 months
A9275*	1 per month
***A client may receive only one per calendar month of either procedure code A4253 or A9275.**	

The following diagnosis codes apply to the tables listed above:

Diabetic Diagnosis Codes							
E0800	E0801	E0810	E0811	E0821	E0822	E0829	E08311
E08319	E083211	E083212	E083213	E083219	E083291	E083292	E083293
E083299	E083311	E083312	E083313	E083319	E083391	E083392	E083393
E083399	E083411	E083412	E083413	E083419	E083491	E083492	E083493
E083499	E083511	E083512	E083513	E083519	E083521	E083522	E083523
E083529	E083531	E083532	E083533	E083539	E083541	E083542	E083543
E083549	E083551	E083552	E083553	E083559	E083591	E083592	E083593
E083599	E0836	E0837X1	E0837X2	E0837X3	E0837X9	E0839	E0840
E0841	E0842	E0843	E0844	E0849	E0851	E0852	E0859
E08610	E08618	E08620	E08621	E08622	E08628	E08630	E08638
E08641	E08649	E0865	E0869	E088	E089	E0900	E0901
E0910	E0911	E0921	E0922	E0929	E09311	E09319	E093211
E093212	E093213	E093219	E093291	E093292	E093293	E093299	E093311
E093312	E093313	E093319	E093391	E093392	E093393	E093399	E093411
E093412	E093413	E093419	E093491	E093492	E093493	E093499	E093511
E093512	E093513	E093519	E093521	E093522	E093523	E093529	E093531
E093532	E093533	E093539	E093541	E093542	E093543	E093549	E093551
E093552	E093553	E093559	E093591	E093592	E093593	E093599	E0936
E0937X1	E0937X2	E0937X3	E0937X9	E0939	E0940	E0941	E0942
E0943	E0944	E0949	E0951	E0959	E09610	E09618	E09620
E09621	E09622	E09628	E09630	E09638	E09641	E09649	E0965
E0969	E098	E099	E1010	E1011	E1021	E1022	E1029
E10311	E10319	E103211	E103212	E103213	E103219	E103291	E103292
E103293	E103299	E103311	E103312	E103313	E103319	E103391	E103392
E103393	E103399	E103411	E103412	E103413	E103419	E103491	E103492
E103493	E103499	E103511	E103512	E103513	E103519	E103521	E103522
E103523	E103529	E103531	E103532	E103533	E103539	E103541	E103542
E103543	E103549	E103551	E103552	E103553	E103559	E103591	E103592
E103593	E103599	E1036	E1037X1	E1037X2	E1037X3	E1037X9	E1039

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Diabetic Diagnosis Codes							
E1040	E1041	E1042	E1043	E1044	E1049	E1051	E1052
E1059	E10610	E10618	E10620	E10621	E10622	E10628	E10630
E10638	E10641	E10649	E1065	E1069	E108	E109	E10A0
E10A1	E10A2	E1100	E1101	E1110	E1121	E1122	E1129
E11311	E11319	E113211	E113212	E113213	E113219	E113291	E113292
E113293	E113299	E113311	E113312	E113313	E113319	E113391	E113392
E113393	E113399	E113411	E113412	E113413	E113419	E113491	E113492
E113493	E113499	E113511	E113512	E113513	E113519	E113521	E113522
E113523	E113529	E113531	E113532	E113533	E113539	E113541	E113542
E113543	E113549	E113551	E113552	E113553	E113559	E113591	E113592
E113593	E113599	E1136	E1137X1	E1137X2	E1137X3	E1137X9	E1139
E1140	E1141	E1142	E1143	E1144	E1149	E1151	E1152
E1159	E11610	E11618	E11620	E11621	E11622	E11628	E11630
E11638	E11641	E11649	E1165	E1169	E118	E119	E11A
E1300	E1301	E1310	E1311	E1321	E1322	E1329	E13311
E13319	E133211	E133212	E133213	E133219	E133291	E133292	E133293
E133299	E133311	E133312	E133313	E133319	E133391	E133392	E133393
E133399	E133411	E133412	E133413	E133419	E133491	E133492	E133493
E133499	E133511	E133512	E133513	E133519	E133521	E133522	E133523
E133529	E133531	E133532	E133533	E133539	E133541	E133542	E133543
E133549	E133551	E133552	E133553	E133559	E133591	E133592	E133593
E133599	E1336	E1337X1	E1337X2	E1337X3	E1337X9	E1339	E1340
E1341	E1342	E1343	E1344	E1349	E1351	E1352	E1359
E13610	E13620	E13621	E13622	E13628	E13638	E13641	E13649
E1365	E1369	E138	E139	O24011	O24012	O24013	O2402
O2403	O24414	O24415	O24424	O24425	O24434	O24435	O99810
O99814	O99815	P702					

Non-diabetic Diagnosis Codes

Non-diabetic Diagnosis Codes								
E161	E162	E16A1	E16A2	E16A3	E71111	E71310	E71311	E71312
E71313	E71314	E71318	E7132	E7420	E7421	E7429	E88810	E88811
E88818	E88819	E8882	E88A	K911	R7303	R7309	R81	

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

Alcohol wipes (procedure code A4245) and urine test or reagent strips or tablets (procedure code A4250) are a benefit of Texas Medicaid when they are necessary for the treatment of some diabetic conditions or other conditions and therefore are not limited to the diagnoses listed in the diagnosis code table above.

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Procedure code A4245 is limited to four boxes per month and must be submitted with modifier U4. Procedure code A4250 is limited to one box per six months. Prior authorization is not required for these procedure codes up to the quantities listed.

The quantity of glucose testing supplies billed for a one-month supply should relate to the number of tests ordered per day by the prescribing provider.

Glucose testing supplies may be reimbursed for the quantities prescribed or the quantity prior authorized.

Blood glucose test or reagent strips (procedure code A4253) and home glucose disposable monitors with test strips (procedure code A9275) are limited to a combined total of two per month.

2.2.12.3.1 Prior Authorization

Glucose tablets or gel (procedure code A9150) requires prior authorization with documentation supporting medical necessity.

Glucose testing supplies for quantities beyond the limits listed in the procedure code table above or for diagnoses other than those listed in the diagnosis code table above in subsection 2.2.12.3, "Glucose Testing Equipment and Other Supplies" in this handbook may be considered for prior authorization with documentation of medical necessity. Quantities will be prior authorized based on the documentation of medical necessity related to the number of tests ordered per day by the physician or allowed practitioner.

2.2.12.4 Blood Glucose Monitors (BGM)

Blood glucose monitors with integrated voice synthesizers (procedure code E2100) and blood glucose monitors with integrated lancing blood sample (procedure code E2101) may be considered for prior authorization with documentation of medical necessity.

Glucose monitors that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable.

Standard home glucose monitors (procedure code E0607) are not a benefit of Texas Medicaid.

2.2.12.4.1 Prior Authorization

Blood glucose monitors with special features (procedure code E2100 or E2101) may be considered for prior authorization with documentation supporting medical necessity for the special feature requested.

Purchase of a blood glucose monitor with integrated voice synthesizer (procedure code E2100) may be considered for prior authorization with documentation that includes a diagnosis of diabetes and significant visual impairment.

Purchase of a blood glucose monitor with integrated lancing and blood sample (procedure code E2101) may be considered for prior authorization with documentation that includes a diagnosis of diabetes and significant manual dexterity impairment related but not limited to neuropathy, seizure activity, cerebral palsy, or Parkinson's disease.

2.2.12.5 External Insulin Pump and Supplies

An external insulin infusion pump is a programmable, battery-powered mechanical syringe or reservoir device controlled by a microcomputer to provide a basal continuous subcutaneous insulin infusion (CSII) and release a "bolus" dose at meals and at programmed intervals. The pump is connected to an infusion set with an attached small needle or cannula that is inserted into the subcutaneous tissue. The purpose of the insulin pump is to provide an accurate, continuous, controlled delivery of insulin which can be regulated by the user to achieve intensive glucose control and prevent the metabolic complications of hypoglycemia, hyperglycemia and diabetic ketoacidosis. The typical external insulin pump capacity is two to three days of insulin.

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An external insulin pump must be ordered by, and the client's follow-up care must be managed by, a prescribing provider with experience managing clients with insulin infusion pumps and who is knowledgeable in the use of insulin infusion pumps.

The external insulin pump (procedure code E0784) may be considered for prior authorization with documentation of medical necessity. Procedure code E0784 is limited to one purchase every three years, and one rental per month. External insulin pumps that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable.

The following procedure codes for external insulin pump supplies are a benefit through Title XIX Home Health Services and do not require prior authorization up the maximum quantities allowed. Additional quantities may be considered with documentation of medical necessity and prior authorization.

Procedure Code	Limitation
A4224	4 per month
A4225	15 per month
A4230	15 per month
A4231	15 per month
A4232	10 per month
A4601	1 per 180 days
A4602	1 per 180 days
A6257	30 per month
A6258	30 per month
A6259	15 per month
K0601	4 per 2 months
K0602	4 per 2 months
K0603	4 per 2 months
K0604	1 per 6 months
K0605	1 per 6 months

Providers must bill replacement batteries (procedure codes K0601, K0602, K0603, K0604, and K0605 with modifier U1.

When there is not an appropriate procedure code for supplies providers may request prior authorization using procedure code A9900.

The external insulin pump supplies (including batteries) are not included in the external insulin pump rental. Routine maintenance of rental equipment is the provider's responsibility.

Infusion sets for the external insulin pump (procedure codes A4230 or A4231) are limited to clients with a previously billed external insulin pump device or supply. Infusion sets for clients who did not receive the external insulin pump through Texas Medicaid are considered for reimbursement on appeal with a physician or allowed practitioner's statement documenting medical necessity.

An internal insulin pump will not be prior authorized as it is considered part of the surgery to place the pump.

2.2.12.5.1 Prior Authorization

Prior authorization is required for an external insulin pump (procedure code E0784) with carrying cases.

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Rental of External Insulin Pump

An external insulin pump may be considered for prior authorization of rental with submission of clinical documentation indicating one of the following:

- A client who has a diagnosis of type 1 or 2 diabetes must meet at least two of the following criteria while on multiple daily administrations of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) > 7.0 percent
  - History of dawn phenomenon or Somogyi phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
  - History of severe glycemic excursions with wide fluctuations in blood glucose
  - History of problematic hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
  - Anticipation of pregnancy within three months
- A client with a diagnosis of gestational diabetes must meet at least one of the following criteria:
  - Erratic blood sugars in spite of maximal compliance and split dosing
  - Other evidence that adequate control is not being achieved by current methods

In addition to the clinical documentation the provider must submit the External Insulin Pump form indicating:

- The client or caregiver possess the following competencies:
  - The cognitive and physical abilities to use the recommended insulin pump treatment regimen
  - An understanding of cause and effect
  - The willingness to support the use of the external insulin pump
- The prescribing provider must attest that:
  - A training/education plan will be completed prior to initiation of pump therapy.
  - The client or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

Purchase of External Insulin Pump

An external insulin pump may be considered for prior authorization of purchase after it has been rented for a three-month trial and all of the following documentation is provided:

- The training/education plan has been completed
- The pump is the appropriate equipment for the specific client
- The client is compliant with the use of the pump

2.2.12.6 Insulin and Insulin Syringes

Insulin and insulin syringes (0.5 and 1.0 cc sizes only) that are prescribed to fee-for-service clients are reimbursed through the Texas Vendor Drug Program (VDP) and are not covered under Title XIX Home Health Services. The Texas Vendor Drug Program only enrolls pharmacies.

Refer to: The *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about VDP.

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2.2.12.7 Continuous Glucose Monitors (CGM)

CGMs are devices that measure glucose levels taken from interstitial fluid continuously throughout the day and night, providing real-time data to the client, physician, or an allowed practitioner.

The CGM is comprised of three parts:

- A disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels)
- A transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor)
- A receiver/monitor (records and stores the data and alerts the client when glucose levels are too high or too low)

Only CGM consisting of all three parts including the sensor, transmitter, and receiver/monitor are covered. Coverage requires a dedicated receiver/monitor. A CGM that uses a smart device (e.g., smart phone, tablet, watch, personal computer, etc.) as a receiver is not classified as durable medical equipment and therefore not covered by Medicaid.

The general term CGM refers to both non-adjunctive (formerly referred to as therapeutic) and adjunctive (formerly referred to as nontherapeutic) CGMs.

A non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone BGM to confirm testing results. An adjunctive CGM requires the user to verify their glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions.

A long-term personal CGM system for clients who have diabetes to use at home may be considered as a Medicaid DME benefit with prior authorization using procedure codes E2102 (device) and A4238 (supplies) for adjunctive CGM; procedure codes E2103 (device) and A4239 (supplies) for non-adjunctive CGM.

Note: *There are no devices on the United States market that function as stand-alone adjunctive CGM devices. Current technology for adjunctive CGM devices operates in conjunction with an insulin pump.*

The short-term CGM (worn a minimum of 72 hours) is used for diagnostic purposes to establish or modify the client's treatment plan, which is a distinct and separate Texas Medicaid benefit.

When a CGM (procedure code E2102 or E2103) is covered, the related supply allowance (procedure code A4238 or A4239) is also covered. Supplies (procedure code A4238) for an adjunctive CGM integrated into an external insulin infusion pump are covered when the client meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion.

The following non-adjunctive CGM device procedure codes and related supplies will be a benefit when provided by medical supplier durable medical equipment (DME) providers in the home setting:

Procedure Code	Limitation
E2102	1 per 3 years
E2103	1 per 3 years
A4238	1 per month
A4239	1 per month

Refer to: Subsection 9.2.24, "Continuous Glucose Monitoring (CGM)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*)

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2.2.12.7.1 Prior Authorization

A personal CGM for clients with diabetes to use at home may be considered as a Medicaid DME benefit with prior authorization using procedure code E2102 for adjunctive CGM and E2103 for non-adjunctive CGM.

A CGM must be prescribed by the client's treating practitioner performing the glucose monitoring.

The following initial criteria must be met for the client to qualify for the CGM benefit:

- A client must have diabetes mellitus and meet all of the following medical necessity criteria:
  - The client is insulin treated; or
  - The client has a history of problematic hypoglycemia with documentation of at least one of the following:
    - Recurrent (more than one) level 2 hypoglycemic events (glucose <54 mg/dL [3.0 mmol/L] that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or
    - A history of one level 3 hypoglycemic event (glucose <54 mg/dL [3.0 mmol/L]) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia.
- A client with hypoglycemia unawareness or several episodes of hypoglycemia a day also qualifies for the CGM benefit if the client does not meet the criteria outlined above.
- The client's treating practitioner has concluded that the client (or the client's caregiver) has sufficient training using the CGM prescribed as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing.
- Have documentation of medical necessity and a provider statement in the medical record that the client has a history of performing daily self-blood glucose monitoring.
- The CGM is prescribed in accordance with its FDA indications for use.

Note: *Daily blood glucose logs are not required for prior authorization.*

Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person or Medicaid-approved telemedicine visit with the client to evaluate their diabetes control and determined that the criteria in this section are met.

For continued CGM coverage, every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person or Medicaid-approved telemedicine visit with the client to document adherence to the CGM regimen and diabetes treatment plan.

Prior authorization is not required for CGM supplies once a device is approved. When a CGM (procedure code E2102 or E2103) is covered, the related supply allowance (procedure code A4238 or A4239) is also covered.

There are no devices on the United States market that function as stand-alone adjunctive CGM devices according to the CMS definition of DME. Current technology for adjunctive CGM devices (procedure code E2102) operates in conjunction with an insulin pump, and its supplies (procedure code A4238) are covered when the beneficiary meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion pump.

CGM devices that have been purchased are expected to last a minimum of three years and may be considered for replacement when three years have passed, or the equipment is no longer repairable. The replacement of the equipment may also be considered when the equipment has been lost or irreparably damaged. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent a reoccurence must be submitted. Additional services may be reimbursed with prior authorization based on documentation of medical necessity.

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2.2.12.7.2 Claims Filing Requirements

Only one CGM system may be authorized for the qualified diabetic client. The ordering provider is responsible for requesting the appropriate device and supplies according to the client's medical need.

The ordering provider should also verify that the client's condition meets the manufacturers' recommendations for appropriate age range, testing and calibration requirements, etc., prior to prescribing the CGM device.

The provider must submit procedure codes E2102 or E2103 with the KF modifier when billing for a class III CGM device (designated by FDA). No modifier is required for a class II device (designated by FDA).

No prior authorization is required for CGM integrated insulin pump supplies. When a CGM integrated pump is covered, its supplies (procedure code A4238 or A4239) are also covered.

The supply allowance (procedure code A4238 or A4239) is billed as one unit of service per 30 days. Only one unit of service of procedure code A4238 or A4239 may be billed to the claim system at a time. Billing more than one unit of service per 30 days of procedure code A4238 or A4239 will be denied as not reasonable and necessary.

Non-adjunctive CGM devices replace standard home BGMs and related supplies. The following procedure codes for BGM and its related supplies will be denied when billed with a non-adjunctive CGM (procedure code E2103) and its associated supply allowance (procedure code A4239):

Procedure Code									
A4233	A4234	A4235	A4236	A4244	A4245	A4246	A4247	A4250	A4253
A4255	A4256	A4257	A4258	A4259	E0607	E2100	E2101		

Adjunctive CGM devices do not replace a standard home BGM. The supply allowance for an adjunctive CGM (procedure code A4238) encompasses all items necessary for the use of the device and includes, but is not limited to, CGM sensors and transmitters. Procedure code A4238 does not include a home BGM and related BGM testing supplies. Clients on an insulin pump with adjunct CGM capability may be billed separately, in addition to procedure code A4238:

- Two boxes for test strips (procedure code A4253), and
- One box for lancets (procedure code A4259) during the same calendar year by any provider.

The initial order from a health-care provider who manages the client's diabetes is valid for the first six months. If the client continues to be compliant with use of the CGM and treatment plan, the provider may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitter, and receiver (following frequency rules) may be written for a 12-month period.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

Requests for the supplies for client-owned CGM devices require the ordering provider to submit a statement attesting that the client meets one of the following conditions:

- The client owns a CGM device and the client's current condition meets the criteria outlined in this policy for the CGM.
- The client owns a CGM device and is compliant with using the CGM device to manage their diabetes.

2.2.12.7.3 Non-Covered Services

CGM devices (procedure code A9278) and supplies (procedure codes A9276 and A9277) for use with non-durable medical equipment are informational only. DME is defined as:

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- Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician or allowed practitioner for use in the home, and required to correct or ameliorate a client's disability, condition, or illness.

Refer to: Subsection 2.2.2, "Durable Medical Equipment (DME) and Supplies" in this handbook.

The following services are not benefits of Texas Medicaid:

- Rental of adjunct CGM devices
- Smart devices (smart phones, tablets, personal computers, etc.) used as GCM monitors
- Medical supplies used with non-covered equipment

2.2.12.8 CGM Integrated External Insulin Pump

A CGM integrated pump is an insulin pump that has the CGM capability. The system uses an algorithm to calculate insulin doses from the CGM readings based on thresholds of measured glucose levels and tells the pump to deliver or suspend the insulin into the client's body.

A CGM integrated pump system may be considered for prior authorization when the client meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion pump. Use pump procedure code E0784 with modifier UD and procedure code E2102 with modifier U4 for an insulin pump that has adjunctive CGM capability. Pump procedure code E0784 with modifier UD and procedure code E2103 with modifier U4 may be used for an insulin pump that has non-adjunctive CGM capability.

A tubeless external insulin pump (Omnipod) may be considered as an alternative to the CGM integrated pump system through prior authorization using pump procedure code E0784 with modifier U1 combined with the disposable supply procedure code A9274.

Procedure Code	Limitation
E0784	1 per 3 years
E2102	1 per 3 years
E2103	1 per 3 years
A9274	15 per month

2.2.12.8.1 Prior Authorization

A CGM integrated pump system may be considered for prior authorization when the client meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion pump outlined in this handbook.

Providers must submit the pump (procedure code E0784) with modifier UD and CGM device (procedure code E2102 or E2103) to specify a CGM integrated pump system.

Some CGM integrated pump systems use smart devices to monitor the system to carry out their function. The device provider is responsible for supplying the software applications to make the system work appropriately.

Prior authorization requests for the tubeless external insulin pump (Omnipod) must be submitted using procedure code E0784 with U1 modifier. Disposable pods requests are submitted using supply procedure code A9274.

2.2.12.8.2 Claims Filing Requirements

To qualify for a CGM integrated external insulin pump, the client must meet both CGM criteria and external insulin pump criteria outlined in this handbook.

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Only one CGM integrated pump may be authorized for the qualified diabetic client. The ordering provider is responsible for requesting the appropriate device and supplies according to the client's medical need using the appropriate procedure codes.

Once the client is on a CGM integrated insulin pump, either with non-adjunctive CGM capability or with adjunctive CGM capability, claims for a stand-alone CGM will be denied.

Once the client is on a CGM integrated insulin pump, either with non-adjunctive CGM capability or with adjunctive CGM capability, claims for a regular external insulin pump will be denied.

Provider's must bill the pump (procedure code E0784) used in the CGM integrated system with modifier UD. Providers also must bill the CGM capability device (procedure code J-E2102 or J-E2103) with modifier U4 for the integrated system.

Some CGM integrated pump systems might use smart devices to monitor the system. The Medicaid DME Benefit excludes coverage for non-medical items, even when the items may be used to serve a medical purpose. The device provider is responsible for supplying the software applications to make the system work appropriately.

The alternative tubeless external insulin pump (Omnipod) should be billed using the same external insulin pump code E0784 with a U1 modifier and A9274 for its disposable pod including all supplies and accessories.

Refer to: Subsection 2.2.12.5.1, "Prior Authorization" in this handbook for prior authorization criteria that will also apply to a CGM integrated pump system or an Omnipod.

2.2.13 Donor Human Milk

Donor human milk is a benefit for clients who are birth through 11 months of age when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include all of the following:

- The ordering physician or allowed practitioner has documented medical necessity and appropriateness.
- The parent or guardian has signed and dated an informed consent form indicating that the risks and benefits of using banked donor human milk have been discussed with them.
- The donor human milk bank adheres to quality guidelines consistent with the Human Milk Bank Association of North America or such other standards as may be adopted by HHSC.

Additional donor human milk benefits beyond the limitations listed in this handbook may be available to clients who are birth through 20 years of age with documentation of medical necessity.

Procedure code B9998 must be used when requesting or billing for donor human milk.

Donor human milk is reimbursed at a maximum fee determined by HHSC or manual pricing.

Donor human milk is only reimbursed to a Texas Medicaid-enrolled donor milk bank and only for children who are in the home setting.

The physician or allowed practitioner must address the benefits and risks of using donor human milk, such as HIV, freshness, effects of pasteurization, nutrients, and growth factors to the parent. The physician or allowed practitioner also must address donor screening, pasteurization, milk storage, and transport of the donor milk. The physician or allowed practitioner may obtain this information from the donor milk bank.

2.2.13.1 Prior Authorization and Documentation Requirements

Donor human milk may be considered for a maximum of six months per authorization. The authorization may be extended with documentation of medical necessity.

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Prior authorization is required for donor human milk provided through Texas Medicaid THSteps CCP Services.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

To obtain prior authorization, ordering providers must complete the CCP Prior Authorization Request Form and a Donor Human Milk Request Form every 180 days. The completed CCP Prior Authorization Request Form must be signed and dated by a physician or allowed practitioner familiar with the client before submitting the prior authorization request, and must include the procedure codes and quantities for the services requested.

The physician or allowed practitioner ordering the donor human milk must complete all of the fields in Part A of the original form, including the documentation of medical necessity. This information must be substantiated by written documentation in the clinical report. The physician or allowed practitioner must specify the quantity and the time frame in the Quantity Requested field (e.g., cubic centimeters per day or ounces per month). All of the fields in Part B of the form must be completed by the donor milk bank providing the donor human milk.

The completed CCP Prior Authorization Request Form and Donor Human Milk Request Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the milk bank in the client's medical record.

To complete the prior authorization process by paper, the rendering provider must fax or mail the completed form to the CCP prior authorization unit. To complete the prior authorization process electronically, the rendering provider must submit the prior authorization requirements through any approved electronic methods.

The completed documentation of medical necessity and appropriateness and the signed and dated written informed consent form must be maintained in the client's clinical records. The documentation must address all of the following:

- Medical necessity, including why the particular client cannot survive and gain weight on any appropriate formula (e.g., elemental, special, or routine formula or food), or any enteral nutritional product other than donor human milk.
- Clinical feeding trial of an appropriate nutritional product has been considered with each authorization.
- The informed consent provided to the parent or guardian details the risks and benefits of using banked donor human milk.
- A copy of the CCP Prior Authorization Request Form and the Donor Human Milk Request Form.

Refer to: Donor Human Milk Request Form on the TMHP website at www.tmhp.com.

CCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.

2.2.13.2 Donor Human Milk Services for Inpatient Clients

Donor human milk may be reimbursed to hospital providers for services rendered to inpatient clients. Hospital providers may receive reimbursement for the donor human milk service separate from the inpatient diagnosis-related group (DRG) payment.

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The hospital may be reimbursed using the following revenue and procedure code combination as an outpatient hospital service using the CMS-1450 (UB-04) claim form with the most appropriate outpatient type of bill (TOB):

Revenue Code	Procedure Code
220 (special charges)	T2101

For proper reimbursement when billing procedure code T2101, the Units field on the claim form must indicate the number of ounces rendered to the client.

Procedure code T2101 may be reimbursed for donor human milk as medically necessary for clients who are 6 months of age and younger. Prior authorization is not required.

Hospitals must follow clinical recommendations for administering donor human milk to inpatient clients, and must maintain all applicable and appropriate medical necessity documentation in the client's medical record.

2.2.14 Hospital Beds and Equipment

A hospital bed and related equipment are considered for reimbursement for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. A hospital bed is not one that is typically sold as home furniture. A standard bed typically sold as furniture may consist of a frame, box spring, and mattress, and is of fixed height, and has no head or leg elevation adjustments. These types of beds are not:

- Primarily medical in nature.
- Made with materials that can withstand frequent cleaning and disinfecting.
- Primarily used in the treatment of disease or injury.
- Considered Durable Medical Equipment (DME) by Texas Medicaid.

The following items are a benefit of Home Health Services with prior authorization:

- Hospital bed
- Air-fluidized bed
- Pressure pads or a nonpowered pressure-reducing mattress overlay
- Nonpowered pressure-reducing mattress
- Powered pressure-reducing mattress overlay system
- Powered pressure-reducing mattress
- Advanced nonpowered pressure-reducing mattress overlay
- Powered pressure-reducing mattress overlay
- Advanced nonpowered pressure-reducing mattress
- Sheepskin and lamb's wool pads
- Decubitus care accessories

Note: *For clients who are 20 years of age and younger and do not meet criteria through Title XIX Home Health Services, hospital beds and equipment may be considered through the Texas Health Steps—Comprehensive Care Program (THSteps-CCP).*

Note: *For clients who are 21 years of age or older, requests for hospital beds and equipment that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

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Beds which are primarily used for the purpose of safety are not a benefit of Texas Medicaid. These beds do not meet the definition of durable medical equipment as described by 42 CFR § 414.202. Side rails or mattresses may be considered for replacement only and may be considered if it is a client-owned hospital bed and the client's condition requires a replacement of an innerspring mattress or side rails.

The following items may be considered for clients who are birth through 20 years of age when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition:

- Pediatric hospital cribs and beds
- Enclosure frame, canopy, or bubble tops
- Positioning pillows or cushions
- Reflux wedges
- Reflux slings

Hospital beds, cribs, and equipment are a benefit when all the following criteria are met:

- FFP must be available.
- The requested equipment or supplies must be safe for use in the home.

2.2.14.1 Hospital Beds

A hospital bed is defined as a medical device with all of the following features:

- An articulating frame that allows adjustment of the head and foot of the bed for the purpose of repositioning
- A headboard
- A foot board
- A mattress
- Side rails of any type (Texas Medicaid defines side rail as a hinged or removable rail, board, or panel of any height.)

Note: *Without all the components listed above, Texas Medicaid will not consider a request for any hospital bed.*

2.2.14.2 Pediatric Hospital Bed

A pediatric hospital bed or pediatric crib is defined as a medical device with all of the following features:

- A bed that allows adjustment of the head and foot of the bed.
- A manual pediatric hospital bed (procedure code E0328) or pediatric crib (procedure code E0300) allows manual adjustment to the head and leg elevation.
- A semi-electric or fully electric hospital bed (procedure code E0329) allows manual or electric adjustments to height and electric adjustments to head and leg elevation.
- A headboard
- A footboard
- A mattress
- Side rails of any type (A side rail is defined as a hinged or removable rail, board, or panel.)

Pediatric hospital beds and pediatric cribs that do not have all of these features will not be considered for prior authorization.

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A bed that has side rails that extend 24 inches or less above the mattress is considered a pediatric hospital bed (procedure code E0328 or E0329). A pediatric hospital bed may be fixed or variable height. Variable height beds may be adjusted manually or electrically as required for the client's medical condition.

Procedure codes E0328 and E0329 are restricted to clients who are 20 years of age and younger.

A bed that has side rails that extend more than 24 inches above the mattress is considered a pediatric crib (procedure code E0300).

A pediatric hospital bed or pediatric crib of any width that has all of the features defined above may be considered for prior authorization using only procedure code E0300, E0328, or E0329.

Hospital beds that are not fully enclosed can be considered through Texas Medicaid home health services.

Note: *Texas Medicaid defines a fully enclosed crib or bed as having 360-degree side enclosures.*

The following procedure codes are used when billing for the rental or purchase of pediatric hospital beds, cribs, and equipment:

Procedure Codes									
E0190*	E0300	E0316	E0328	E0329	E1399	K0739*			
*** Purchase only**									

Note: *Reflux slings must be billed using procedure code E1399.*

The purchase of a safety enclosure frame, canopy, or bubble top (procedure code E0316) may be a benefit when the protective crib top or bubble top is for safety use. It is not considered a benefit when it is used as a restraint or for the convenience of family or caregivers.

Procedure code E0316 may be used in conjunction with procedure codes E0300, E0328, or E0329 to request a pediatric fully-enclosed bed with a canopy.

Reflux slings or wedges may be considered for clients who are birth through 11 months of age. Reflux slings or wedges may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician or allowed practitioner as medically necessary and appropriate.

Procedure code E0190 with modifier UD must be used to bill the purchase of reflex wedges and positional devices (positioning pillows and cushions). This code and modifier will require manual pricing. Procedure code E0190 is limited to once per three years, per client, any provider.

Procedure code K0739 may be reimbursed for the repair of equipment.

2.2.14.3 Prior Authorization

Hospital beds may be considered for prior authorization for clients who cannot safely utilize a regular bed.

2.2.14.3.1 Fixed-Height Hospital Bed

A fixed-height bed (procedure code E0250), which allows for manual adjustment to the head and leg elevation but not height, may be considered for prior authorization if at least one of the following criteria exists:

- The client's medical condition requires positioning of the body in ways that are not feasible in an ordinary bed.
- The client's medical condition requires special positioning to alleviate pain.

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- It is necessary to elevate the head of the bed 30 or more degrees most of the time due to, but not limited to, congestive heart failure, chronic pulmonary disease, or problems with aspiration, and alternative measures such as wedges or pillows, have been attempted but have failed to manage the client's medical condition.

  Note: *Texas Medicaid defines a failed measure as having no clinically significant improvement after being introduced.*

- The client requires traction equipment that can only be attached to a hospital bed.

2.2.14.3.2 Variable-Height Hospital Bed

A variable-height hospital bed (procedure E0255), which allows manual adjustments to height as well as to head and leg elevations, may be considered for prior authorization if the client meets the criteria for a fixed -height hospital bed and requires a bed height that is different from a fixed-height hospital bed to permit transfers in and out of the bed to a chair, wheelchair, or to a standing position. Medical conditions that require a variable-height hospital bed include, but are not limited to, the following:

- Severe arthritis and other injuries to lower extremities that require the variable height feature to assist in ambulation by enabling the client to place his or her feet on the floor while sitting on the edge of the bed.
- Severe cardiac conditions, where the client is able to leave the bed, but must avoid the strain of "jumping" up and down.
- Spinal cord injuries (including quadriplegia and paraplegia), multiple limb amputations, and stroke, where the client is able to transfer from a bed to a wheelchair with or without help.
- Other severely debilitating diseases and conditions if the client requires a bed height different than a fixed-height hospital bed to permit transfers to a chair, wheelchair, or to a standing position.

2.2.14.3.3 Semi-Electric Hospital Bed

A semi-electric hospital bed (procedure code E0260), which allows manual adjustments to height and electric adjustments to head and leg elevation, may be considered for prior authorization if the client meets the criteria for a fixed-height hospital bed and has a condition that requires frequent changes in body position or might require an immediate change in body position to avert a life-threatening situation.

2.2.14.3.4 Fully-Electric Hospital Bed

A fully-electric bed (procedure code E0265), which allows electric adjustments to height and head and leg elevation, may be considered for prior authorization when all of the following criteria are met:

- The client has paraplegia or hemiplegia.
- The fully-electric hospital bed will allow the client to have functional independence with self-care.

Documentation must include an attestation statement from the client's physician, allowed practitioner, or physical or occupational therapist that verifies a determination has been made that the fully-electric hospital bed will allow the client to independently meet their daily self-care needs.

The following hospital beds may be considered for prior authorization if the client meets the criteria for a hospital bed and the weight requirements for a bariatric bed as listed below:

- Heavy-duty, extra-wide hospital bed (procedure code E0303) capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds
- Extra heavy-duty, extra-wide hospital bed (procedure code E0304) capable of supporting a client who weighs more than 600 pounds

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2.2.14.3.5 Pediatric Hospital Beds and Safety Enclosure

Pediatric hospital beds and pediatric cribs (procedure codes E0300, E0316, E0328, and E0329) may be considered for prior authorization when the documentation submitted clearly shows that the requested bed or crib will correct or ameliorate the client's condition. The documentation must meet at least one of the following criteria:

- The client's medical condition requires positioning of the body in ways that are not feasible in an ordinary bed, including, but not limited to, the need for positioning to alleviate pain.
- The head of the bed must be elevated 30 or more degrees most of the time due to, but not limited to, congestive heart failure, chronic pulmonary disease, or problems with aspiration, and alternative measures, such as wedges or pillows, have been attempted but have failed to manage the client's medical condition.

  Note: *Texas Medicaid defines a failed measure as having no clinically significant improvement after being introduced.*

- The client requires traction equipment that can only be attached to a hospital bed.

A semi-electric or fully electric hospital bed (procedure code E0329) may be considered for prior authorization when the submitted documentation shows that the client has a medical condition that requires frequent changes in body position or might require an immediate change in body position to avert a life-threatening situation.

The safety enclosure frame, canopy, or bubble top may be considered for prior authorization with documentation that the protective canopy top or bubble will provide for the client's safety. Prior authorization will not be considered when it will be used as a restraint or for the convenience of family or caregivers.

Reminder: *A safety enclosure (procedure code E0316) is an accessory used in conjunction with a pediatric hospital bed or crib.*

Reflux slings or wedges may be considered for prior authorization for clients who are 11 months of age and younger. These may be used as positioning devices for infants who require the head of the bed or crib to be elevated greater than 30 degrees after feedings when prescribed by a physician or an allowed practitioner as medically necessary and appropriate.

Positioning pillows and cushions may be considered for prior authorization with documentation of medical necessity that indicates the item will provide for or assist in the positioning needs of the client to maintain proper body alignment and skin integrity. Documentation must include what other devices have been used previously and why they proved to be ineffective.

Items used for PT or rehabilitation in the home are provided by the therapist. Requests for authorization for these purposes will not be considered.

2.2.14.4 Documentation Requirements

To request prior authorization for a hospital bed, the following documentation must be submitted:

- Accurate diagnostic information pertaining to the underlying medical diagnoses or conditions (e.g., gastrostomy feeding, suctioning, ventilator dependent, other respiratory equipment or ventilation assistance devices) to include the client's overall health status
- Client height and weight
- Client functional mobility status
- Client use of any pressure-reducing support surfaces, if applicable

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The following documentation must be submitted for clients who are birth through 20 years of age:

- The diagnosis, medical needs, treatments, developmental level, and functional skills of the child. A diagnosis alone is insufficient information to consider prior authorization of the requested equipment.
- The age, length, and weight of the child.
- Description of any other devices that have been used, the length of time used, and why they were ineffective.
- How the requested equipment will correct or ameliorate the client's condition beyond that of a standard child's crib, regular bed, or standard hospital bed.
- The name of the manufacturer and the manufacturer's suggested retail price (MSRP).

A determination will be made by HHSC or its designee whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment. All modifications, adjustments, and repairs within the first six months after delivery are considered to be part of the purchase price.

2.2.14.5 Mattresses and Support Surfaces

A pressure-reducing support surface includes three separate groups of mattress or mattress-like equipment designed to assist in the healing of wounds. These devices are used in conjunction with conventional wound care therapy to prevent the occurrence of said wounds in susceptible clients. Pressure-reducing support surfaces are designed to prevent skin breakdown or to promote the healing of pressure ulcers by reducing or eliminating tissue interface pressure. Most of these devices reduce interface pressure by conforming to the contours of the body so that pressure is distributed over a larger surface area rather than concentrated on a more circumscribed location.

For all types of pressure-reducing support surfaces, the support surface provided for the client should be one in which the client does not "bottom out." The Centers for Medicare & Medicaid Services (CMS) defines "bottoming out" as: when an outstretched hand, palm up, between the undersurface of the overlay or mattress and in an area under the bony prominence can readily palpate the bony prominence (coccyx or lateral trochanter). This "bottoming out" criterion should be tested with the client in the supine position with head flat, in the supine position with head slightly elevated (no more than 30 degrees), and in the side-lying position.

Pressure-reducing support surfaces containing multiple components are categorized according to the clinically predominant component (usually the top-most layer of a multi-layer product) and the presence and stage of pressure ulcers.

The staging of pressure ulcers is as follows:

Stage I: Observable pressure related alteration of intact skin whose indicators are as follows:

- Compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), or sensation (pain, itching).
- The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III: Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

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Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

2.2.14.5.1 Documentation Requirements

A support surface that does not meet the characteristics specified in the criteria for grouping levels may be denied and considered to be not medically necessary.

To request prior authorization for a pressure-reducing support surface, the following documentation must be provided:

- Client's overall health status and all other medical diagnoses or conditions (e.g., history of decubitus)
- Documentation of the client's limited mobility or confinement to a bed
- History of previous use and results of pressure-reducing support surfaces, (e.g., wound improvement, stasis, or degradation)
- Current wound therapy, if any

2.2.14.5.2 Group 1 Support Surfaces

A group 1 Support Surface may be considered for prior authorization with documentation of medical necessity if the client is completely immobile without assistance, or the client has limited mobility or existing pressure ulcer on the pelvis or trunk and at least one of the following conditions:

- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception
- Compromised circulatory status

All of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 1 support surfaces are met.

Pressure pads or a nonpowered pressure-reducing mattress overlay for mattresses with the following features may be considered for reimbursement with documentation of medical necessity:

- A gel or gel-like layer with a height of two inches or greater
- An air mattress overlay with interconnected air cells that are inflated with an air pump and a cell height of three inches or greater
- A water mattress overlay with a filled height of three inches or greater
- A foam mattress overlay with all the following features:
    - Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is an unconvoluted overlay
    - Foam with a density and other qualities that provide adequate pressure reduction
    - Durable, waterproof cover

Nonpowered pressure-reducing mattresses, with the following features, may be considered for reimbursement with documentation supporting medical necessity:

- A foam mattress with all the following features may be considered with documentation supporting medical necessity. Documentation must include all the following features:
    - A foam height of five inches or greater

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  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover
  - Can be placed directly on a hospital bed frame
- An air, water, or gel mattress with all the following features may be considered for reimbursement:
  - A height of five inches or greater
  - Durable, waterproof cover

A powered pressure reducing mattress overlay system, with all the following features, may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of air cells, or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduces pressure, and prevents bottoming out.

2.2.14.5.3 Group 2 Support Surfaces

A Group 2 support surface may be considered for prior authorization with documentation of medical necessity if the client has multiple stage II ulcers on the trunk or pelvis and has been on a comprehensive ulcer treatment program for at least the past month which has included the use of a Group 1 support surface.

The client must also have at least one of the following:

- The ulcers have remained the same or worsened over the past month.
- There are large or multiple stage III or IV pressure ulcers on the trunk or pelvis.
- Received a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the last 60 days, and have been prescribed or placed on a Group 2 or 3 support surface immediately before discharge (within the last 30 days) from the hospital or a nursing facility

All of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 2 support surfaces are met.

The powered pressure reducing mattress (alternating pressure low air loss, or powered flotation without air loss) device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress.
- Inflated cell height of the air cells through which air is being circulated is five inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattress), and air pressure to provide adequate client lift, reduce pressure, and prevent bottoming out.
- A surface designed to reduce friction and shear.

A semi-electric hospital bed with fully integrated powered pressure-reducing mattress that has all the features described above may be considered for reimbursement when documentation supports medical necessity.

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The advanced nonpowered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- Height and design of individual cells which provide significantly more pressure reduction than Group 1 overlay and prevent bottoming out
- Total height of 3 inches or greater
- A surface designed to reduce friction and shear
- Manufacturer product information that substantiates the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

The powered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower that provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is three and a half inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate client lift, reduce pressure and prevent bottoming out.

The advanced nonpowered pressure-reducing mattress device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- Height and design of individual cells designed to provide significantly more pressure than a Group 1 mattress and prevent bottoming out
- Total height of 5 inches or greater
- A surface designed to reduce friction and shear
- Documented evidence substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

Sheepskin and lamb's wool pads are considered a benefit of the Home Health Services Program under the same conditions as alternating pressure pads and mattresses (Group 2 pressure-reducing support surfaces) when prior authorized.

2.2.14.5.4 Group 3 Support Surfaces

A Group 3 support surface may be considered for prior authorization with documentation of medical necessity when all the following criteria are met:

- There is a presence of a stage III or IV ulcer.
- Severely limited mobility rendering the client bed or chair bound.
- Without an air-fluidized bed, the client would be institutionalized.
- The client has been placed on a Group 2 support surface for at least a month before ordering the air-fluidized bed with the ulcers not improving or worsening.
- There has been at least weekly assessment of the wound by the physician, a nurse or other licensed health-care professional and the treating physician or allowed practitioner has done a comprehensive evaluation of the client's condition within the week before ordering the air-fluidized bed.

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- A trained adult caregiver is available to assist the client with activities of daily living, maintaining fluid balance, supplying dietary needs, aiding in repositioning and skin care, administering prescribed treatments, recognizing and managing altered mental status, and managing the air-fluidized bed system and its potential problems, such as leakage.
- The physician or allowed practitioner continues to re-evaluate and direct the home treatment regimen monthly.
- All other alternative equipment has been considered and ruled out.

The existence of any one of the following conditions may result in noncoverage of the air-fluidized bed:

- Coexisting pulmonary disease (the lack of firm back support can render coughing ineffective and dry air inhalation thickens pulmonary secretions).
- Wounds requiring moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material (if wet-to-dry dressings are being utilized, dressing changes must be frequent enough to maintain their effectiveness).
- For clients who are 21 years of age and older, the caregiver is unwilling or unable to provide the type of care required by the client who uses an air-fluidized bed.
- The home's structural support or electrical system cannot safely accommodate the air-fluidized bed.

Initial prior authorization for a Group 3 pressure-reducing support surface will be for no more than 30 days. Prior authorized extensions may be considered for reimbursement in increments of 30-day periods, up to a maximum of four months, when documentation supports continued significant improvement in wound healing. Coverage beyond four months will be on a case-by-case basis after review by the medical director or designee.

Air-fluidized beds may be considered for reimbursement when the medical necessity criteria for Group 3 support surfaces are met.

2.2.14.6 Equipment and Other Accessories

The following equipment or accessories may be considered with documentation of medical necessity:

- Positioning devices
- Bed cradle (keeps bed covers from touching affected skin)
- Trapeze bars

2.2.14.6.1 Accessories

A mattress of any size with innerspring may be considered for prior authorization with procedure code E0271.

Replacement rails and hospital bed frame padding or covers may be considered for prior authorization as a hospital bed accessory (procedure code E0315) with documentation that the padding, covers or rails are required to prevent injury (for example, related to seizure activity) or to prevent entrapment.

2.2.14.6.2 Prior Authorization

Heel or elbow protector (procedure code E0191) does not require prior authorization. Prior authorization is required for all other hospital beds, equipment, and services provided through Texas Medicaid Title XIX Home Health Services. Prior authorization also includes any accessories, modifications, adjustments, and repairs of the equipment. Positioning cushions or pillows (procedure code E0190) may be considered with documentation of medical necessity that the item will provide pressure relief and positioning in the treatment of decubiti, burns, or musculoskeletal injuries. Documentation must include a listing of other devices that have been used and why the devices proved ineffective.

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A trapeze bar attached to a bed (procedure code E0910 or E0911) may be considered if the client requires this device to sit up, to change body position, to get in or out of bed, or for other medical reasons with documentation of medical necessity.

"Free-standing" trapeze equipment (procedure code E0912 or E0940) may be considered if the client does not have an eligible hospital bed, but the client needs this device to sit up, to change body position, to get in or out of bed, or for other medical reasons with documentation of medical necessity.

An over-bed table (procedure code E0315) may be considered if the client is bed-bound and needs the over-bed table for treatments.

2.2.14.7 Decubitus Care Accessories

For prior authorization of decubitus care accessories, the following documentation must be provided:

- Wound measurements including location, length, width, and depth
- Any undermining or tunneling
- Odor, if applicable

2.2.14.8 Replacement

Beds rails and frames that have been purchased are anticipated to last a minimum of five years.

2.2.14.8.1 Prior Authorization

Prior authorization for replacement may be considered within five years of purchase when one of the following occurs:

- There has been a significant change in the client's condition, such that the current equipment no longer meets the client's needs.
- The equipment is no longer functional and cannot be repaired or it is not cost effective to repair.

Replacement of equipment may be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the Department of State Health Services (DSHS) Health Screening and Case Management unit will be made by the Home Health Services prior authorization unit for clients who are 20 years of age and younger. Providers will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Repairs require replacement of components that are no longer functional. Technician fees are considered to be part of the cost of the repair.

Repairs to client-owned equipment may be considered with documentation of medical necessity.

Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

Rental equipment may be considered during the period of repair. Routine maintenance of rented equipment is the provider's responsibility.

Pediatric hospital cribs and beds, enclosed beds, and safety enclosure frames, canopies, or bubble tops that have been purchased are anticipated to last a minimum of five years.

2.2.14.9 Non-covered Items

A safety enclosure (procedure code E0316) used to prevent a client from leaving the bed is not a benefit of Home Health Services. A safety enclosure or enclosed bed may be considered through CCP for safety use.

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Traction equipment (procedure codes E0890, E0947, and E0948) is not a benefit of Home Health Services.

The following types of beds will not be considered for prior authorization, because they are not considered medically necessary or are inappropriate for use in the home setting:

- Institutional type beds (procedure code E0270)
- An ordinary or standard bed typically sold as furniture (may consist of a frame, box spring, and mattress, and is of fixed height with no head or leg elevation adjustments). These types of beds are not primarily medical in nature, not primarily used in the treatment of disease of injury, and are not made with materials that can withstand frequent cleaning and disinfecting. They are not considered durable medical equipment (DME) by Texas Medicaid.
- All non-hospital adjustable beds available to the general public as furniture. These types of beds are not primarily medical in nature, not primarily used in the treatment of disease or injury, and are normally of use in the absence of illness or injury. They are a comfort and convenience item and are not considered DME by Texas Medicaid.
- Hospital beds without rails. Texas Medicaid considers side rails an integral part of medically necessary bed.
- Beds with rails of any height that do not allow head and foot elevation (e.g., platform beds with rails), and are primarily used to prevent clients from leaving the bed. This types of beds are not primarily medical in nature.

2.2.14.10 Hospital Beds and Equipment Procedure Code Table

Procedure Code	Maximum Limitation
E0184	1 purchase every 5 years; 1-month rental
E0185	1 purchase every 5 years; 1-month rental
E0186	1 purchase every 5 years; 1-month rental
E0187	1 purchase every 5 years; 1-month rental
E0188	1 every year; Only one of either procedure code E0188 or E0189 is allowed every rolling year.
E0189	1 every year; Only one of either procedure code E0188 or E0189 is allowed every rolling year.
E0193	1 per month
E0194	1 per month
E0196	1 per month
E0197	1 per month
E0198	1 purchase every 5 years; 1-month rental
E0199	1 every 5 years
E0250	1 purchase every 5 years; 1-month rental
E0255	1 purchase every 5 years; 1-month rental
E0260	1 purchase every 5 years; 1-month rental
E0265	1 purchase every 5 years; 1-month rental
E0271	1 every 5 years
E0277	1 per month
E0280	1 purchase every 5 years; 1-month rental
E0303	1 purchase every 5 years; 1-month rental, 4 rentals per lifetime

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Procedure Code	Maximum Limitation
E0304	1 purchase every 5 years; 1-month rental, 4 rentals per lifetime
E0305	1 every 5 years
E0310	1 every 5 years
E0315	1 every 5 years
E0371	1 purchase every 5 years; 1-month rental
E0372	1 purchase every 5 years; 1-month rental
E0373	1 purchase every 5 years; 1-month rental
E0910	1 purchase every 5 years; 1-month rental
E0911	1 purchase every 5 years; 1-month rental
E0912	1 purchase every 5 years; 1-month rental
E0940	1 purchase every 5 years; 1-month rental

2.2.15 Incontinence Supplies

Incontinence supplies, such as diapers, briefs, pull-ons, liners, wipes, and underpads, may be considered for reimbursement through CCP for those clients who are birth through 3 years of age with a medical condition resulting in an increased urine or stool output beyond the typical output for this age group, such as celiac disease, short bowel syndrome, Crohn's disease, thymic hypoplasia, Acquired Immunodeficiency Syndrome (AIDS), congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung's disease, or radiation enteritis.

For clients who are 4 years of age or older, incontinence supplies may be considered through Title XIX Home Health Services when their medical conditions result in an impairment of urination and/or stool. For clients who do not meet criteria through Title XIX Home Health Services, incontinence supplies may be considered through CCP with documentation of medical necessity.

Note: *For clients who are 21 years of age or older, requests for incontinence supplies that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Lack of bladder or bowel control is considered normal development for clients who are 4 years of age or younger.

Reusable diapers, briefs, pull-ons, liners, wipes, and underpads are not a benefit of CCP. Gloves used to change diapers, briefs, and pull-ons are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine.

- Incontinence supplies billed for a one-month period must be based on the frequency or quantity ordered by the physician or allowed practitioner on the Home Health Services (Title XIX) DME/ Medical Supplies Prescribing Provider Order Form.

2.2.15.1 Skin Sealants, Protectants, Moisturizers, and Ointments for Incontinence-Associated Dermatitis

Incontinence-associated dermatitis is classified by category:

- Category 1—Small area of skin breakdown (<20 cm2) with mild redness (blotchy and non-uniform) and mild erosion involving the epidermis only.
- Category 2—Moderate area of skin breakdown (20-50 cm2) with moderate redness (severe in spots, but not uniform in appearance) and moderate erosion involving epidermis and dermis with no or little exudate.

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- Category 3—Large area of skin breakdown (>50 cm2) with severe redness (uniformly severe in appearance) and severe erosion of epidermis with moderate involvement of the dermis and no or small volume of exudate.
- Category 4—Large area of skin breakdown (>50 cm2) with severe redness (uniformly severe in appearance) and extreme erosion of epidermis and dermis with moderate volume of persistent exudate.

Skin sealants, protectants, moisturizers, and ointments (procedure code A6250) may be considered for clients who are 4 years of age or older and have documented incontinence-associated dermatitis.

For clients who have Category 1 or Category 2 incontinence-associated dermatitis, prior authorization is not required for a maximum quantity of 2 containers (no less than 4 ounces per container) per month and 12 containers per year of skin sealants, protectants, moisturizers, and ointments. Providers must use procedure code A6250 with modifier UA to bill for these products.

For clients who have Category 3 or Category 4 incontinence-associated dermatitis, prior authorization and documentation of medical necessity is required for skin sealants, protectants, moisturizers, and ointments that are not used for Category 1 or Category 2 incontinence-associated dermatitis. Providers must use procedure code A6250 without a modifier to bill for these products.

Providers must use procedure code A6250 instead of procedure code A5120 when billing for skin sealants, protectants, moisturizers, and ointments.

Note: *Skin sealants, protectants, moisturizers, ointments for diagnoses other than incontinence related dermatitis (i.e., wounds, decubitus ulcers, periwound skin complications, peristomal skin complications) may be considered for reimbursement with prior authorization.*

2.2.15.2 Diapers, Briefs, Pull-ons, and Liners

Diapers and briefs are defined as incontinence items attached with tabs. Pull-ons are defined as incontinence items that do not attach with tabs and are slip-on items, such as "pull-ups." Liners are intended to be worn inside diapers, briefs, and pull-ons to increase absorbency. Reusable diapers or briefs are not a benefit of Home Health Services.

For clients who are 4 years of age and older and have a medical condition that results in chronic incontinence, up to a maximum total combination of 240 per month of diapers, briefs, or liners may be considered without prior authorization. Quantities in excess of 240 per month may be considered with documentation of medical necessity and prior authorization.

The following procedure codes must be used when billing for diapers, briefs, and liners and are limited to a combined total of 240 per month:

Procedure Codes									
T4521	T4522	T4523	T4524	T4525	T4526	T4527	T4528	T4529	T4530
T4531	T4532	T4533	T4534	T4535	T4543	T4544			

Note: *Gloves used to change diapers and briefs are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine or stool.*

2.2.15.3 Diaper Wipes

For clients who are 4 years of age and older and are receiving diapers, briefs, or pull-ons up to 2 boxes of diaper wipes per month do not require prior authorization. Additional quantities may be considered, with documentation of medical necessity and prior authorization, for clients:

- Who are 4 through 20 years of age, through THSteps-CCP.

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- Who are 21 years of age or older, through the Texas Medicaid Home Health – Durable Medical Equipment (DME) Exceptional Circumstances process.

Providers must use procedure code A4335 with modifier U9 instead of procedure code A5120 when billing for diaper wipes.

If there is not an appropriate procedure code for supplies, providers may request prior authorization using procedure code A4335.

Diaper wipes may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP.

2.2.15.4 Underpads

For clients who are 4 years of age and older and are receiving diapers/briefs/pull-ons/liners/urine collection devices/bowel management supplies, up to a maximum of 120 underpads per month may be considered without prior authorization. Quantities in excess of 120 per month may be considered with documentation of medical necessity and prior authorization.

Reusable underpads are not a benefit of Home Health Services.

Underpads may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP.

Providers must use procedure code A4554 when billing for underpads. Procedure code A4554 is limited to 120 per month.

Note: *The Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form for the supplies listed above must reflect no more than a one-month's supply of the incontinence product. The Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must not reflect more than the maximum allowed quantity per month without requesting prior authorization.*

2.2.15.5 Ostomy Supplies

The physician or allowed practitioner must specify the type of ostomy device or system to be used and how often it is to be changed on the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. The quantity of ostomy supplies billed for a one-month period must relate to the number of changes per month based on the frequency ordered by the physician or allowed practitioner.

Ostomy supplies may be considered for reimbursement without prior authorization.

2.2.15.6 Indwelling or Intermittent Urine Collection Devices

The home setting is considered a clean environment, not a sterile one. Sterile incontinence supplies, (including the supplies in procedure codes A4311, A4312, A4313, A4314, A4315, A4316, and A4353) are a benefit in the home setting when requested for the following:

- Indwelling urinary catheters
- Intermittent catheters for clients who:
  - Are immunosuppressed
  - Have radiologically documented vesico-ureteral reflux
  - Are pregnant and have a neurogenic bladder due to spinal cord injury
  - Have a history of distinct, recurrent urinary tract infections, defined as a minimum of two within the prior 12-month period, while on a program of clean intermittent catheterization

Nonsterile or sterile gloves for use by a health-care provider in the home setting, such as a registered nurse (RN), licensed vocational nurse (LVN), or attendant, are not a benefit of Home Health Services.

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2.2.15.6.1 Indwelling Catheters and Related Insertion Supplies

Indwelling catheters and related supplies may be considered without prior authorization up to a maximum of two per month for clients who have a medical condition that results in an impairment of urination. Quantities in excess of two per month may be considered with documentation of medical necessity and prior authorization.

2.2.15.6.2 Intermittent Catheters and Related Insertion Supplies

Intermittent catheters (A4351, A4352, A4295, A4296) and related supplies, up to a maximum of 150 per month, may be considered without prior authorization for clients who have a medical condition that results in an impairment of urination. Quantities in excess of 150 per month may be considered with documentation of medical necessity and prior authorization.

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form may be valid for up to 12 months for intermittent catheters and related insertion supplies for quantities within the stated benefit limits for clients who have one of the following chronic conditions:

Diagnosis Codes							
G35A	G35B0	G35B1	G35B2	G35C0	G35C1	G35C2	G35D
G8221	G8222	G8250	G8253	G8254	G834	N310	N311
N312	N319	Q054	Q057	Q058	Q0701	Q0702	Q0703
Q6410	Q6412	Q6419	Q760	Q794			

Note: *The diagnosis codes R32 and R339 are not specific enough to allow for the extension of the prior authorization to 12 months.*

For clients who have a diagnoses other than those listed in the above table, the completed Title XIX Form may be valid for up to six months for intermittent catheters and related insertion supplies for quantities within the stated benefit limits.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

For quantities greater than the stated benefit limits, prior authorization will be required and may be granted for up to six months regardless of diagnosis.

Nonsterile gloves are a benefit with prior authorization when a family member or friend is performing the catheterization.

Providers must use procedure codes A4351, A4352, A4295, or A4296 when billing for intermittent catheters. Providers must use procedure code A4353 when billing for intermittent catheters with insertion supplies.

2.2.15.6.3 External Urinary Collection Devices

For clients who are 4 years of age and older and have a medical condition that results in a permanent impairment of urination, external urinary collection devices, including, but not limited to, male external catheters, female collection devices, and related supplies may be considered without prior authorization. Male external catheters are limited to 31 per month. Female collection devices are limited to 4 per month. Male external catheters in excess of 31 per month and female collection devices in excess of 4 per month may be considered with documentation of medical necessity and prior authorization.

External urinary collection devices, including, but not limited to, male external catheters, female collection devices, and related supplies may be considered with a documented medical condition resulting in an increased urine or stool output beyond the typical output.

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The following procedure codes must be used when billing for external urinary collection devices:

Procedure Code	Maximum Limitation
A4326	31 per month
A4327	4 per month
A4328	4 per month
A4349	31 per month

2.2.15.6.4 Urinals and Bed Pans

Urinals and bed pans may be considered without prior authorization for clients who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids) up to a limit of 2 per year. Quantities in excess of 2 per year may be considered with documentation of medical necessity and prior authorization.

Urinals and bed pans are purchase only.

2.2.15.7 Prior Authorization

Prior authorization is required for incontinence supplies if amounts greater than the maximum limits are medically necessary.

Prior authorization is required for incontinence supplies through CCP.

A determination is made by HHSC or its designee as to the number of incontinence supplies prior authorized based on the client's medical needs.

Additional quantities may be considered with documentation of medical necessity.

The quantity of incontinence supplies billed for a one-month period must be consistent with the number of times per day the physician or allowed practitioner has ordered the supply be used on the CCP Prior Authorization Request Form.

To request prior authorization for incontinence supplies, the following documentation must be provided for the items requested:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status
- Diagnosis or condition causing increased urination or stooling
- Client's height, weight, and waist size
- Number of times per day the physician or allowed practitioner has ordered the supply be used
- Quantity of disposable supplies requested per month

Additional information may be requested to clarify or complete a request for the supplies and equipment.

2.2.15.8 Documentation Requirements

To request prior authorization for incontinence supplies and equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnosis or condition, the diagnosis causing incontinence, and any other medical diagnoses or conditions, including the client's overall health status
- Weight and height or waist size, when applicable
- Number of times per day the physician or allowed practitioner has ordered the supply be used

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- Quantity of disposable supplies requested per month by the physician or allowed practitioner

Additional information may be requested to clarify or complete a request for the supplies.

2.2.15.9 Incontinence Procedure Codes with Limitations

Any service or combination of services requires prior authorization if the maximum limitation is exceeded.

Requests for prior authorization of diaper wipes that exceed more than two boxes per month will be considered for clients:

- Who are 4 through 20 years of age through THSteps-CCP.
- Who are 21 years of age or older, through the Texas Medicaid Home Health-Durable Medical Equipment (DME) Exceptional Circumstances process.

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	4 per month
A4326	31 per month
A4327	4 per month
A4328	4 per month
A4330	As needed
A4331	2 per month
A4332	50 per month
A4333	2 per month
A4334	2 per month
A4335	2 per month
A4338	2 per month
A4340	2 per month
A4344	2 per month
A4346	2 per month
A4349	31 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

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Procedure Code	Maximum Limitation
A4358	2 per month
A4360	31 per month
A4361	As needed
A4362	As needed
A4363	As needed
A4364	8 per month
A4366	As needed
A4367	As needed
A4368	As needed
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

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Procedure Code	Maximum Limitation
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
A4416	As needed
A4417	As needed
A4418	As needed
A4419	As needed
A4420	As needed
A4421	As needed
A4422	As needed
A4423	As needed
A4424	As needed
A4425	As needed
A4426	As needed
A4427	As needed
A4428	As needed
A4429	As needed
A4430	As needed
A4431	As needed
A4432	As needed
A4433	As needed
A4434	As needed
A4435	As needed
A4436	4 per month
A4437	4 per month
A4455	4 per month
A4456	60 per month
A4554	120 per month
A4927	1 per month
A5051	As needed
A5052	As needed
A5053	As needed
A5054	As needed

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Procedure Code	Maximum Limitation
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	30 per month
A5122	15 per month
A5126	40 per month
A5131	1 per month
A5200	2 per month
T4521	*240 per month
T4522	*240 per month
T4523	*240 per month
T4524	*240 per month
T4525	*240 per month
T4526	*240 per month
T4527	*240 per month
T4528	*240 per month
T4529	*240 per month
T4530	*240 per month
T4531	*240 per month
T4532	*240 per month
T4533	*240 per month
T4534	*240 per month
T4535	*240 per month
T4543	*240 per month

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Procedure Code	Maximum Limitation
T4544	*240 per month
E0275	1 per 180 days
E0276	1 per 180 days
E0325	1 per 180 days
E0326	1 per 180 days

Refer to: Subsection 2.2.15.2, "Diapers, Briefs, Pull-ons, and Liners" in this handbook for an explanation of the item limitations identified with an asterisk (*).

The following procedure codes always require prior authorization even if the maximum benefit limitation allowed has not been exceeded:

Procedure Code	Maximum Limitation
A4927	1 per month
A6250	2 per month

2.2.16 * Intravenous (IV) Therapy Equipment and Supplies

The following equipment and supplies are used in the delivery of IV therapy and are a benefit of Home Health Services. The following procedure codes require prior authorization unless otherwise specified:

[Revised] Procedure Code									
A4221	A4222	A4223	A4228	A4305	A4306	A4649	A4930	A9900	E0776
E0779	E0780	E0781	E0791	K0455	K0552	S1015	S5036		

Note: *Additional supply procedure codes not listed may be considered with documentation of medical necessity.*

The following IV supplies listed are available without prior authorization up to the stated quantity limitations. Prior authorization is required for any quantities exceeding the limitations with documentation supporting the medical necessity of the quantity requested.

Procedure Code	Limitation
A4206	30 per month
A4207	30 per month
A4208	30 per month
A4209	180 per month
A4202	2 per month
A4216	60 per month
A4245	1 per month
A4247	1 per month
A4248	1 per month
A4300	4 per month
A4450	100 per month
A4452	100 per month
A4602	1 per 180 days
A4927	1 per month

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Procedure Code	Limitation
A5200	2 per month
A6206	60 per month
A6207	30 per month
A6216	200 per month
A6257	30 per month
A6258	30 per month
A6402	200 per month
K0601	1 per 180 days
K0602	1 per 180 days
K0603	1 per 180 days
K0604	1 per 180 days
K0605	1 per 180 days

Types of IV access devices include but are not limited to:

- Peripheral IV lines.
- Central IV lines, including but not limited to, peripherally-inserted central catheters, subclavian catheters, and vena cava catheters.
- Central venous lines, including but not limited to, tunneled and peripherally inserted central venous catheters.
- Implantable ports, including but not limited to, access devices with subcutaneous ports.

Stopcocks increase the risk of infection and should not be routinely used for infusion administration. Routine use of in-line filters is not recommended for infection control.

> ***Note:*** *Nonsterile or sterile gloves for use by a health-care provider in the home setting, such as an RN, LVN, or attendant, are not a benefit of Home Health Services.*

Stationary infusion pumps may be a benefit when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Ambulatory infusion pumps may be a benefit when the length of infusion is greater than two hours, the client must be involved in activities away from home, and when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Elastomeric infusion pumps may be a benefit for short-term use when the client or the caregiver cannot administer the infusion by pump. Dial flow regulators are a benefit and are incorporated into IV extension sets or IV tubing. Elastomeric devices may be reimbursed using procedure codes A4305 and A 4306.

Rental of an infusion pump may be prior authorized on a monthly basis for a maximum of 10 months per lifetime, with the same provider. Rentals for the same infusion pump exceeding 10 months with the same provider within a one-year period will be considered purchased. Purchase of an infusion pump (ambulatory or stationary) may be prior authorized with documentation of medical necessity that supports repeated IV administration for a chronic condition.

For clients who require cardiovascular medications, infusion pumps will be rented, but not purchased.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Providers are responsible for maintaining documentation in the client's medical record that specifies the repairs and supports medical necessity. The documentation must include the date of purchase, serial number, and the reason for the

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repairs. All repairs and replacement parts, including batteries, within the first six months after delivery are considered part of the purchase price. Rental equipment includes all necessary accessories, supplies, modifications, adjustments, replacement parts, and repairs.

Note: *For clients who are 21 years of age or older, requests for IV supplies and equipment that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

IV therapy, supplies, and equipment are not considered a benefit when the infusion or medication being administered:

- Is not considered medically necessary to the treatment of the client's illness.
- Exceeds the frequency or duration ordered by the physician or allowed practitioner.
- Is a chemotherapeutic agent.
- Is not FDA-approved, unless the physician or allowed practitioner documents why the off-label use is medically appropriate and not likely to result in an adverse reaction. In order to consider coverage of an off-label (non-FDA approved) use of a drug, documentation must include why a drug usually indicated for the specific diagnosis or condition has not been effective for the client.

Routine maintenance of rental equipment is included in the rental price.

Repairs or replacement parts may be reimbursed with documentation of a client-owned device.

Replacement batteries (procedure codes K0601, K0602, K0603, K0604, and K0605) for client-owned pumps are limited to one battery per 180 days.

2.2.16.1 Prior Authorization

Additional replacement batteries for client-owned pumps (procedure codes K0601, K0602, K0603, K0604, and K0605) beyond the limit of 1 per 180 days may be considered for prior authorization with documentation of medical necessity.

All IV equipment and supplies, with the exception of implantable access catheter (A4300) require prior authorization. Prior authorization of IV equipment and supplies may be considered when administration of the drug in the home is medically necessary and is appropriate in the home setting. IV equipment may be prior authorized for rental or purchase depending on the clinician's predicted length of treatment.

The following standards are used when considering prior authorization of IV supplies:

- The aseptic technique is acceptable for IV catheter insertion and site care; the sterile technique is not required:
  - Nonsterile gloves are acceptable for the insertion of a peripheral IV catheter and for changing any IV site dressing.
  - The sterile technique may be medically necessary. Examples of medical necessity include, but are not limited to, a client who is immuno-compromised.
- A peripheral IV site is rotated no more frequently than every 72 hours, but it is rotated at least weekly.
- The IV administration set (with or without dial flow regulator), extension set (with or without dial flow regulator), and any add-on devices are changed every 72 hours.
- One IV access catheter is used per insertion.
- Saline or heparin-locked catheters:

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    - Use one syringe to flush the catheter, and one syringe per each additional lumen(s) if applicable, before administration of an intermittent infusion to assess.
    - Use two syringes to flush the catheter and two syringes per each additional lumen(s) if applicable, after the intermittent infusion—one to clear the medication and one to infuse the anticoagulant or other medication used to maintain IV patency between doses, including, but not limited to, heparin.
- An injection port is cleaned before administering an intermittent infusion and capped after the infusion.
- IV catheter site care:
    - Disinfect the site with an appropriate antiseptic (including but not limited to 2 percent chlorhexidine-based preparation, tincture of iodine, or 70 percent alcohol).
    - Cover with sterile gauze, transparent dressing, or semi-permeable dressing.
    - Replace the dressing if it becomes damp, loosened, or visibly soiled.

Elastomeric devices and dial flow regulators are specialized infusion devices that may be considered for prior authorization when the device:

- Will be used for short-term medication administration (less than two weeks duration).
- Is expected to increase client compliance.
- Will better facilitate drug administration.
- Costs less than the cost of pump rental or tubing.
- The caregiver can not administer the infusion by pump.

The following criteria must be met for prior authorization of a stationary infusion pump:

- An infusion pump is required to safely administer the drug.
- The standard method of administration of the drug is through prolonged infusion or intermittent infusion, and the infusion rate must be more consistent than can be obtained with gravity drainage.
- The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or by push technique).

The following criteria must be met for prior authorization of an ambulatory infusion pump:

- An infusion pump is required to safely administer the drug.
- The standard method of administration of the drug is through prolonged infusion or intermittent infusion and the infusion rate must be more consistent than can be obtained with gravity drainage.
- The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or by push technique).
- The infusion administration is more than two hours and the client is involved in activities away from home, including but not limited to, physician or allowed practitioner visits.

2.2.16.2 Documentation Requirements

To request prior authorization for IV supplies and equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnosis or condition
- A completed signed and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Form and documentation supporting medical necessity

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- The medication and dose being administered, the duration of drug therapy, and the frequency of administration

If additional supplies are needed beyond the standards listed, prior authorization may be considered with documentation supporting medical necessity.

For additional IV access catheters, supporting documentation must have evidence that includes, but is not limited to, the following:

- Dehydration
- Vein scarring
- Fragile veins, including but not limited to, clients who are infants or elderly

For more frequent IV site changes, supporting documentation must have evidence that includes, but is not limited to, the following:

- Phlebitis
- Infiltration
- Extravasation

For more frequent IV tubing or add-on changes, supporting documentation must have evidence that includes, but is not limited to, the following:

- Phlebitis
- IV catheter-related infection
- The administered infusion requires more frequent tubing changes

2.2.17 Mobility Aids

Mobility aids and related supplies, including, but not limited to canes, crutches, walkers, wheelchairs, and ramps are a benefit through Title XIX Home Health Services to assist clients to move about in their environment.

Mobility aids and related supplies, including, but not limited to, strollers, special-needs car seats, travel safety restraints, and thoracic-hip-knee-ankle orthoses (THKAO)/parapodiums are a benefit to assist clients to move about in their environment when medically necessary and Federal Financial Participation is available.

Mobility aids and related supplies may be considered for reimbursement through CCP for clients who are 20 years of age or younger who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following:

- The client's mobility status would be compromised without the requested equipment.
- The requested equipment or supplies are safe for use in the home.

Mobility aids may be considered through CCP if the requested equipment is not available through Title XIX Home Health Services or the client does not meet criteria through Title XIX Home Health Services

> ***Note:*** *A mobility aid for a client who is birth through 20 years of age is medically necessary when it is required to correct or ameliorate a disability or physical illness or condition.*

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2.2.17.1 Canes, Crutches, and Walkers

Canes, crutches, and walkers are a benefit through Title XIX Home Health Services when medically necessary to assist clients to move about in their environment. Walkers require prior authorization. Prior authorization is not required for canes, crutches, or walker accessories. Documentation of medical necessity must be provided by a physician or allowed practitioner familiar with the client and must include information on the client's impaired mobility.

2.2.17.2 Wheeled Mobility Systems

A wheeled mobility system is a manual or power wheelchair, or scooter that is a customized power or manual mobility device, or a feature or component of the mobility device, including, but not limited to, the following:

- Seated positioning components
- Manual seating options
- Adjustable frame
- Other complex or specialized components

A stroller (a multipositional client transfer system with integrated seat, operated by caregiver) for medical needs may be considered for clients who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following:

- The client does not own another seating system, including, but not limited to, a wheelchair
- The client's condition does not require another type of seating system, including, but not limited to, a wheelchair

If the client does not meet criteria for a stroller, a wheelchair may be considered through Texas Medicaid (Title XIX) Home Health Services.

Scooters may be considered for reimbursement through Texas Medicaid (Title XIX) Home Health Services.

A wheelchair is a non-customized chair mounted on four wheels that incorporates a non-adjustable frame, a sling or solid back and seat, and arm rests. Optional items included in this definition include, but are not limited, to the following:

- Handles at the back
- Foot rest
- Seat belt or safety restraint

A wheelchair includes all of the following:

- Standard (manual) wheelchairs
- Standard hemi (manual) wheelchairs
- Standard reclining (manual) wheelchairs
- Lightweight (manual) wheelchairs
- High strength lightweight (manual) wheelchairs

2.2.17.2.1 Prior Authorization

A wheelchair may be prior authorized for short-term rental or for purchase with documentation supporting medical necessity and an assessment of the accessibility of the client's residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions).

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2.2.17.2.2 Documentation Requirements

Documentation by a physician or an allowed practitioner familiar with the client must include information on the client's impaired mobility and physical requirements. In addition, the following information must be submitted with documentation of medical necessity:

- Why the client is unable to ambulate a minimum of 10 feet due to their condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy)
- If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client's needs
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements.

Refer to: Section "Seating Assessment for Manual and Power Custom Wheelchairs"

  - A description of growth allowance for clients
    - For clients who are 12 years of age or younger, if the wheelchair frame allows for at least a 3 inch growth potential in both width and depth, accept as sufficient growth potential.
    - For clients who are 13 years of age through 17 years of age, if the wheelchair frame allows for at least a 2 inch growth potential in both width and depth, accept as sufficient growth potential.
    - For clients who are 18 years of age or older, if the wheelchair frame allows for at least a 1 inch growth potential in depth and 2 inches in width, accept as sufficient growth potential.
  - Growth allowance to the dimensions specified may be made with frame modification or growth kit.

2.2.17.3 Manual Wheelchairs-Standard, Standard Hemi, and Standard Reclining

A standard manual wheelchair is defined as a manual wheelchair that:

- Weighs more than 36 pounds.
- Does not have features to appropriately accept specialized seating or positioning.
- Has a weight capacity of 250 pounds or less.
- Has a seat depth of between 15 and 19 inches.
- Has a seat width of between 15 and 19 inches.
- Has a seat height of 19 inches or greater.
- Is fixed height only, fixed, swing away, or detachable armrest.
- Is fixed, swing away, or detachable footrest.

A standard hemi (low seat) wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard manual wheelchair.
- Has a seat to floor height of less than 19 inches.

A standard reclining wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard or standard hemi manual wheelchair.
- Has the ability to allow the back of the wheelchair to move independently of the seat to provide a change in orientation by opening the seat-to-back angle and, in combination with leg rests, open the knee angle.

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2.2.17.3.1 Prior Authorization

A standard manual wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client has impaired mobility and is unable to consistently ambulate more than 10 feet.
- The client does not require specialty seating components.

A standard hemi wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and the following criteria is met:

- The client requires a low seat-to-floor height.
- The client must use their feet to propel the wheelchair.

A standard reclining wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and one or more of the following criteria are met:

- The client develops fatigue with longer periods of sitting upright.
- The client is at increased risk of pressure sores with prolonged upright position.
- The client requires assistance with respirations in a reclining position.
- The client needs to perform mobility related activities of daily living (MRADLs) in a reclining position.
- The client needs to improve venous return from lower extremity in a reclining position.
- The client has severe spasticity.
- The client has excess extensor tone of the trunk muscles.
- The client has quadriplegia.
- The client has a fixed hip angle.
- The client must rest in a reclining position two or more times per day.
- The client has the inability or has great difficulty transferring from wheelchair to bed.
- The client has trunk or lower extremity casts or braces that require the reclining feature for positioning.

2.2.17.4 Manual Wheelchairs-Lightweight and High-Strength Lightweight

A lightweight manual wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard or hemi manual wheelchair.
- Weighs 34 to 36 pounds.
- Has available arm styles that are height adjustable.

A high-strength lightweight wheelchair is defined as a manual wheelchair that:

- Has the same features as a lightweight manual wheelchair.
- Weighs 30 to 34 pounds.
- Has a lifetime warranty on side frames and cross braces.

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2.2.17.4.1 Prior Authorization

A lightweight manual wheelchair may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client is unable to propel a standard manual wheelchair at home.
- The client is capable of independently propelling a lightweight wheelchair to meet their MRADLs at home.

A high-strength lightweight wheelchair may be considered for prior authorization for rental or purchase when the client meets all of the criteria for a lightweight manual wheelchair and meets one or more of the following criteria:

- The high-strength lightweight wheelchair will allow the client to self-propel while engaging in frequently performed activities that cannot otherwise be completed in a standard or lightweight wheelchair.
- The client requires frame dimensions (seat width, depth, or height) that cannot be accommodated in a standard, lightweight, or hemi wheelchair and the wheelchair is used at least 2 hours a day.

2.2.17.5 Manual Wheelchairs-Heavy-Duty and Extra Heavy Duty

A heavy duty wheelchair is defined as a manual wheelchair that:

- Meets the standard manual wheelchair definition.
- Has a weight capacity greater than 250 pounds.

An extra heavy duty wheelchair is defined as a manual wheelchair that:

- Meets the standard manual wheelchair definition.
- Has a weight capacity greater than 300 pounds.

2.2.17.5.1 Prior Authorization

A heavy-duty wheelchair may be considered for prior authorization for short-term rental or purchase when the client has severe spasticity or all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs between 250 and 300 pounds.

An extra heavy duty wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs more than 300 pounds.

2.2.17.6 Wheeled Mobility Systems

A wheeled mobility system is a manual or power wheelchair, or scooter that is a customized power or manual mobility device, or a feature or component of the mobility device, including but not limited to, the following:

- Seated positioning components
- Powered or manual seating options
- Specialty driving controls for powered chairs
- Adjustable frame
- Other complex or specialized components

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A wheeled mobility system includes all of the following:

- Tilt-in-space (manual) wheelchairs
- Pediatric size (manual) wheelchairs and strollers
- Custom ultra lightweight (manual) wheelchairs
- All power wheelchairs
- All scooters

2.2.17.6.1 Definitions and Responsibilities

The following definitions and responsibilities apply to the provision of wheeled mobility systems.

Adjustments—The adjustment of a component or feature of a wheeled mobility system.

Adjustments require labor only and do not include the addition, modification, or replacement of components or supplies needed to complete the adjustment.

Texas Medicaid will consider adjustments only to client-owned equipment that is considered a benefit of Texas Medicaid.

Major Modification—The addition of a custom or specialized feature or component of a wheeled mobility system that did not previously exist on the system due to changes in the client's needs, including, but not limited to, the items listed in this paragraph. This definition also includes the modification of a custom or specialized feature or component due to a change in the client's needs, including, but not limited to, the following:

- Seated positioning components, including, but not limited to, specialized seating or positioning components
- Powered or manual seating options, including, but not limited to, power tilt or recline seating systems and seat elevation systems
- Specialty driving controls, including, but not limited to, non-standard alternative power drive control systems
- Adjustable frame, including, but not limited to, non-standard seat frame dimensions
- Other complex or specialized components, including, but not limited to, power elevating leg rests and specialized electronic interfaces

The replacement of a previously existing custom or specialized feature or component with an identical or comparable component is considered a repair and not a major modification.

Texas Medicaid will consider major modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Minor Modification—The addition or modification of non-custom or non-specialized features or components due to changes in the client's needs, including but not limited to, the following:

- Arm pads/armrests
- Leg rests/Leg extensions
- Modification of seating and positioning components to accommodate for a change in the client's size.

The replacement of a previously existing non-custom or non-specialized feature or component with an identical or comparable component is considered a repair and not a minor modification.

Texas Medicaid will consider minor modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

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Mobility Related Activity of Daily Living (MRADL)—An activity of daily living, including, but not limited to, toileting, feeding, dressing, grooming, and bathing performed in customary locations in the residence.

Occupational Therapist—A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice occupational therapy.

Physical Therapist—A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice physical therapy.

> ***Note:*** *A physical or occupational therapist is responsible for completing the seating assessment of a client obtaining a wheeled mobility system.*

Qualified Rehabilitation Professional (QRP)—A person who meets one or more of the following criteria:

- Holds a certification as an Assistive Technology Professional (ATP) or a Rehabilitation Engineering Technologist (RET) issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).
- Holds a certification as a Seating and Mobility Specialist (SMS) issued by, and in good standing with, RESNA.
- Holds a certification as a Certified Rehabilitation Technology Supplier (CRTS) issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS).

The QRP is responsible for:

- Being present at and involved in the seating assessment of the client for the rental or purchase of a wheeled mobility system.
- Being present at the time of delivery of the wheeled mobility system to direct the fitting of the system to ensure that the system functions correctly relative to the client.

Repairs—The replacement of a component or feature of a wheeled mobility system that is no longer functioning as designed, with an identical or comparable component that does not change the size or function of the system.

Texas Medicaid will consider repairs only to client-owned equipment that is considered a benefit of Texas Medicaid. Rental of a wheeled mobility system during the time of repair should be offered at the time of equipment pick-up, if appropriate.

Additional Benefit Information

The initial purchase of all manual wheelchairs and wheeled mobility systems must include the wheelchair base or frame, and the following standard components, which will not be prior authorized separately:

- Complete set of standard propulsion and caster wheels, including all of the following:
  - Propulsion or caster tires of any size, made of solid rubber or plastic
  - Standard hand rims
  - Complete wheel lock assembly
  - Bearings
- Standard footrest assembly (fixed, detachable, or swing away), including standard footplates, calf rests/pads, and ratchet assembly
- Standard armrests (fixed non-adjustable or detachable non-adjustable), including standard foam or plastic arm pads
- Standard seat and back upholstery

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Medically necessary non-standard components may be considered for prior authorization with documentation of medical necessity for the requested component. Such components include, but are not limited to, the following:

- Flat-free inserts
- Foam filled propulsion or caster tires
- Pneumatic propulsion or caster tires
- Non-standard hand rims (including ergonomic and contoured)
- Non-standard length footrests
- Custom footrests
- Elevating footrests
- Angle adjustable footplates
- Adjustable height fixed armrests
- Adjustable height detachable armrests
- Custom size arm pads
- Gel arm pads
- Arm troughs
- Elevating leg rests

Claims for wheelchairs, components, and accessories must be submitted using the most appropriate procedure code that describes the item.

2.2.17.6.2 Prior Authorization

A wheeled mobility system may be prior authorized for short-term rental or for purchase with documentation supporting medical necessity and an assessment of the accessibility of the client's residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions).

2.2.17.6.3 Documentation Requirements

Documentation by a physician or an allowed practitioner familiar with the client must include information on the client's impaired mobility and physical requirements. In addition, the following information must be submitted with documentation of medical necessity:

- Why the client is unable to ambulate a minimum of 10 feet due to their condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy).
- If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client's needs.
- An itemized component list for custom manual or power wheeled mobility systems.
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements that includes documentation supporting medical necessity, including:
- For clients 12 years of age and younger, the wheelchair frame must accommodate a minimum of 3 inches of growth potential in width and depth.
- For clients 13 years of age through 17 years of age, the wheelchair frame must accommodate a minimum of 2 inches of growth potential in width and depth.

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- For clients 18 years of age and older, the wheelchair frame must accommodate a minimum of 1 inch in depth and 2 inches in width of growth potential.

Documentation of frame modifications or growth kits may be submitted to demonstrate growth allowances to the dimensions specified above.

When medically necessary, prior authorization may also be considered for the rental or purchase of an alternative wheelchair on a case-by-case basis, as follows:

- A manual wheelchair will be considered for a client who owns or is requesting a power wheeled mobility system with no custom features.
- A manual wheelchair or a manual wheeled mobility system will be considered for a client who owns or is requesting a power wheeled mobility system with custom features.

2.2.17.7 Manual Wheeled Mobility System - Tilt-in-Space

A tilt-in-space manual wheeled mobility system is defined as a manual wheelchair that meets the following requirements:

- Has the ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining a constant back to seat angle to provide a change of orientation and redistribute pressure from one area (such as the buttocks and the thighs) to another area (such as the trunk and the head)
- Adult size has a weight capacity of at least 250 pounds
- Pediatric size has a seat width or depth of less than 15 inches

2.2.17.7.1 Prior Authorization

A tilt-in-space wheeled mobility system may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client has a condition that meets criteria for a tilt-in-space feature, including but not limited to:
  - Severe spasticity
  - Hemodynamic problems
  - Quadriplegia
  - Excess extensor tone
  - Range of motion limitations prohibit a reclining system, such as hip flexors, hamstrings, or even heterotopic ossification
  - The need to rest in a recumbent position two or more times per day and the client has an inability to transfer between bed and wheelchair without assistance
  - Documented weak upper extremity strength or a disease that will lead to weak upper extremities
  - At risk for skin break down because of inability to reposition body in a chair to relieve pressure areas

2.2.17.8 Manual Wheeled Mobility System-Pediatric Size

A pediatric sized wheeled mobility system is defined as a manual standard/custom wheelchair (including those optimally configured for propulsion or custom seating) that has a seat width or depth of less than 15 inches.

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2.2.17.9 Manual Wheeled Mobility System-Custom (Includes Custom Ultra-Lightweight)

Custom manual wheeled mobility systems may be considered for a client who meets criteria for a manual wheelchair, has a condition that requires specialized seating, and cannot safely utilize a standard manual wheelchair.

A custom ultra lightweight wheeled mobility system is defined as an optimally configured wheelchair for independent propulsion which cannot be achieved in a standard, lightweight, or high-strength light-weight wheelchair that:

- Meets the high-strength lightweight definition and weighs less than 30 pounds.
- Has one or more of the following features to appropriately accept specialized seating or positioning:
  - Adjustable seat-to-back angle
  - Adjustable seat depth
  - Independently adjustable front and rear seat-to-floor dimensions
  - Adjustable caster stem hardware
  - Adjustable rear axle
  - Adjustable wheel camber
  - Adjustable center of gravity
- Has a lifetime warranty on side frames and cross braces

2.2.17.9.1 Prior Authorization

A custom ultra-lightweight wheeled mobility system may be considered for prior authorization for rental or purchase when the client meets all the criteria for a lightweight manual wheelchair and one or more of the following criteria:

- The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, and meets all of the following criteria:
  - The client uses the wheelchair for a significant portion of their day to complete MRADLs.
  - The client uses the wheelchair in the community to complete MRADLs.
- The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, has a medical condition that cannot be accommodated by the seating available on a standard, lightweight, or high-strength lightweight wheelchair and one or more of the following features needed by the client to ensure optimal independence with MRADLs:
  - Adjustable seat to back angle.
  - Adjustable seat depth.
  - Independently adjustable front and rear seat-to-floor dimensions.
  - Adjustable caster stem hardware.
  - Adjustable rear axle (adjustable center of gravity).
- The client meets all of the following criteria:
  - The client is unable to self-propel.
  - The client has a documented condition that requires custom seating, including, but not limited to:
    - Poor trunk control.

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- Contractures of elbow or shoulders.
- Muscle spasticity.
- Tone imbalance through shoulders or back.
- Kyphosis or lordosis.
- Lack of flexibility in pelvis or spine.
- The client requires custom seating that cannot be accommodated on a standard, lightweight, or hemi-wheelchair.

Prior authorization for labor to create a custom molded seating system is limited to a maximum of 15 hours.

A medical stroller does not have the capacity to accommodate the client's growth. Strollers for medical use may be considered for prior authorization when all of the following criteria are met:

- The client weighs 30 pounds or more.
- The client does not already own another seating system, including, but not limited to, a standard or custom wheelchair.
- The stroller must have a firm back and seat, or insert.
- The client is expected to be ambulatory within one year of the request date or is not expected to need a wheelchair within two years of the request date.

To request prior authorization for the purchase of procedure code E1035, the criteria must be met for the level of stroller requested:

- Level One, Basic Stroller—The client meets the criteria for a stroller. Providers must use procedure code E1035.
- Level Two, Stroller with Tray for Oxygen or Ventilator—The client meets the criteria for a level-one stroller and is oxygen- or ventilator-dependent. Providers must use procedure code E1035 with modifier TF.
- Level Three, Stroller with Positioning Inserts—The client meets the criteria for a level-one or level-two stroller and requires additional positioning support. Providers must use procedure code E1035 with modifier TG.

The following supporting documentation must be submitted:

- A completed Wheelchair/Stroller Seating Assessment Form that includes documentation supporting medical necessity. This documentation must address why the client is unable to ambulate a minimum of 10 feet due to his or her condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy), or if able to ambulate further, why a stroller is required to meet the client's needs.
- If the client is three years of age or older, documentation must support that the client's condition, stature, weight, and positioning needs allow adequate support from a stroller.

Note: *A stroller may be considered on a case-by-case basis with documentation of medical necessity for a client who does not meet the criteria listed above.*

A seating assessment must be completed by a physician or licensed occupational therapist or physical therapist, who is not employed by the equipment supplier, before requesting prior authorization.

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2.2.17.10 Seating Assessment for Manual and Power Custom Wheelchairs

A seating assessment is required for:

- The rental or purchase of any device meeting the definition of a wheeled mobility system as defined in subsection 2.2.17.6, "Wheeled Mobility Systems" in this handbook.
- The purchase of any device meeting the definition of a wheelchair as defined under subsection 2.2.17.2, "Wheeled Mobility Systems" in this handbook for a client with a congenital or neurological condition, myopathy, or skeletal deformity, which requires the use of a wheelchair.

A seating assessment is required for the rental or purchase of any device meeting the definition of a wheeled mobility system or purchase of any device meeting the definition of a wheelchair for a client with a congenital or neurological condition, myopathy, or skeletal deformity that requires the use of a wheelchair as defined under subsection 2.6.9.1.2, "Wheeled Mobility Systems" in this handbook.

A seating assessment with measurements, including specifications for exact mobility/seating equipment and all necessary accessories, must be completed by a physician, licensed occupational therapist, or licensed physical therapist.

A qualified rehabilitation professional (QRP) directly employed or contracted by the DME provider must be present at and participate in all seating assessments, including those provided by a physician.

Upon completion of the seating assessment, the QRP must attest to his or her participation in the assessment by signing the Wheelchair/Scooter/Stroller Seating Assessment Form. This form must be submitted with all requests for wheeled mobility systems.

When the practitioner completing the seating assessment is an occupational or physical therapist, the occupational or physical therapist may perform the seating assessment as the therapist, or as the QRP, but may not perform in both roles at the same time. If the occupational or physical therapist is attending the seating assessment as the QRP, the occupational or physical therapist must meet the credentialing requirements and be enrolled in Texas Medicaid as a QRP.

If the practitioner completing the seating assessment is a physician, the seating assessment is considered part of the evaluation and management service provided.

If the seating assessment is completed by a physician, reimbursement is considered part of the physician's office visit and will not be reimbursed separately.

Specialized evaluations required for the provision of new complex rehabilitation technology, such as power mobility and adaptive seating systems, require physical in-person presence of the rendering provider. Texas Medicaid may reimburse only for seating assessments, fitting, or training completed in-person.

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about telehealth services.

2.2.17.10.1 * Prior Authorization

A seating assessment performed by an occupational therapist, physical therapist, or a physician, with the participation of a QRP, does not require prior authorization. A seating assessment performed by a physician is considered part of the physician evaluation and management service.

The QRP's participation in the seating assessment requires authorization before the service can be reimbursed. Authorization must be requested at the same time and on the same prior authorization request form as the prior authorization request for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

Prior authorization requests for the QRP's participation in the seating assessment will be returned to the provider if the seating assessment is requested separately from the prior authorization for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

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The QRP participating in the seating assessment must be directly employed by or contracted with the DME provider requesting the wheeled mobility system or major modification to a wheeled mobility system.

An authorization for the QRP's participation in the seating assessment for a wheeled mobility system or major modification to a wheeled mobility system may be issued to the QRP in 15-minute increments, for a time period of up to one hour (4 units).

If the seating assessment is completed by a physician, reimbursement is considered part of the physician office visit and will not be reimbursed separately.

The physical therapist completing the seating assessment must submit procedure code 97542 with the GP and UC modifiers to bill for the seating assessment.

The occupational therapist completing the seating assessment must submit procedure code 97542 with the GO and UC modifiers to bill for the seating assessment.

Services for the QRP's participation in the seating assessment must be submitted for reimbursement by the DME provider billing for the wheeled mobility system using procedure code 97542 with modifier U1 (used for participation in the seating assessment up to four units or one hour). The DME provider must include the QRP specialty as the performing provider on the claim for all components of the wheeled mobility system, including the QRP's participation in the seating assessment.

Seating assessments are reimbursed in 15-minute increments (units) and are limited to four units (one hour).

Clients who are not receiving therapy services may require a therapy evaluation or re-evaluation. The therapy evaluation or re-evaluation may be performed on the same day as the seating assessment, at different times. The claim must be submitted with documentation showing that the evaluation or re-evaluation and seating assessment were performed at distinctly separate times to be considered for reimbursement.

2.2.17.10.2 Documentation Requirements

The seating assessment must clearly show that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition.

Documentation must include the following:

- Explain how the client or family will be trained in the use of the equipment.
- Anticipate changes in the client's needs and include anticipated modifications or accessory needs, as well as the growth potential of the wheelchair.
- Include significant medical information pertinent to the client's mobility and how the requested equipment will accommodate these needs, including intellectual, postural, physical, sensory (visual and auditory), and physical status.
- Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, as well as any recent changes in the client's physical and/or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- Include information on the client's current mobility/seating equipment, how long the client has been in the current equipment and why it no longer meets the client's needs.
- Include the client's height, weight, and a description of where the equipment is to be used.
- Include seating measurements.
- Include the accessibility of client's residence.

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- Include manufacturer's information, including the description of the specific base, any attached seating system components, and any attached accessories, as well as the manufacturer's retail pricing information and itemized pricing for manually priced components.
- Include documentation supporting medical necessity for all accessories.
- Be documented on the Wheelchair/Scooter/Stroller Seating Assessment Form, which must be signed and dated by the qualified practitioner completing the assessment (occupational therapist, physical therapist, or physician), and the QRP who was present and participated in the assessment.
- Be submitted with the prior authorization request for the wheeled mobility system. The Form must be completed, signed and dated as outlined above.

2.2.17.11 Fitting of Custom Wheeled Mobility Systems

The fitting of a wheeled mobility system is defined as the time the QRP spends with the client fitting the various systems and components of the system to the client. It may also include time spent training the client or caregiver in the use of the wheeled mobility system. Time spent setting up the system, or travel time without the client present, is not included.

A fitting is required for any device meeting the definition of a wheeled mobility system as defined under subsection 2.2.17.6, "Wheeled Mobility Systems" in this handbook.

The fitting of a wheeled mobility system must be:

- Performed by the same QRP that was present for, and participated in, the seating assessment of the client.
- Completed prior to submitting a claim for reimbursement of a wheeled mobility system.

The QRP performing the fitting will:

- Verify the wheeled mobility system has been properly fitted to the client.
- Verify that the wheeled mobility system will meet the client's functional needs for seating, positioning, and mobility.
- Verify that the client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the wheeled mobility system's proper use and maintenance.

The QRP must complete and sign the DME Certification and Receipt form after the wheeled mobility system has been delivered and fitted to the client. Completion of this form by the QRP signifies that all components of the fitting as outlined above have been satisfied. The form must be completed prior to submission of a claim for a wheeled mobility system and submitted to HHSC's designee according to instructions on the form to allow for proper claims processing.

Services for fitting of a wheeled mobility system by the QRP must be submitted for reimbursement by the DME provider of the wheeled mobility system using procedure code 97542 with modifier U2 (used for final fitting of wheeled mobility system performed by QRP up to eight units or two hours). The DME provider must list the QRP who participated in the seating assessment as the performing provider on the claim for all components of the wheeled mobility system, including the fitting performed by the QRP.

All adjustments, modifications, and repairs to the wheeled mobility system within the first six months after delivery are considered part of the purchase price.

Procedure code 97542 with modifier U2 must be billed on the same claim as the procedure code(s) for the wheeled mobility system in order for both services to be reimbursed.

2.2.17.11.1 Prior Authorization

Prior authorization is required for the QRP performing the fitting of a wheeled mobility system and must be included with the request for the wheeled mobility system.

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The QRP must be directly employed by or contracted with the DME company providing the system and must be the same QRP who was present at and participated in the client's seating assessment.

A prior authorization may be issued to the QRP in 15-minute increments, for a time period of up to two hours (8 units), for the fitting of any manual or power wheeled mobility system. Up to one additional hour (4 units) may be authorized to the QRP with documentation of medical necessity demonstrating that fitting of three or more major systems is required, or that additional client training is required for such systems. Major systems can include, but are not limited to, the following:

- Complete complex seating system (planar system with trunk supports and hip supports or abductor or custom contoured seating system such as a molded system) Off-the-shelf seat and back cushions do not constitute a complex seating system.
- Alternative drive controls (such as a head array, mini-proportional system, etc.).
- Additional specialty control features (such as infrared access).
- Power positioning features (such as power tilt, power recline).
- Specific purpose specialty features (such as power seat elevation systems, power elevating leg rests).

2.2.17.11.2 Documentation Requirements

When the QRP that participated in the assessment of the client is not available to conduct the fitting of the wheeled mobility system, the DME provider must update the prior authorization for the wheeled mobility system and fitting by submitting all of the following information:

- A letter written on the DME provider's letterhead, signed and dated by a representative of the DME provider other than the new QRP.
- Documentation explaining why the original QRP could not conduct the fitting. Examples may include, but are not limited to, documentation that the QRP:
  - Is no longer associated with the DME provider requesting the wheeled mobility system.
  - Is on an extended leave from the DME provider requesting the wheeled mobility system.

An extended leave is any leave of more than 30 consecutive calendar days.

- The name and NPI of the original QRP who performed the initial assessment, and the date the assessment was completed.
- The name and NPI of the QRP who will be performing the fitting.
- A copy of the original, physician- or allowed practitioner-signed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form.

A copy of this documentation must be maintained by the provider in the client's medical record and be available upon request by HHSC or its designee.

2.2.17.12 Power Wheeled Mobility Systems- Group 1 through Group 5

A power wheeled mobility system or powered mobility device (PMD) is a professionally manufactured device that provides motorized wheeled mobility and body support specifically for individuals with impaired mobility. PMDs are four- or six-wheeled motorized vehicles whose steering is operated by an electronic device or joystick to control direction, turning, and alternative electronic functions, such as seat controls.

Each PMD must include all of the following basic components that may not be billed separately:

- Lap belt or safety belt (This does not include multiple-attachment-point positioning belts or padded belts.)
- Battery charger, single mode

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- Batteries (initial)
- Complete set of tires and casters, any type
- Leg rests
- Foot rests or foot platform
- Arm rests
- Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by client weight capacity
- Controller and input device

The following definitions apply to PMDs:

- No-Power Option - A category of PMDs that cannot accommodate a power tilt, recline, or seat elevation system. A PMD that can accept only power-elevating leg rests is considered to be a no-power option chair.
- Single-Power Option - A category of PMDs that can accept and operate a power tilt, power recline, or a power seat elevation system, but not a combination power tilt and recline seating system. A single-power option PMD might be able to accommodate power elevating leg rests, or seat elevator, in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to meet this definition.
- Multiple-Power Option - A category of PMDs that can accept and operate a combination power tilt and recline seating system. A multiple-power option PMD might also be able to accommodate power elevating leg rests, or a power seat elevator. A PMD does not have to accommodate all features to qualify to meet this definition.

2.2.17.12.1 Prior Authorization

Prior authorization for a power wheeled mobility system/PMD requires the following documentation in addition to all documentation required for a custom manual wheelchair:

- The client's physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client must be able to operate a PMD independently. The therapist must provide written documentation that the client is physically and cognitively capable of managing a PMD.
- How the PMD will be operated (i.e., joystick, head pointer, puff-and-go).
- The capability of the client to understand how the PMD operates.
- The capability of the caregiver or client to care for the PMD and accessories.

2.2.17.12.2 Group 1 PMDs

All Group 1 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- May have cross brace construction
- Accommodates nonpowered options and seating systems (e.g., recline-only backs, manually elevating leg rests [except captains chairs])

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- Length - less than or equal to 40 inches
- Width - less than or equal to 24 inches
- Minimum top end speed - 3 mph
- Minimum range - 5 miles
- Minimum obstacle climb - 20 mm
- Dynamic stability incline - 6 degrees

Prior Authorization Requirements

A Group 1 PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client will use the PMD for less than 2 hours per day.
- The client will use the PMD indoors on smooth, hard surfaces.
- The client will not encounter obstacles in excess of 0.75 inch.

2.2.17.12.3 Group 2 PMDs

All Group 2 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- May have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medical thigh supports [except captains chairs])
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 3 mph
- Minimum range - 7 miles
- Minimum obstacle climb - 40 mm
- Dynamic stability incline - 6 degrees

Prior Authorization Requirements

A Group 2 PMD may be considered for prior authorization for rental or purchase when the following criteria are met:

- The client will use the PMD for 2 or more hours per day.
- The client will not routinely use the PMD for MRADLs outside the home.
- The client will not encounter obstacles in excess of 1.5 inches.

2.2.17.12.4 Group 3 PMDs

All Group 3 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices

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- May not have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports [except captains chairs])
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 4.5 mph
- Minimum range - 12 miles
- Minimum obstacle climb - 60 mm
- Dynamic stability incline - 7.5 degrees

Prior Authorization Requirements

A Group 3 PMD may be considered for prior authorization for rental or purchase when the following criteria are met:

- The client's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
- The client may routinely use the PMD for MRADLs outside of the home.
- The client will use the PMD primarily on smooth or paved surfaces.
- The client will not encounter obstacles in excess of 2.5 inches.

2.2.17.12.5 Group 4 PMDs

All Group 4 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports [except captains chairs])
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 6 mph
- Minimum range - 16 miles
- Minimum obstacle climb - 75 mm
- Dynamic stability incline - 9 degrees

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Prior Authorization Requirements

A Group 4 PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- In addition to using the PMD in the home, the client will routinely use the PMD for MRADLs outside the home.
- The client will routinely use the PMD on rough, unpaved or uneven surfaces.
- The client will encounter obstacles in excess of 2.25 inches.
- The client has a documented medical need for a feature that is not available on a lower level PMD.

Documentation Requirements

The submitted documentation for a Group 4 PMD must include a completed assessment that is signed and dated by a physician, an allowed practitioner, or a licensed occupational or physical therapist and includes the following:

- A description of the environment where the PMD will be used in the routine performance of MRADLs.
- A listing of the MRADLs that would be possible with the use of a Group 4 PMD that would not be possible without the Group 4 PMD.
- The distance the client is expected to routinely travel on a daily basis with the Group 4 PMD.

Note: *The enhanced features found on a Group 4 PMD must be medically necessary to meet the client's routine MRADL and will not be approved for leisure or recreational activities.*

In addition to meeting criteria for Group 2 through Group 4 PMDs, the submitted documentation of medical necessity must demonstrate that the client requires the requested power option (e.g., the need for a power recline or tilt in space, or a combination power tilt and power recline), the no-power option, single-power option, or multiple-power option as defined in subsection 2.2.17.12, "Power Wheeled Mobility Systems- Group 1 through Group 5" in this handbook.

2.2.17.12.6 Additional Requirements - Group 2 through Group 4 No-Power Option

Group 2 through Group 4 no-power option PMDs must have all the specified basic components and meet all the following requirements:

- Nonexpandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- Meets the definition of no-power option
- Accommodates nonpowered options and seating systems (e.g., recline-only backs, manually elevating leg rests [except captains chairs])

2.2.17.12.7 Group 2 through Group 4 Single-Power Option

Group 2 through Group 4 single-power option PMDs must have all the specified basic components and meet all the following requirements:

- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- Meets the definition of single-power option

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2.2.17.12.8 Group 2 through Group 4 Multiple-Power Option

Group 2 through Group 4 multiple-power option PMDs must have all the specified basic components and meet all the following requirements:

- Nonexpandable controller
- Capable of upgrade to expandable controller
- Meets the definition of multiple-power option
- Accommodates a ventilator

2.2.17.12.9 Group 5 PMDs

All Group 5 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Seat width - minimum of 5 one-inch options
- Seat depth - minimum of 3 one-inch options
- Seat height - adjustment requirements = 3 inches
- Back height - adjustment requirements minimum of 3 options
- Seat-to-back angle range of adjustment - minimum of 12 degrees
- Accommodates nonpowered options and seating systems
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports)
- Adjustability for growth (minimum of 3 inches for width, depth, and back height adjustment)
- Special developmental capability (i.e., seat to floor, standing, etc.)
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 4 mph
- Minimum range - 12 miles
- Minimum obstacle climb - 60 mm
- Dynamic stability incline - 9 degrees
- Passed crash test

Prior Authorization Requirements

A Group 5 pediatric PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client weighs less than 125 pounds.
- The client is expected to grow in height.
- The client may require growth of up to 5 inches in width.

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- The client may require a change in seat to floor height up to 3 inches.
- The client may require a seat to back angle range of adjustment in excess of 12 degrees.
- The client requires special developmental capability (i.e., seat to floor, standing, etc.).

2.2.17.12.10 Group 5 Single-PMDs

A group 5 single-power option PMD must have all the specified basic components and have the capability to accept and operate a power tilt or recline or seat elevation system, but not a combination power tilt and recline seating system, and may be able to accommodate power elevating leg rests, or seat elevator, in combination with a power tilt or power recline.

Prior Authorization Requirements

A Group 5 pediatric PMD with single power option may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client meets criteria for a Group 5 PMD.
- The client requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, or switch control).

2.2.17.12.11 Group 5 Multiple-PMDs

Group 5 multiple-power option PMD must have all the specified basic components and meet all the following requirements:

- Has the capability to accept and operate a combination power tilt and recline seating system, and may also be able to accommodate power elevating leg rests, or a power seat elevator.
- Accommodates a ventilator.

Prior Authorization Requirements

A Group 5 pediatric PMD with multiple power option may be considered for prior authorization for rental or purchase when the following criteria are met:

- The client meets criteria for a Group 5 PMD.
- The client requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
- The client has a documented medical need for a power tilt and recline seating system and the system is being used on the wheelchair or the client uses a ventilator which is mounted on the wheelchair.

2.2.17.13 Wheelchair Ramp-Portable and Threshold

Portable and threshold ramps are a benefit of Texas Medicaid.

A portable ramp is defined as a unit that is able to be carried as needed to access a home, weighs no more than 90 pounds, or measures no more than 10 feet in length. A threshold ramp is defined as a unit that provides access over elevated thresholds.

Portable ramps exceeding the above criteria may be considered on a case-by-case basis with documentation of medical necessity and a statement that the requested equipment is safe for use.

One portable ramp and one threshold ramp for wheelchair or stroller access may be considered for prior authorization when documentation supports medical necessity. The following documentation supporting medical necessity is required:

- The date of purchase and serial number of the client's wheelchair or documentation of a wheelchair request being reviewed for purchase
- Diagnosis with duration of expected need

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- A diagram of the house showing the access points with the ground-to-floor elevation and any obstacles

Providers must use procedure code E1399 for the purchase of portable and threshold stroller ramps.

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Permanent ramps, vehicle ramps, and home modifications are not a benefit of Texas Medicaid.

Ramps may be considered for rental for short term disabilities and for purchase for long term disabilities. Mobility aid lifts for vehicles and vehicle modifications are not a benefit of Texas Medicaid.

2.2.17.14 Power Elevating Leg Lifts

A power elevation feature involves a dedicated motor and related electronics with or without variable speed programmability, which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s).

2.2.17.14.1 Prior Authorization

Power elevating leg lifts may be prior authorized for clients who have compromised upper extremity function that limits the client's ability to use manual elevating leg rests. The client must meet criteria for a PMD with a reclining back and at least one of the following:

- The client has a musculoskeletal condition such as flexion contractures of the knees and legs, or the placement of a brace that prevents 90-degree flexion at the knee.
- The client has significant edema of the lower extremities that requires elevating the client's legs.
- The client experiences hypotensive episodes that require frequent positioning changes.
- The client needs power tilt-and-recline and is required to maintain anatomically correct positioning and reduce exposure to skin shear.

2.2.17.14.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician, an allowed practitioner, or a licensed occupational or physical therapist that includes the following:

- A description of the client's current level of function without the device
- Documentation that identifies how the power elevating leg lifts will improve the client's function
- A list of MRADLs the client will be able to perform with the power elevating leg lifts that the client is unable to perform without the power elevating leg lifts and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client's goals for use of the power elevating leg lifts

2.2.17.15 Power Seat Elevation System

A power seat elevation system is used to raise and lower the client in their seated position without changing the seat angles to provide varying amounts of added vertical access.

The use of a power seat elevation system will:

- Facilitate independent transfers, particularly uphill transfers, to and from the wheelchair, and
- Augment the client's reach to facilitate independent performance of MRADLs in the home.

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2.2.17.15.1 Prior Authorization

A power seat elevation system may be prior authorized to promote independence in a client who meets all of the following criteria:

- The client does not have the ability to stand or pivot transfer independently.
- The client requires assistance only with transfers across unequal seat heights, and as a result of having the power seat elevation system, the client will be able to transfer across unequal seat heights unassisted.
- The client has limited reach and range of motion in the shoulder or hand that prohibits independent performance of MRADLs (such as, dressing, feeding, grooming, hygiene, meal preparation, and toileting).

2.2.17.15.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician, an allowed practitioner, or a licensed occupational or physical therapist that includes the following:

- A description of the client's current level of function without the device
- Documentation that identifies how the power seat elevation system will improve the client's function
- A list of MRADLs the client will be able to perform with the power seat elevation system that the client is unable to perform without the power seat elevation system and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client's goals for use of the power seat elevation system

Note: *A power seat elevation system option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs and transfers.*

2.2.17.16 Seat Lift Mechanisms

A medically necessary seat lift mechanism is one that operates smoothly, can be controlled by the client, and effectively assists the client in standing up and sitting down without other assistance.

The payment for a recliner or chair with the incorporated seat lift mechanism is limited to the amount of the seat lift mechanism.

2.2.17.16.1 Prior Authorization

A seat lift mechanism may be prior authorized for clients who meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The seat lift mechanism must be a part of the physician or allowed practitioner's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in their home.

Note: *The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.*

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Seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and can effectively assist a client in standing up and sitting down without other assistance. A seat lift operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of Texas Medicaid.

2.2.17.16.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician, an allowed practitioner, or a licensed occupational or physical therapist that includes the following:

- A description of the client's current level of function without the device
- Documentation that identifies how the seat lift mechanism will improve the client's function
- A list of MRADLs the client will be able to perform with the seat lift mechanism that the client is unable to perform without the seat lift mechanism and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client's goals for use of the seat lift mechanism

Supporting documentation must be kept in the client's record that shows that all appropriate therapeutic modalities (such as medication, physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

2.2.17.17 Batteries and Battery Charger

A battery charger and initial batteries are included as part of the purchase of a PMD. Replacement batteries or a replacement battery charger may be considered for reimbursement if they are no longer under warranty.

A maximum of one hour of labor may be considered to install new batteries. Labor is not reimbursed with the purchase of a new PMD or with replacement battery chargers.

2.2.17.17.1 Prior Authorization

Batteries and battery chargers will not be prior authorized for replacement within six months of delivery. Batteries and battery chargers within the first six months after delivery are considered part of the purchase price.

A maximum of one hour of labor may be prior authorized to install new batteries. Labor will not be prior authorized for a new power wheelchair or for replacement battery chargers.

2.2.17.17.2 Documentation Requirements

To request prior authorization for replacement batteries or a replacement battery charger, the provider must document the date of purchase and serial number of the currently owned wheelchair as well as the reason for the replacement batteries or battery charger.

Documentation required supporting the need to replace the batteries or battery charger must include:

- Why the batteries are no longer meeting the client's needs, or
- Why the battery charger is no longer meeting the client's needs

2.2.17.18 Power Wheeled Mobility Systems- Scooter

A scooter is a professionally manufactured three- or four-wheeled motorized base operated by a tiller with a professionally manufactured basic seating system for clients who have little or no positioning needs.

A scooter must meet all the following requirements:

- Length- less than or equal to 48 inches

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- Width- less than or equal to 28 inches
- Minimum top end speed- 3 mph
- Minimum range- 5 miles
- Minimum obstacle climb- 20 mm
- Radius pivot turn of less than or equal to 54 inches
- Dynamic stability incline- 6 degrees

Custom seating for scooters is not a benefit of Texas Medicaid Title XIX Home Health Services. Repairs to scooters will be considered only for a scooter purchased by the Texas Medicaid.

2.2.17.18.1 Prior Authorization

A scooter may be prior authorized for ambulatory-impaired clients with good head, trunk, and arm/hand control, without a diagnosis of progressive illness (including, but not limited to, progressive neuromuscular diseases such as amyotrophic lateral sclerosis [ALS]).

To request prior authorization for a scooter, the client must not own a power wheelchair.

A scooter may be prior authorized for a short-term rental or an initial three-month trial rental period based on documentation supporting the medical necessity and appropriateness of the device.

Assessment of the accessibility of the client's residence must be completed and included in the prior authorization documentation to ensure that the scooter is usable in the home (i.e., doors and halls wide enough, no obstructions).

2.2.17.18.2 Documentation Requirements

Prior authorization for a scooter requires all the documentation required for a standard power wheelchair and meets all the following criteria:

- The client's physical and cognitive ability to receive and follow instructions related to the responsibilities of using the equipment.
- The ability of the client to physically and cognitively operate the scooter independently.
- The capability of the client to care for the scooter and understand how it operates.

2.2.17.19 Push-Rim Activated Power Assist Wheelchair (PAPAW) System

A push-rim activated power assist wheelchair (PAPAW) system is a wheelchair accessory that adds a power component to manual wheelchairs for additional power for propulsion and for braking. These systems may include specially designed wheels with sensors and motors embedded to determine the force that is exerted by the person upon the wheel. The system includes components, such as the drive wheels, batteries, battery chargers, controls, and mounting hardware.

2.2.17.19.1 Prior Authorization Documentation Requirements

A PAPAW system can be prior authorized using the Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services). All sections of the form must be completed, including the wheelchair and power wheelchair section.

The client must have the physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client must have the capability to:

- Understand how the PAPAW system and components function.
- Operate and control the PAPAW system safely.
- Self-propel and maneuver a manual wheelchair independently.

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  - Clients who primarily use one arm to self-propel and maneuver independently utilizing a one-arm drive manual wheelchair may be considered.
- The PAPAW must be medically necessary for the client to perform MRADLs in a typical day. Medical necessity may include but is not limited to:
  - Client's medical needs, such as limitations in upper body strength and endurance, and can include the presence of pain.
  - Prevention of the client from completing an MRADL within a reasonable time frame in their environment.
  - Heightened risk of repetitive strain injuries.
- The client or caregiver must have the capability to maintain care for the PAPAW system and accompanying components.

The cost of purchasing new equipment as opposed to the cost of modifying current equipment is not required for the PAPAW system prior authorization.

2.2.17.19.2 Seating Assessment

The addition of a PAPAW system as a wheelchair accessory is considered a type of major modification, which requires a seating assessment and a completed copy of the Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services).

Documentation of a new seating assessment demonstrating criteria of medical necessity is required for the PAPAW system.

A description is required of a trial with the equipment requested during the seating assessment by a therapist, in a variety of environments (or simulations of customary environments), including safety awareness, ability to navigate in the environment, and operate the PAPAW system independently. The description of a trial is required on the Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services) for a PAPAW system with a new wheeled mobility system or a major modification.

If a wheeled mobility system has been fitted and delivered to the client's home by a QRP, a PAPAW system may be considered for prior authorization with submission of a new Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services) any time within or beyond the first six months after fitting and delivery.

If a wheeled mobility system has not previously been fitted and delivered to the client's home by a QRP, initial prior authorization may be considered with submission of the same Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services) for both a manual wheelchair and PAPAW system.

2.2.17.20 Client Lifts

A lift is an item of DME that is a mechanical system used to lift or transfer a nonambulatory client between a bed, chair, wheelchair, bedside commode, bathroom, or other location. A lift may be medically necessary to ameliorate a client's medical condition or disability that results in impaired functional mobility impacting mobility related activities of daily living (MRADLs).

Electric and hydraulic lifts are movable single-stand mechanisms, often on casters, with a lifting arm attached to a sling, and lifting power that is provided by a manual hydraulic pump or an electric motor. Electric and hydraulic lifts are benefits for clients of all ages through Title XIX Home Health Services with documented medical necessity.

2.2.17.21 Hydraulic Lifts

Hydraulic lifts require prior authorization.

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2.2.17.21.1 Documentation Requirements

Prior authorization for a hydraulic lift may be considered with the following documentation:

- The inability of clients to assist in their own transfers
- The weight of the client and the weight capacity of the requested lift
- The availability of a caregiver to operate the lift
- Training by the provider to the client and the caregiver on the safe use of the lift

2.2.17.22 Electric Lifts

Prior authorization for an electric lift may be considered when the client meets criteria for a hydraulic lift and additional documentation explains why a hydraulic lift does not meet the client's needs.

2.2.17.23 Overhead, Fixed, and Portable Lifts

Overhead and fixed client lifts will be considered for reimbursement through CCP for clients who are 20 years of age or younger and are CCP-eligible. In order to consider a client lift outside of those specified in the home health benefit, consideration must be given to the client's medical needs (e.g., muscle tone, pain, fear, etc.), environmental factors, and caregiver abilities.

A client lift will not be prior authorized solely for the convenience of a caregiver. Prevention of caregiver injury or consideration of client safety during transfer due to caregiver factors, such as physical abilities, is not considered "caregiver convenience."

Final set up and installation costs of client lifts, including labor costs associated with ceiling or other fixed lifts, are included in the initial purchase price of the client lift and will not be separately reimbursed. Components and accessories are also considered part of the initial purchase price of a client lift. Components and accessories include, but are not limited to, the following:

- Lift motor and gear box
- Any type of sling
- Hand controls and connectors
- Carry or spreader bar and sling attachments or straps
- Ceiling tracks or rails and components
- All mounting hardware and brackets
- Batteries
- Charger system
- Emergency stop and lowering systems
- Lifting tape
- Wheels or castors of any type
- Installation of the fixed lift systems

Repair or replacement of components, such as a sling, to client-owned equipment may be considered a benefit as needed with documentation of medical necessity. Rental of an electric or hydraulic lift may be considered during a repair of a client lift.

2.2.17.24 Overhead Lifts

The purchase of a free-standing overhead client lift (procedure code E0639) is a benefit in the home setting when services are provided by DME providers.

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An overhead lift is anticipated to last a minimum of five years but may be replaced in less than five years with documentation of medical necessity.

Delivery and labor to assemble the overhead lift are not separately reimbursed.

2.2.17.24.1 Prior Authorization

Procedure code E0639 requires prior authorization.

A free-standing overhead lift may be considered for prior authorization when the client meets the criteria for a hydraulic or electric lift and additional documentation explains why a hydraulic or electric lift will not meet the client's needs. Documentation that supports the medical necessity of the requested free-standing overhead lift must include all of the following:

- A written statement from a licensed physical therapist, licensed occupational therapist, physician, or allowed practitioner that clearly outlines the client's medical need to be transferred with a free-standing overhead lift versus a hydraulic or electric lift.
- Diagrams of the home (rooms) indicating the location where the free-standing lift will be used. Diagrams must include dimensions of the rooms, including doorways, as well as the dimensions and placement of all furnishings and equipment (i.e., hospital bed, wheelchair, bedside commode, etc.) in the room.
- A list of all equipment the lift will interact with (i.e., wheelchair, hospital bed, or therapy equipment). Documentation should clearly indicate if the client owns other mobility aids, including any type of bath chair or bath lift, and explain why those pieces of equipment are not sufficient for mobility.

2.2.17.25 Fixed Lifts

The purchase of a fixed client lift (procedure code E0640) is a benefit in the home setting when the services are provided by home health medical supplier DME providers.

Home modifications that are necessary for the final set up and installation of a fixed lift are not benefits of Texas Medicaid. Suppliers must not submit claims for any structural changes or remodeling necessitated by the installation of a lift system.

> ***Note:*** *Home modifications are physical changes to the home to prepare the structure for the final set up and installation of the equipment.*

A fixed lift is anticipated to last a minimum of five years but may be replaced in less than five years with documentation of medical necessity.

Delivery and labor to assemble and install the fixed lift are not separately reimbursed.

2.2.17.25.1 Prior Authorization

Procedure code E0640 requires prior authorization.

A fixed lift may be considered for prior authorization when the client meets criteria for a hydraulic or electric lift and additional documentation explains why a hydraulic, electric, or free-standing overhead lift will not meet the client's needs. Documentation that supports the medical necessity of the requested fixed lift must include all of the following:

- A signed and dated statement from the DME provider attesting that the home in which the lift will be installed meets the manufacturer's requirements for installation, including documentation that the ceiling and wall structures of the residence are adequate to safely support the fixed lift.
- Documentation of whether the home is owned by the client, parent, guardian, or responsible party, such as a signed and dated document attesting to the ownership of the home. If the home is not owned by the client, parent, guardian, or responsible party, written consent of the installation from the home owner or property manager must be submitted.

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- A written statement from a licensed physical therapist, licensed occupational therapist, physician, or allowed practitioner that clearly outlines the client's medical need to be transferred with a fixed lift.
- Indication of what type of home the client lives in (i.e., traditional 1-story or 2-story home, mobile home, or apartment), including diagrams of the home where the fixed lift system will be installed. Diagrams must include dimensions of the rooms including doorways, as well as the dimensions and placement of all furnishings and equipment (i.e. hospital bed, wheelchair, bedside commode, etc.) in the room. Diagrams must also include the proposed placement of all fixed components (i.e. railing or track) of the system.
- A list of all equipment the lift will interact with (i.e., wheelchair, hospital bed, or therapy equipment). Documentation should clearly indicate if the client owns other mobility aids, including any type of bath chair or bath lift, and explain why those pieces of equipment are not sufficient for mobility.
- Attestation from the DME provider stating that the provider has personnel who have been trained to install the lift system.
- Documentation confirming the home modifications necessary to allow for installation of the lift have been done or are scheduled to be completed prior to installation.

2.2.17.26 Portable Client Lifts for Outside Home Setting

Portable client lifts are benefits for clients who are 20 years of age and younger. Providers must bill procedure code E0635 with modifier TG for the purchase of the portable client lift. Purchase of procedure code E0635 is limited to once per lifetime, any provider. Rental for E0635 is limited to once per month.

2.2.17.26.1 Prior Authorization

Prior authorization is required and will be considered on a case-by-case basis for portable client electric lifts that fold-up for transport and are necessary for use outside the home setting.

The provider must submit a prior authorization request with the following documentation for consideration of medical necessity:

- An explanation of why a home-based portable lift will not meet the client's needs
- A description of the circumstances, including duration of need
- The family member or caregivers who support the client with the use of the portable client lift when the client travels outside the home setting

2.2.17.27 Standers

A stander is a device used by a client with a neuromuscular condition who is unable to stand alone. Standers and standing programs can improve digestion, increase muscle strength, decrease contractures, increase bone density, and minimize decalcification (this list is not all inclusive).

2.2.17.27.1 Prior Authorization

Standers, including all accessories, require prior authorization. Standers and gait trainers will not be prior authorized for a client within one year of each other.

2.2.17.27.2 Documentation Requirements

Prior authorization may be considered for standers with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory status
- Anticipated benefits of the equipment
- Frequency and duration of the client's standing program

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- Anticipated length of time the client will require this equipment
- Client's height, weight, and age
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

2.2.17.28 Gait Trainers

Gait trainers are devices with wheels that are used to train clients with ambulatory potential. They provide the same benefits as a stander, in addition to assisting with gait training.

2.2.17.28.1 Prior Authorization

Prior authorization for a gait trainer may be considered with the following documentation:

- Documentation of medical necessity
- An assessment of the accessibility of the client's residence to ensure that a gait trainer is usable in the home (i.e., doors and halls are wide enough and have no obstructions)
- A physician or allowed practitioner familiar with the client documents that the client has ambulatory potential and will benefit from a gait training program
- The client meets the criteria for a stander

2.2.17.29 Accessories, Modifications, Adjustments and Repairs

Accessories, modifications, adjustments, and repairs are benefits of Texas Medicaid as outlined below.

- All major and minor modifications, adjustments, and repairs to standard mobility aid equipment within the first six months after delivery are considered part of the purchase price.
- All modifications and adjustments to a wheeled mobility system within the first six months after delivery are considered part of the purchase price.

Mobility aids that have been purchased are anticipated to last a minimum of five years.

A major modification to a wheeled mobility system requires the completion of a new seating assessment by a qualified practitioner (physician, occupational therapist, or physical therapist), with the participation of a QRP.

Prior authorization for equipment replacement is considered within five years of equipment purchase when one of the following occurs:

- There has been a significant change in the client's condition such that the current equipment no longer meets the client's needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.

A wheeled mobility system that has been fitted and delivered to the client's home by a QRP and then found to be inappropriate for the client's condition will not be eligible for an upgrade, replacement, or major modification within the first six months following purchase unless there has been a significant change in the client's condition. The significant change in the client's condition must be documented by a physician or allowed practitioner familiar with the client.

2.2.17.29.1 Prior Authorization

Modifications

Modifications to custom equipment after the first six months from fitting and delivery may be considered for prior authorization if a change occurs in the client's needs, capabilities or physical/mental capability, that cannot be anticipated.

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Documentation supporting the medical necessity of the requested modification must include the following:

- Description of the change in the client's condition that requires accommodation by different seating, drive controls, electronics, or other mobility base components.
- All projected changes in the client's mobility needs.
- The date of purchase, the serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

Major modifications to a wheeled mobility system also require that a new seating assessment be completed by a qualified practitioner (physician, physical therapist, or occupational therapist) and submitted with the prior authorization request. A request for authorization of the QRP's participation in the seating assessment for the major modification must be included with the prior authorization request for the major modification.

Minor modifications to a wheeled mobility system do not require the completion of a new seating assessment.

Requests for equipment submitted as a minor modification or a repair to a wheeled mobility system must be submitted with modifier RB.

Adjustments

Adjustments within the first six months after delivery, including adjustments to a wheeled mobility system within the first six months after fitting and delivery by a QRP will not be prior authorized.

A seating or positioning component alteration that does not require replacement components to accommodate a change in the client's size (height or weight) is considered an adjustment and not a major modification.

A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months from delivery.

Documentation must include the date of purchase, the serial number of the current equipment, and the reason for adjustments.

Repairs

Repairs to client-owned equipment may be considered for prior authorization as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair.

HHSC or its designee reserves the right to request additional documentation about the need for repairs when there is evidence of abuse or neglect to equipment by the client, client's family, or caregiver. Requests for repairs when there is documented proof of abuse or neglect will not be authorized.

Requests for equipment submitted as a repair to a wheeled mobility system must be submitted with modifier RB.

Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

Documentation must include the date of purchase and serial number of the current equipment, the cause of the damage or need for repairs, the steps the client or caregiver will take to prevent further damage if repairs are due to an accident, and when requested, the cost of purchasing new equipment as opposed to repairing current equipment.

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2.2.17.30 Replacement

Replacement of equipment is also considered when loss or irreparable damage has occurred. The following must be submitted with the prior authorization request:

- A copy of the police or fire report, when appropriate.
- A statement about the measures to be taken in order to prevent reoccurrence.
- Replacement equipment for clients who are birth through 20 years of age and do not meet the criteria in this handbook may be considered for prior authorization through Texas Health Steps CCP.

2.2.17.31 Procedure Codes and Limitations for Mobility Aids

For clients who are 20 years of age and younger, the limitations listed below may not apply with evidence of medical necessity. Procedures include, but are not limited to, the following:

Procedure Code	Maximum Limit
Canes	
E0100	1 per 5 years
E0105	1 per 5 years
Crutches	
A4635	As needed
E0110	1 purchase every 5 years; 1-month rental
E0111	1 purchase every 5 years; 1-month rental
E0112	1 purchase every 5 years; 1-month rental
E0113	1 purchase every 5 years; 1-month rental
E0114	1 purchase every 5 years; 1-month rental
E0116	1 purchase every 5 years; 1-month rental
E0153	1 purchase every 5 years
Walkers	
A4636	1 per month
A4637	As needed
E0130	1 purchase every 5 years; 1-month rental
E0135	1 purchase every 5 years; 1-month rental
E0141	1 purchase every 5 years; 1-month rental
E0143	1 purchase every 5 years; 1-month rental
E0144	1 purchase every 5 years; 1-month rental
E0147	1 purchase every 5 years; 1-month rental
E0148	1 purchase every 5 years; 1-month rental
E0149	1 purchase every 5 years; 1-month rental
E0154	1 per 5 years
E0155	1 per 5 years
E0157	1 per 5 years
E0158	1 per 5 years
E0159	1 per 5 years
Gait Trainers	

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Procedure Code	Maximum Limit
E8001	1 purchase every 5 years
Wheelchairs	
97542	N/A
E1050	1 purchase every 5 years; 1-month rental
E1060	1 purchase every 5 years; 1-month rental
E1070	1 purchase every 5 years; 1-month rental
E1100	1 purchase every 5 years; 1-month rental
E1110	1 purchase every 5 years; 1-month rental
E1161	1 purchase every 5 years; 1-month rental
E1220	1 per 5 years
E1229	1 per 5 years
E1231	1 purchase every 5 years; 1-month rental
E1232	1 purchase every 5 years; 1-month rental
E1233	1 purchase every 5 years; 1-month rental
E1234	1 purchase every 5 years; 1-month rental
E1235	1 purchase every 5 years; 1-month rental
E1236	1 purchase every 5 years; 1-month rental
E1237	1 purchase every 5 years; 1-month rental
E1238	1 purchase every 5 years; 1-month rental
E1239	1 per 5 years
Power Wheelchairs	
K0001	1 purchase every 5 years; 1-month rental
K0002	1 purchase every 5 years; 1-month rental
K0003	1 purchase every 5 years; 1-month rental
K0004	1 purchase every 5 years; 1-month rental
K0005	1 purchase every 5 years; 1-month rental
K0006	1 purchase every 5 years; 1-month rental
K0007	1 purchase every 5 years; 1-month rental
K0008	1 purchase every 5 years; 1-month rental
K0009	1 purchase every 5 years; 1-month rental
K0010	1 per 5 years; 1 per month rental
K0011	1 per 5 years
K0012	1 per 5 years
K0013	1 purchase every 5 years; 1-month rental
K0015	As needed
K0017	As needed
K0018	As needed
K0019	As needed
K0020	As needed
K0037	As needed

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Procedure Code	Maximum Limit
K0038	As needed
K0039	As needed
K0040	As needed
K0041	As needed
K0042	As needed
K0043	As needed
K0044	As needed
K0045	As needed
K0046	As needed; 1 per month
K0047	As needed; 1 per month
K0050	As needed
K0051	As needed
K0052	As needed
K0053	As needed; 1 per month
K0056	As needed
K0065	As needed
K0069	As needed; 1 per month
K0070	As needed
K0071	As needed
K0072	As needed
K0073	As needed
K0077	As needed
K0098	As needed
K0105	As needed; 1 per month
K0195	As needed; 1 per month
K0669	As needed
K0813	1 purchase every 5 years; 1-month rental
K0814	1 purchase every 5 years; 1-month rental
K0815	1 purchase every 5 years; 1-month rental
K0816	1 purchase every 5 years; 1-month rental
K0820	1 purchase every 5 years; 1-month rental
K0821	1 purchase every 5 years; 1-month rental
K0822	1 purchase every 5 years; 1-month rental
K0823	1 purchase every 5 years; 1-month rental
K0824	1 purchase every 5 years; 1-month rental
K0825	1 purchase every 5 years; 1-month rental
K0826	1 purchase every 5 years; 1-month rental
K0827	1 purchase every 5 years; 1-month rental
K0828	1 purchase every 5 years; 1-month rental
K0829	1 purchase every 5 years; 1-month rental

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Procedure Code	Maximum Limit
K0835	1 purchase every 5 years; 1-month rental
K0836	1 purchase every 5 years; 1-month rental
K0837	1 purchase every 5 years; 1-month rental
K0838	1 purchase every 5 years; 1-month rental
K0839	1 purchase every 5 years; 1-month rental
K0840	1 purchase every 5 years; 1-month rental
K0841	1 purchase every 5 years; 1-month rental
K0842	1 purchase every 5 years; 1-month rental
K0843	1 purchase every 5 years; 1-month rental
K0848	1 purchase every 5 years; 1-month rental
K0849	1 purchase every 5 years; 1-month rental
K0850	1 purchase every 5 years; 1-month rental
K0851	1 purchase every 5 years; 1-month rental
K0852	1 purchase every 5 years; 1-month rental
K0853	1 purchase every 5 years; 1-month rental
K0854	1 purchase every 5 years; 1-month rental
K0855	1 purchase every 5 years; 1-month rental
K0856	1 purchase every 5 years; 1-month rental
K0857	1 purchase every 5 years; 1-month rental
K0858	1 purchase every 5 years; 1-month rental
K0859	1 purchase every 5 years; 1-month rental
K0860	1 purchase every 5 years; 1-month rental
K0861	1 purchase every 5 years; 1-month rental
K0862	1 purchase every 5 years; 1-month rental
K0863	1 purchase every 5 years; 1-month rental
K0864	1 purchase every 5 years; 1-month rental
K0868	1 purchase every 5 years; 1-month rental
K0869	1 purchase every 5 years; 1-month rental
K0870	1 purchase every 5 years; 1-month rental
K0871	1 purchase every 5 years; 1-month rental
K0877	1 purchase every 5 years; 1-month rental
K0878	1 purchase every 5 years; 1-month rental
K0879	1 purchase every 5 years; 1-month rental
K0880	1 purchase every 5 years; 1-month rental
K0884	1 purchase every 5 years; 1-month rental
K0885	1 purchase every 5 years; 1-month rental
K0886	1 purchase every 5 years; 1-month rental
K0890	1 purchase every 5 years; 1-month rental
K0891	1 purchase every 5 years; 1-month rental
K0898	1 purchase every 5 years; 1-month rental

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Procedure Code	Maximum Limit
K0899	1 purchase every 5 years; 1-month rental
K0900	1 purchase every 5 years; 1-month rental
Scooters	
E1230	1 per 5 years
K0800	1 per 5 years
K0801	1 per 5 years
K0802	1 per 5 years
Wheelchair Parts	
E0942	1 per year
E0944	2 per year
E0945	2 per year
E0950	1 per year
E0951	2 per year
E0952	2 per year
E0953	As needed
E0954	2 per year
E0955	As needed
E0956	As needed
E0957	As needed
E0958	1 per year
E0959	As needed; 1 per month
E0960	As needed
E0961	2 per year
E0967	As needed; 1 per month
E0969	1 per 5 years
E0970	1 pair per year
E0971	2 per year
E0973	2 per year
E0974	2 per year
E0978	1 per year
E0980	1 per year
E0981	As needed
E0982	As needed
E0986	1 per 5 years
E0990	2 per year; 1 per month
E0992	1 per year
E0994	2 per year
E0995	2 per year
E1002	1 per 5 years
E1003	1 per 5 years

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Procedure Code	Maximum Limit
E1004	1 per 5 years
E1005	1 per 5 years
E1006	1 per 5 years
E1007	1 per 5 years
E1008	1 per 5 years
E1009	1 per 5 years
E1010	1 per 5 years
E1011	As needed
E1012	1 per 5 years
E1014	1 per 5 years
E1015	2 per year
E1016	2 per year
E1017	2 per year
E1018	2 per year
E1020	1 per 5 years
E1022	2 per year
E1028	1 per 5 years
E1032	1 per 5 years
E1033	As needed
E1034	As needed
E1029	1 per 5 years
E1225	As needed; 1 per month
E1226	As needed; 1 per month
E2201	1 per 5 years
E2202	1 per 5 years
E2203	1 per 5 years
E2204	1 per 5 years
E2205	1 per 5 years
E2206	1 per 5 years
E2207	1 purchase every 5 years
E2208	1 purchase every 5 years
E2209	1 purchase every 5 years
E2210	4 per year
E2211	2 per year
E2212	2 per year
E2213	2 per year
E2214	2 per year
E2215	2 per year
E2216	2 per year
E2217	2 per year

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Procedure Code	Maximum Limit
E2218	2 per year
E2219	2 per year
E2220	2 per year
E2221	2 per year
E2222	2 per year
E2224	2 per year
E2225	2 per year
E2226	2 per year
E2227	1 per 5 years
E2228	1 per 5 years
E2291	1 per 5 years
E2292	1 per 5 years
E2293	1 per 5 years
E2294	1 per 5 years
E2298	1 per 5 years
E2310	1 per 5 years
E2311	1 per 5 years
E2312	1 purchase every 5 years; 1-month rental
E2313	1 per 5 years
E2321	1 per 5 years
E2323	1 per 5 years
E2324	1 per 5 years
E2325	1 per 5 years
E2326	1 per 5 years
E2327	1 per 5 years
E2328	1 per 5 years
E2329	1 per 5 years
E2330	1 per 5 years
E2340	1 per 5 years
E2341	1 per 5 years
E2342	1 per 5 years
E2343	1 per 5 years
E2351	1 per 5 years
E2359	1 per 5 years
E2368	1 per 5 years
E2369	1 per 5 years
E2370	1 per 5 years
E2373	1 per 5 years
E2374	1 per 5 years
E2375	1 per 5 years

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Procedure Code	Maximum Limit
E2376	1 per 5 years
E2377	1 per 5 years
E2378	1 per 5 years
E2381	2 per year
E2382	2 per year
E2383	2 per year
E2384	2 per year
E2385	2 per year
E2386	2 per year
E2387	2 per year
E2388	2 per year
E2389	2 per year
E2390	2 per year
E2391	2 per year
E2392	2 per year
E2394	1 per 5 years
E2395	1 per 5 years
E2396	1 per 5 years
E2398	1 per 5 years
Wheelchair/Pressure/Positioning Cushions	
E0190	1 per 3 years
E2601	1 per year
E2602	1 per year
E2603	1 per year
E2604	1 per year
E2605	1 per year
E2606	1 per year
E2607	1 per year
E2608	1 per year
E2609	1 per year
E2611	1 per year
E2612	1 per year
E2613	1 per year
E2614	1 per year
E2615	1 per year
E2616	1 per year
E2617	1 per year
E2619	1 per year
E2620	1 per year
E2621	1 per year

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Procedure Code	Maximum Limit
E2622	1 per year
E2623	1 per year
E2624	1 per year
E2625	1 per year
Batteries	
E2361	1 per 5 years
E2363	1 per 5 years
E2366	1 per 5 years
E2371	1 per 5 years
K0733	2 per year
Safety Equipment	
E0700	2 per year
E0705	1 per 5 years
Lifts	
E0627	1 per 5 years
E0629	1 per 5 years
E0630	1 per 5 years; 1 per month rental
E0635	1 per 5 years; 1 per month rental
E0637	1 per 5 years
E0638	1 per 5 years
E0641	1 per 5 years
Miscellaneous	
A9900	As needed
E1399	As needed
K0108	As needed
K0739	As needed

The following mobility aids are not a benefit of Home Health Services:

- Items including but not limited to tire pumps, a color for a wheelchair, gloves, back packs, and flags are not considered medically necessary
- Mobile standers, power standing system on a wheeled mobility device
- Vehicle lifts and modifications
- Permanent ramps, vehicle ramps, and home modifications
- Stairwell lifts of any type
- Elevators or platform lifts of any type
- Chairs with incorporated seat lifts
- An attendant control, for safety, all power chairs are to include a stop switch

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- Powered mobility device for use only outside the home

  Note: *For clients who are 21 years of age or older, requests for mobility aids that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Texas Medicaid does not reimburse separately for associated DME charges, including battery disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment. White canes for the blind are considered self help adaptive aids and are not a benefit of Home Health Services.

2.2.18 Nutritional (Enteral) Products, Supplies, and Equipment

Medical nutritional products including enteral formulas and food thickener, may be approved for clients who have specialized nutritional requirements.

Medical nutritional products must be prescribed by a physician or allowed practitioner and be medically necessary.

Enteral nutritional products are those food products that are included in an enteral treatment protocol. They serve as a therapeutic agent for health maintenance and are required to treat an identified medical condition. Nutritional products, supplies, and equipment may be a benefit when provided in the home under Home Health Services.

For clients who are 20 years of age and younger and do not meet criteria through Home Health Services, products, supplies, and equipment can be considered through the Comprehensive Care Program (CCP).

Note: *For clients who are 21 years of age or older, requests for nutritional (enteral) products, supplies and equipment that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

2.2.18.1 Enteral Nutritional Products, Feeding Pumps, and Feeding Supplies

Enteral nutritional products and related feeding supplies and equipment are a benefit through Home Health Services for clients who are 21 years of age and older and require tube feeding as their primary source of nutrition. The enteral product, supply, or equipment must be part of the medical POC outlined and maintained by the treating physician or allowed practitioner.

Enteral nutritional products may be reimbursed with the following procedure codes:

Procedure Codes									
B4100	B4103	B4104	B4149	B4150	B4152	B4153	B4154	B4155	B4157
B4158	B4159	B4160	B4161	B4162					

Enteral formulas consisting of semi-synthetic intact protein or protein isolates (procedure codes B4150 and B4152) are appropriate for the majority of clients requiring enteral nutrition.

Special enteral formulas or additives (procedure code B4104) may be considered for prior authorization with supporting documentation submitted by the client's physician or allowed practitioner indicating the client's medical needs for these special enteral formulas.

Special enteral formula may be reimbursed with the following procedure codes:

Procedure Codes						
B4149	B4153	B4154	B4155	B4157	B4161	B4162

Pediatric nutritional products (procedure codes B4103, B4158, B4159, B4160, B4161, and B4162) are restricted to clients who are 20 years of age and younger.

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Food thickener may be considered for clients with a swallowing disorder. B4100 is reimbursed per unit; 1 unit = 1 ounce. Food thickener option (powder, gel, or liquid) should be appropriate for the client's medical condition.

Enteral nutritional supplies and equipment may be reimbursed with the following procedure codes and limitations:

Procedure Codes	Limitations
A4322	30 per month
A5200	2 per month
B4034	Up to 31 per month
B4035	Up to 31 per month
B4036	Up to 31 per month
B4081	As needed
B4082	As needed
B4083	As needed
B4087	As needed
B4088	As needed
B4105	Up to 62 per month
B9002	1 purchase every 5 years; 1 rental per month
T1999*	As needed* If procedure code T1999 is used for a needleless syringe, the allowed amount is 8 per month.
*** Appropriate limitations for miscellaneous procedure code T1999 are determined on a case-by-case basis through prior authorization.**	

Procedure code B9998 may be reimbursed as needed without a modifier or with the following modifiers and limitations:

Procedure Codes	Descriptions	Limitations
B9998		As Needed
B9998 with modifier U1	Disposable G-tube adapter set	4 per month
B9998 with modifier U2	Nonobturated gastrostomy or jejunostomy tube with insertion supplies and extensions	2 per rolling year
B9998 with modifier U3	Low profile enteral extension set	4 per month
B9998 with modifier U4	Standard gastrostomy tube	2 per rolling year
B9998 with modifier U5	Standard enteral extension set	4 per month

Note: *Appropriate limitations for miscellaneous procedure codes B9998 without a modifier are determined on a case-by-case basis through prior authorization. Specific items may be requested using procedure code B9998 using the modifiers outlined in the table above.*

A backpack or carrying case for a portable enteral nutrition infusion pump may be a benefit of Home Health Services, when medically necessary and prior authorized, using procedure code B9998.

2.2.18.2 Prior Authorization Requirements

Prior authorization is required for most enteral products, supplies, and equipment provided through Home Health Services. Requests are reviewed for medically necessary amounts based on caloric needs as indicated by the client's physician or an allowed practitioner.

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2.2.18.2.1 Clients who are 21 years of age and older

Enteral nutrition and related supplies and equipment may be considered for prior authorization for clients who are 21 years of age and older when all or part of the client's nutritional intake is received through a feeding tube, and the enteral formula is:

- The client's sole source of nutrition
- The client's primary source of nutrition
  - An enteral tube feeding is considered the primary source of nutrition when it comprises more than 70 percent of the caloric intake needed to maintain the client's weight.
  - The percent of calories provided by an enteral formula may be calculated by dividing the client's daily calories supplied by the enteral formula by the daily caloric intake ordered by the physician or allowed practitioner to maintain the client's weight. The result is multiplied by 100 to determine the percentage of calories provided by the enteral formula.

Related supplies and equipment may be considered for prior authorization when criteria for nutritional products are met, and medical necessity is included for each item requested.

Renewal of the prior authorization will be considered based on medical necessity.

Prior authorization may be given for up to six months. Prior authorization may be recertified with documentation supporting ongoing medical necessity for the nutritional products requested.

2.2.18.2.2 Clients who are 20 years of age and younger

Prior authorization for nutritional products is not required for a client who is 20 years of age and younger and who meets at least one of the following criteria:

- Client receives all or part of their nutritional intake through a tube.
- Client has a metabolic disorder that has been documented with one of the following diagnosis codes:

Diagnosis Codes							
C8800	C8801	C965	C966	D472	D800	D801	D802
D803	D804	D805	D806	D807	D808	D809	D810
D811	D812	D814	D816	D817	D8189	D819	D820
D821	D822	D823	D824	D828	D829	D830	D831
D832	D838	D839	D840	D841	D8481	D84821	D84822
D8489	D849	D890	D891	D893	D8982	D8989	D899
E201	E670	E671	E672	E673	E678	E68	E700
E701	E7020	E7021	E7029	E7030	E70310	E70311	E70318
E70319	E70320	E70321	E70328	E70329	E70330	E70331	E70338
E70339	E7039	E7040	E7041	E7049	E705	E7081	E7089
E709	E710	E71110	E71111	E71118	E71120	E71121	E71128
E7119	E712	E7130	E71310	E71311	E71312	E71313	E71314
E71318	E7132	E7139	E7140	E7141	E7142	E7143	E71440
E71448	E7150	E71510	E71511	E71518	E71520	E71521	E71522
E71528	E71529	E7153	E71540	E71541	E71542	E71548	E7200
E7201	E7202	E7203	E7204	E7209	E7210	E7211	E7212
E7219	E7220	E7221	E7222	E7223	E7229	E723	E724
E7250	E7251	E7252	E72530	E72538	E72539	E72540	E72541

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Diagnosis Codes							
E72548	E72549	E7259	E7289	E729	E730	E738	E739
E7400	E7401	E7402	E7403	E7404	E7405	E7409	E7410
E7411	E7412	E7419	E7420	E7421	E7429	E7431	E7439
E744	E74810	E74818	E74819	E74820	E74829	E7489	E749
E7500	E7509	E7510	E7511	E7519	E7521	E7522	E7523
E75240	E75241	E75242	E75243	E75244	E75248	E75249	E7526
E7527	E7528	E7529	E753	E755	E756	E7601	E7602
E7603	E761	E76210	E76211	E76219	E7622	E7629	E763
E768	E769	E770	E771	E778	E779	E781	E782
E783	E785	E786	E7870	E7879	E7881	E7889	E789
E791	E792	E7981	E7982	E7989	E799	E800	E801
E8020	E8021	E8029	E803	E804	E805	E806	E807
E8300	E8301	E8309	E8310	E8319	E8330	E8331	E8332
E8339	E8340	E8341	E8342	E8349	E8350	E8351	E8352
E8359	E8381	E83820	E83821	E83822	E83823	E83824	E83825
E8389	E839	E840	E8411	E8419	E848	E849	E850
E851	E852	E853	E854	E8581	E8589	E859	E860
E861	E869	E870	E871	E8720	E8721	E8722	E8729
E873	E874	E875	E876	E8770	E8779	E878	E8801
E8802	E8809	E8810	E8811	E8812	E8813	E8814	E8819
E882	E8840	E8841	E8842	E8843	E8849	E88810	E88811
E88818	E88819	E8882	E8889	E889	E88A	H49811	H49812
H49813	M1000	M10011	M10012	M10019	M10021	M10022	M10029
M10031	M10032	M10039	M10041	M10042	M10049	M10051	M10052
M10059	M10061	M10062	M10069	M10071	M10072	M10079	M1008
M1009	M10111	M10112	M10121	M10122	M10131	M10132	M10141
M10142	M10151	M10152	M10161	M10162	M10171	M10172	M10211
M10212	M10221	M10222	M10231	M10232	M10241	M10242	M10251
M10252	M10261	M10262	M10271	M10272	M1030	M10311	M10312
M10319	M10321	M10322	M10329	M10331	M10332	M10339	M10341
M10342	M10349	M10351	M10352	M10359	M10361	M10362	M10369
M10371	M10372	M10379	M1038	M1039	M1040	M10411	M10412
M10419	M10421	M10422	M10429	M10431	M10432	M10439	M10441
M10442	M10449	M10451	M10452	M10459	M10461	M10462	M10469
M10471	M10472	M10479	M1048	M1049	M109	M1A00X0	M1A00X1
M1A0110	M1A0111	M1A0120	M1A0121	M1A0190	M1A0191	M1A0210	M1A0211
M1A0220	M1A0221	M1A0290	M1A0291	M1A0310	M1A0311	M1A0320	M1A0321
M1A0390	M1A0391	M1A0410	M1A0411	M1A0420	M1A0421	M1A0490	M1A0491
M1A0510	M1A0511	M1A0520	M1A0521	M1A0590	M1A0591	M1A0610	M1A0611
M1A0620	M1A0621	M1A0690	M1A0691	M1A0710	M1A0711	M1A0720	M1A0721

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Diagnosis Codes							
M1A0790	M1A0791	M1A08X0	M1A08X1	M1A09X0	M1A09X1	M1A20X0	M1A20X1
M1A2110	M1A2111	M1A2120	M1A2121	M1A2190	M1A2191	M1A2210	M1A2211
M1A2220	M1A2221	M1A2290	M1A2291	M1A2310	M1A2311	M1A2320	M1A2321
M1A2390	M1A2391	M1A2410	M1A2411	M1A2420	M1A2421	M1A2490	M1A2491
M1A2510	M1A2511	M1A2520	M1A2521	M1A2590	M1A2591	M1A2610	M1A2620
M1A2621	M1A2690	M1A2691	M1A2710	M1A2711	M1A2720	M1A2721	M1A2790
M1A2791	M1A28X0	M1A28X1	M1A29X0	M1A29X1	M1A30X0	M1A30X1	M1A3110
M1A3111	M1A3120	M1A3121	M1A3190	M1A3191	M1A3210	M1A3211	M1A3220
M1A3221	M1A3290	M1A3291	M1A3310	M1A3311	M1A3320	M1A3321	M1A3390
M1A3391	M1A3410	M1A3411	M1A3420	M1A3421	M1A3490	M1A3491	M1A3510
M1A3511	M1A3520	M1A3521	M1A3590	M1A3591	M1A3610	M1A3611	M1A3620
M1A3621	M1A3690	M1A3691	M1A3710	M1A3711	M1A3720	M1A3721	M1A3790
M1A3791	M1A38X0	M1A38X1	M1A39X0	M1A39X1	M1A40X0	M1A40X1	M1A4110
M1A4111	M1A4120	M1A4121	M1A4190	M1A4191	M1A4210	M1A4211	M1A4220
M1A4221	M1A4290	M1A4291	M1A4310	M1A4311	M1A4320	M1A4321	M1A4390
M1A4391	M1A4410	M1A4411	M1A4420	M1A4421	M1A4490	M1A4491	M1A4510
M1A4511	M1A4520	M1A4521	M1A4590	M1A4591	M1A4610	M1A4611	M1A4620
M1A4621	M1A4690	M1A4691	M1A4710	M1A4711	M1A4720	M1A4721	M1A4790
M1A4791	M1A48X0	M1A48X1	M1A49X0	M1A49X1	M1A9XX0	M1A9XX1	M3508
M3581	M3589	M359	Z431	Z87738	N200	P7422	P7432
P7441	P74422	P7449	Z931	Z934			

Prior authorization is required for nutritional products that are provided through CCP to clients who do not meet the criteria above.

A completed CCP Prior Authorization Request Form that prescribes the nutritional product and/or related services must be signed and dated by a prescribing physician or an allowed practitioner who was familiar with the client before requesting prior authorization. The completed CCP Prior Authorization Request Form must include the procedure codes and numerical quantities for the services requested. The completed CCP Prior Authorization Request Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

Requests for prior authorization must include the following documentation:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition that resulted in the requirement for a nutritional product, as well as any other medical diagnoses or conditions, including:
  - The client's overall health status.
  - Height and weight.
  - Growth history and growth charts.
  - Why the client cannot be maintained on an age-appropriate diet.
  - Other formulas tried and why they did not meet the client's needs.
- Diagnosis or condition.

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- The goals and timelines on the medical plan of care.
- Total caloric intake prescribed by the physician or allowed practitioner.
- Acknowledgement that the client has a feeding tube in place.

Related supplies and equipment for clients who require nutritional products may be considered for prior authorization when the criteria for nutritional products are met and medical necessity is included for each item requested.

Prior authorization may be given for up to 12 months. Prior authorization may be recertified with documentation that supports the ongoing medical necessity of the requested nutritional products.

A retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service.

Requests for prior authorization, when required, must include the necessary product information.

Prior authorization of nutritional pudding products may be considered for children who have a documented oropharyngeal motor dysfunction and receive greater than 50 percent of their daily caloric intake from a nutritional pudding product.

Requests for electrolyte replacement products, such as Pedialyte or Oralyte, require documentation of medical necessity, including:

- The underlying acute or chronic medical diagnoses or conditions that indicate the need to replace fluid and electrolyte losses.
- The presence of mild to moderate dehydration due to the persistent mild to moderate diarrhea or vomiting.

Electrolyte replacement products are not indicated for clients with:

- Intractable vomiting
- Adynamic ileus
- Intestinal obstruction or perforated bowel
- Anuria, oliguria, or impaired homeostatic mechanism
- Severe, continuing diarrhea, when intended for use as the sole therapy

2.2.18.2.3 Enteral Formulas

Enteral formulas require prior authorization. Requests for prior authorization must include the necessary product information.

2.2.18.2.4 Nasogastric, Gastrostomy, or Jejunostomy Feeding Tubes

Feeding tubes require prior authorization.

Additional feeding tubes may be prior authorized if documentation submitted supports medical necessity, such as infection at gastrostomy site, leakage, or occlusion.

2.2.18.2.5 Enteral Feeding Pumps

Enteral feeding pumps, with and without alarms, require prior authorization.

Enteral feeding pumps may be considered for prior authorization for lease or purchase with documentation of medical necessity indicating that the client meets the following criteria:

- Gravity or syringe feedings are not medically indicated
- The client requires an administration rate of less than 100 ml/hr
- The client requires night-time feedings

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- The client has one of the following medical conditions (this list is not all-inclusive):
  - Reflux or aspiration
  - Severe diarrhea
  - Dumping syndrome
  - Blood glucose fluctuations
  - Circulatory overload

2.2.18.2.6 Enteral Supplies

Enteral supplies require prior authorization, with the exception of irrigation syringes (procedure code A4322) and percutaneous catheter or tube anchoring devices (procedure code A5200) within the allowable limits.

Procedure code B4034 will not be prior authorized for use in place of procedure code A4322 for irrigation syringes when they are not part of a bolus administration kit.

Gravity bags and pump nutritional containers are included in the feeding supply kits and will not be prior authorized separately.

Procedure code B4105 will require prior authorization, and may be considered with documentation of medical necessity indicating that the client meets all the following criteria:

- The client has exocrine pancreatic insufficiency.
- The client utilizes an enteral feeding pump.
- The client utilizes a compatible formula and the amount of formula (mL) the client is receiving daily is documented.

  Note: *One cartridge can be used with up to 500mL of formula, with a maximum of two cartridges used per day. Procedure code B4105 will be limited to 62 per month.*

For clients who are 5 through 20 years of age, procedure code B4105 will be considered through the Comprehensive Care Program (CCP).

Specific items may be considered for prior authorization using miscellaneous procedure code B9998 and modifiers U1, U2, U3, or U5.

Requests for a backpack or carrying case for a portable enteral feeding pump may be considered for prior authorization for purchase only, under miscellaneous code B9998, for clients who meet all of the following medical necessity criteria:

- The client requires enteral feedings lasting greater than eight hours continuously, or feeding intervals exceed the time that the client must be away from home to:
  - Attend school or work.
  - Participate in extensive outpatient therapies ordered by the physician or allowed practitioner.
  - Attend frequent, multiple medical appointments.
- The client is ambulatory, or uses a wheelchair which will not support the use of a portable pump by other means, such as an IV pole.
- The portable enteral feeding pump is client owned.

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2.2.18.3 Documentation Requirements

To request prior authorization for nutritional formula, supplies, or equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status
- Diagnosis or condition (including the appropriate *International Classification of Diseases,* Tenth Revision, Clinical Modification [ICD-10-CM] code)
- A statement from the ordering physician or allowed practitioner noting that enteral nutritional products for tube feedings are the client's sole or primary source of nutrition
- The goals and timelines on the medical POC
- Total caloric intake prescribed by the physician or allowed practitioner
- Acknowledgement that the client has a feeding tube in place

2.2.18.4 Nutritional Counseling

Clients for whom nutritional products are being requested may benefit from nutritional counseling. Nutritional counseling is a benefit of CCP if it is provided to treat, prevent, or minimize the effects of illness, injury, or other impairment.

Refer to: Subsection 2.11, "Medical Nutrition Counseling Services (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about nutritional counseling.

2.2.18.5 Women, Infants, and Children Program (WIC)

Generic nutritional products that have been approved by the United States Department of Agriculture (USDA) for use in the Women, Infants, and Children Program (WIC) may be approved for use by CCP clients.

While CCP does not require that a client access WIC, it is only recommended as another source of services for clients who are 4 years of age and younger, or clients who are pregnant or breast feeding. Nutritional products are not provided to infants who are 11 months of age and younger unless medical necessity is documented.

2.2.18.6 Managed Care Clients

Nutritional products that are provided to WIC clients are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's managed care organization (MCO).

Nutrition products that are provided to other Medicaid Managed Care Program clients (other than WIC clients) are not carved out and must be submitted to the managed care organization that administers the client's Medicaid managed care benefits.

2.2.18.7 Noncovered Services

CCP will not cover the following:

- Nutritional products that are traditionally used for infant feeding.
- Nutritional products for the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth. The underlying cause of failure to thrive, gain weight, and lack of growth is required.
- Nutritional bars.
- Nutritional products for clients who could be sustained on an age-appropriate diet.

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2.2.19 Orthotic Services (CCP)

Orthoses, including orthopedic shoes, wedges, and lifts, are a benefit of Texas Medicaid when provided by a licensed orthotist or a licensed prosthetist/orthotist through CCP for clients who are birth through 20 years of age.

The following orthoses and related services may be reimbursed when medical necessity criteria are met:

- Spinal orthoses and additions to spinal orthoses, including those for scoliosis
- Lower-limb orthoses and additions to lower-limb orthoses, including fracture orthoses
- Foot orthoses, including inserts, orthopedic shoes, surgical boots, heel lifts, and wedges
- Upper-limb orthoses and additions to upper-limb orthoses, including fracture orthoses
- Other orthopedic devices, including protective helmets and dynamic splints
- Repairs, replacements, and modifications
- Orthotic device training

Note: *Training in the use of an orthotic device for a client who has not worn one previously, has not worn one for a prolonged period, or is receiving a different type is a benefit when the training is provided by a physical or occupational therapist.*

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about physical and occupational therapy services.

The following definitions are used by Texas Medicaid:

- An orthosis is defined as: A custom-fabricated or custom-fitted medical device designed to provide for the support, alignment, prevention or correction of neuromuscular or musculoskeletal disease, injury, or deformity. The term does not include a fabric or elastic support, corset, arch support, low temperature plastic splint, a truss, elastic hose, cane, crutch, soft cervical collar, orthosis for diagnostic or evaluation purposes, dental appliance, or other similar device carried in stock and sold by a drugstore, department store or corset shop.
- A brace is defined as: An orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body, and that allows for motion of that part. It must be a rigid or semirigid device used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a diseased or injured body part.

To be considered for reimbursement, orthoses must be dispensed, fabricated, or modified by a licensed orthotist or licensed prosthetist/orthotist enrolled with Medicare and CCP. The following applies:

- Upper extremity customized splints made with low-temperature materials and inhibitive casting may be provided by occupational or physical therapists.
- Other orthopedic devices addressed in the orthotic section may be provided by a Medicaid-enrolled DME vendor.
- Orthopedic shoes must be provided by a shoe vendor enrolled as a DME provider.

The date of service for a custom-made or custom-fitted orthosis is the date the supplier places an order for the equipment and incurs liability for the equipment. The custom-made or custom-fitted orthosis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for an orthotic device and not reimbursed separately:

- Client evaluation, measurement, casting, or fitting of the orthosis.

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- Repairs due to normal wear and tear during the 90 days following delivery.
- Adjustments or modifications of the orthotic device made when fitting the orthosis and for 90 days from the date of delivery (adjustments and modifications during the first 90 days are considered part of the purchase of the initial device).

Orthopedic shoes that are attached to a brace must be billed by the vendor that bills for the brace.

Reimbursement for lifts and wedges may include the cost of the prescription shoe.

2.2.19.1 Noncovered Orthotic Services

The following circumstances are not a benefit of Texas Medicaid:

- Orthoses whose sole purpose is for restraint
- Orthoses provided solely for use during sports-related activities in the absence of an acute injury or other indicated medical condition
- Orthotic devices prescribed by a chiropractor

Diagnoses that are not considered medically necessary include, but are not limited to, the following:

- Tired feet
- Fatigued feet
- Nonsevere bow legs
- Valgus deformity of the foot, except as outlined in the orthotic section
- Pes planus (flat feet), except when there is a coexisting medical condition as outlined in the orthotic section

Orthopedic shoes with deluxe features, such as special colors, special leathers, and special styles, are not considered medically necessary, and the features do not contribute to the accommodative or therapeutic function of the shoe.

A foot-drop splint and recumbent positioning device and replacement interface are not considered medically necessary in a client with foot drop who is nonambulatory, because there are other more appropriate treatment modalities.

A static ankle-foot orthosis (AFO) or AFO component is not medically necessary if:

- The contracture is fixed.
- The client has foot drop without an ankle flexion contracture.
- The component is used to address knee or hip positioning, because the effectiveness of this type of component is not established.

A pneumatic thoracic-lumbar-sacral orthosis is considered experimental and investigational and is not a benefit of Texas Medicaid.

2.2.19.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all orthoses and related services.

Before submitting a request for prior authorization for orthosis, the orthosis provider must have a completed CCP Prior Authorization Form requesting the orthosis or related services that has been signed and dated by a physician who is familiar with the client. The completed CCP Prior Authorization Form must include the procedure codes and quantities for requested services. A copy of the completed, signed, and dated form must be maintained by the orthosis provider in the client's medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

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- To complete the prior authorization process electronically, the orthosis provider must complete the prior authorization requirements through any approved electronic method and retain a copy of the signed and dated CCP Prior Authorization Request form in the client's medical record at the provider's place of business.
- To complete the prior authorization process by paper, the orthosis provider must fax or mail the completed CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client's medical record at the provider's place of business.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment and supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the device is needed for one of the following general indications:

- To reduce pain by restricting mobility of the affected body part.
- To facilitate healing following an injury to the affected body part or related soft tissue.
- To facilitate healing following a surgical procedure on the affected body part or related soft tissue.
- To support weak muscles or a deformity of the affected body part.

Prior authorization requests for some types of orthosis require additional documentation. See the appropriate sections for additional documentation needed for each service.

The provider must keep the following written documentation in the client's medical record:

- The prescription for the device.
- Orthotic devices must be prescribed by a physician (M.D. or D.O.) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot.
- The prescription must be dated on or before the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device. A retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service or device.

A prior authorization is valid for a maximum period of six months from the prescription signature date.

At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.2.19.2.1 Spinal Orthoses

Spinal orthoses include, but are not limited to, cervical orthoses, thoracic rib belts, thoracic-lumbar-sacral orthoses (TLSO), sacroiliac orthoses, lumbar orthoses, lumbar-sacral orthoses (LSO), cervicalthoracic-lumbar-sacral orthoses (CTLSO), halo procedures, spinal corset orthoses, and spinal orthoses for scoliosis.

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Spinal orthoses will be considered for prior authorization with documentation of one of the general indications.

2.2.19.2.2 Lower-Limb Orthoses

Lower-limb orthoses include, but are not limited to, hip orthoses (HO), Legg Perthes orthoses, knee orthoses (KO), ankle-foot orthoses (AFO), knee-ankle-foot orthoses (KAFO), hip-knee-ankle-foot orthoses (HKAFO), fracture orthoses, and reciprocating gait orthoses (RGO).

In addition to the general indication requirements, lower-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices:

Ankle-Foot Orthoses

AFOs used during ambulation will be considered for prior authorization for clients with documentation of all of the following:

- Weakness or deformity of the foot and ankle.
- A need for stabilization for medical reasons.
- Anticipated improvement in functioning during activities of daily living (ADLs) with use of the device.

AFOs not used during ambulation (static AFO) will be considered for prior authorization for clients with documentation of one of the following conditions:

- Plantar fasciitis.
- Plantar flexion contracture of the ankle, with additional documentation that includes all of the following:
  - Dorsiflexion on pretreatment passive range of motion testing is at least ten degrees.
  - The contracture is interfering or is expected to interfere significantly with the client's functioning during ADLs.
  - The AFO will be used as a component of a physician-prescribed therapy plan care, which includes active stretching of the involved muscles or tendons.
  - There is reasonable expectation that the AFO will correct the contracture.

Knee-Ankle-Foot Orthoses

KAFOs used during ambulation will be considered for prior authorization for clients with documentation that supports medical necessity for additional knee stabilization.

KAFOs that are custom-fabricated (molded-to-patient model) for ambulation will be considered for prior authorization when at least one of the following criteria is met:

- The client cannot be fit with a prefabricated AFO/KAFO.
- The condition that necessitates the orthosis is expected to be permanent or of long-standing duration (more than six months).
- There is a need to control the knee, ankle, or foot in more than one plane.
- The client has a documented neurological, circulatory, or orthopedic status that requires custom fabrication to prevent tissue injury.
- The client has a healing fracture that lacks normal anatomical integrity or anthropometric proportions.

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Reciprocating Gait Orthoses

Reciprocating gait orthoses will be considered for prior authorization for clients with spina bifida or similar functional disabilities.

The prior authorization request must include a statement from the prescribing physician that indicates medical necessity for the RGO, the PT treatment plan, and documentation that the client and family are willing to comply with the treatment plan.

2.2.19.2.3 Foot Orthoses

Foot orthoses include, but are not limited to, foot inserts, orthopedic shoes, wedges, and lifts.

Foot orthoses will be considered for prior authorization for clients with documentation of all of the following:

- The client has symptoms associated with the particular foot condition.
- The client has failed to respond to a course of appropriate, conservative treatment, including PT, injections, strapping, or anti-inflammatory medications.
- The client has at least one of the following:
  - Torsional conditions, such as metatarsus adductus, tibial torsion, or femoral torsion
  - Structural deformities
  - Hallux valgus deformities
  - In-toe or out-toe gait
  - Musculoskeletal weakness

In addition to the general indication requirements, foot orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices:

Foot Inserts

Removable foot inserts will be considered for prior authorization for clients with documentation of at least one of the following medical conditions:

- Diabetes mellitus.
- History of amputation of the opposite foot or part of either foot.
- History of foot ulceration or pre-ulcerative calluses of either foot.
- Peripheral neuropathy with evidence of callus formation of either foot.
- Deformity of either foot.
- Poor circulation of either foot.

Removable foot inserts may be covered independently of orthopedic shoes with documentation that the client has appropriate footwear into which the insert can be placed.

A University of California at Berkeley (UCB) removable foot insert will be considered for prior authorization with documentation that the device is required to correct or treat at least one of the following conditions:

- A valgus deformity and significant congenital pes planus with pain.
- A structural problem that results in significant pes planus, such as Down syndrome.
- Acute plantar fasciitis.

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Orthopedic Shoes

Orthopedic shoes must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist. An orthopedic shoe is used by clients whose feet, although impaired, are essentially intact. An orthopedic shoe differs from a prosthetic shoe, which is used by clients who are missing all or most of the forefoot.

Orthopedic shoes will be considered for prior authorization when at least one of the following criteria is met:

- The shoe is permanently attached to a brace.
- The shoe is necessary to hold a surgical correction, postoperative casting, or serial or clubfoot casting.

An orthopedic shoe may be prior authorized up to one year from the date of the surgical procedure.

Only one pair of orthopedic shoes will be prior authorized every three months. Two pairs of shoes may be purchased at the same time; however, additional requests for shoes will not be considered for another six months.

Requests for orthopedic shoes that do not meet the criteria listed above may be considered for prior authorization with documentation of medical necessity.

Wedges and Lifts

Wedges and lifts must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist and must be for treatment of unequal leg length greater than one-half inch.

2.2.19.2.4 Upper-Limb Orthoses

Upper-limb orthoses include, but are not limited to, shoulder orthoses (SO), elbow orthoses (EO), elbow-wrist-hand orthoses (EWHO), elbow-wrist-hand-finger orthoses (EWHFO), wrist-hand-finger orthoses (WHFO), wrist-hand orthoses (WHO), hand-finger orthoses (HFO), finger orthoses (FO), shoulder-elbow-wrist-hand orthoses (SEWHO), shoulder-elbow orthoses (SEO), and fracture orthoses.

In addition to the general indication requirements, upper-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices.

2.2.19.2.5 Other Orthopedic Devices

Protective Helmets

Protective helmets will be considered for prior authorization for clients with a documented medical condition that makes the client susceptible to injury during ADLs. Covered medical conditions include the following:

- Neoplasm of the brain
- Subarachnoid hemorrhage
- Epilepsy
- Cerebral palsy

Requests for all conditions other than those listed above require submission of additional documentation that supports the medical necessity of the requested device.

Dynamic Splints

Static and dynamic mechanical stretching devices will be considered for prior authorization for a four month rental period when the request is submitted with the following documentation:

- Client's condition
- Client's current course of therapy

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- Rationale for the use of the static or dynamic mechanical stretching device
- Agreement by the client or family that the client will comply with the prescribed use of the static or dynamic mechanical stretching device

After completion of the four-month rental period, the provider may submit a request for purchase of the static or dynamic mechanical stretching device. Requests for purchase of the static or dynamic mechanical stretching device must include documentation that the four-month rental period was successful and showed improvement in the client's condition as measured by the following:

- Demonstrated increase in range of motion
- Demonstrated improvement in the ability to complete ADLs or perform activities outside the home

2.2.19.2.6 Related Services

Repairs, Replacements, and Modifications to Orthoses

Within the guarantee of the manufacturer, providers are responsible, without charge to the client or to Texas Medicaid, for replacement or repair of equipment or any part thereof that is found to be nonfunctional because of faulty material or workmanship.

Service and repairs must be handled under any warranty coverage an item may have. If there is no warranty, providers may request prior authorization for the necessary service and repairs.

A repair because of normal wear or a modification because of growth or change in medical status will be considered for prior authorization if it proves to be more cost effective than replacing the device.

The request for repairs must include a breakdown of charges for parts and the number of hours of labor required to complete the repairs. No charge is allowed for pickup or delivery of the item or for the assembly of Medicaid-reimbursed parts. The following information must be submitted with the request:

- The description and procedure code of the item being serviced or repaired.
- The age of the item.
- The number of times the item has been previously repaired.
- The replacement cost for the item.

The anticipated life expectancy of an orthotic device is six months. Requests for prior authorization for the replacement of a device before its usual life expectancy has ended must include documentation that explains the need for the replacement.

Replacement of orthotic equipment will be considered when the item is out of warranty and repairing the item is no longer cost-effective or when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

2.2.19.3 Cranial Remolding Orthosis

2.2.19.3.1 Services, Benefits, and Limitations

Cranial remolding orthoses (CRO) (procedure code S1040) may be a benefit when all of the following criteria are met:

- The client is 3 through 18 months of age.
- The client requires a CRO as part of the treatment plan for a documented diagnosis of deformational plagiocephaly, brachycephaly, asymmetrical brachycephaly, dolichocephaly, or post-operatively following surgery for craniosynostosis.

The limitation for procedure code S1040 is one device per lifetime, any provider. This limitation may be exceeded with prior authorization.

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CRO is defined by Subchapter B, Chapter 32, Human Resources Code, Section 32.03126, as a custom-fitted or custom-fabricated medical device that is applied to the head to correct a deformity, improve function, or relieve symptoms of a structural cranial disease.

Plagiocephaly refers to an asymmetrical, flattened deformity of the skull and can be used to describe both synostotic and non-synostotic head asymmetry.

Craniosynostosis occurs when there is a premature fusion of cranial sutures. Craniosynostosis may cause synostotic plagiocephaly, a flattened deformity of the skull as a result of the premature fusion of cranial suture(s). This pathological condition generally requires surgical intervention, with or without post-operative use of a cranial orthosis.

Non-synostotic deformational plagiocephaly (DP) is head flattening that results from external forces that mold the skull in the first year of life. There are four categories of DP which may require treatment with a CRO:

- Lateral deformational plagiocephaly (LDP) is often simply referred to as plagiocephaly. It describes an asymmetric head which occurs when an infant's skull is flattened on one side. This can be predominantly anterior (forehead flattening) or posterior (occipital flattening). The flattening may be accompanied by anterior displacement of the ear, forehead, and in severe cases the orbit.
- Brachycephaly describes a short, wide head. The occiput flattens and there may be bilateral widening in the tempo-parietal regions. There may be bulging noted above the ears.
- Asymmetric brachycephaly is the combination of plagiocephaly and brachycephaly. It may be characterized by occipital flattening accompanied by parietal asymmetry. The flattening may be accompanied by anterior displacement of the ear, forehead, and in severe cases the orbit.
- Dolichocephaly is characterized by flattening of the sides of the head and elongation from anterior to posterior.

Cosmetic services include surgery or other services used primarily to improve appearance and not to restore or correct significant deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic process. Conservative therapy for treatment of non-synostotic plagiocephaly involves non-surgical, proactive methods to reshape an infant's skull, primarily through consistent repositioning, increased "tummy time," and sometimes physical therapy to treat underlying torticollis. These methods are most effective when started early (before 4–6 months of age) to alleviate pressure on the flat spot.

2.2.19.3.2 Prior Authorization and Documentation Requirements

CRO requires prior authorization. Documentation of medical necessity must be maintained in the client's medical record.

If the client has craniosynostosis, a diagnosis of the type of craniosynostosis and synostotic plagiocephaly must be documented.

If the client has a diagnosis of a non-synostotic plagiocephaly (e.g., brachycephaly, asymmetric bracycephaly, or dolichocephaly), one of the following criteria must be met:

- Cranial vault asymmetry (CVA) confirmed by a right/left discrepancy of greater than six millimeters in a craniofacial anthropometric measurement to include but not limited to criteria set by the Children's Healthcare of Atlanta Plagiocephaly Severity Scale.
- Brachycephalic disproportion in the comparison of head length to head width confirmed by a cephalic index of two standard deviations above the mean.
- Dolichocephalic disproportion in the comparison of head length to head width confirmed by a cephalic index of two standard deviations below the mean.

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If the client has a diagnosis of a non-synostotic plagiocephaly (e.g., brachycephaly, asymmetric brachycephaly, or dolichocephaly), there must be documentation of conservative therapy as described above, or physical or occupational therapy by a qualified health care professional of at least two months' duration that did not achieve a reduction of asymmetry or disproportion that would no longer meet the above criteria.

Prior authorization may be approved for the following diagnoses:

Diagnosis Code	Description
Q040	Congenital malformations of corpus callosum
Q041	Arhinencephaly
Q042	Holoprosencephaly
Q308	Other congenital malformations of nose
Q672	Dolichocephaly
Q673	Plagiocephaly
Q674	Other congenital deformities of skull, face and jaw
Q75001	Craniosynostosis, unspecified type, unilateral
Q75002	Craniosynostosis, unspecified type, bilateral
Q75009	Craniosynostosis, unspecified
Q7501	Sagittal craniosynostosis
Q75021	Coronal craniosynostosis, unilateral
Q75022	Coronal craniosynostosis, bilateral
Q75029	Coronal craniosynostosis, unspecified
Q7503	Metopic craniosynostosis
Q75041	Lambdoid craniosynostosis, unilateral
Q75042	Lambdoid craniosynostosis, bilateral
Q75049	Lambdoid craniosynostosis, unspecified
Q75051	Cloverleaf skull
Q75052	Pansynostosis
Q75058	Other multi-suture craniosynostosis
Q7508	Other single-suture craniosynostosis
Q751	Craniofacial dysostosis
Q752	Hypertelorism
Q753	Macrocephaly
Q754	Mandibulofacial dysostosis
Q755	Oculomandibular dysostosis
Q758	Other specified congenital malformations of skull and face bones
Q759	Congenital malformation of skull and face bones, unspecified
Q781	Polyostotic fibrous dysplasia
Q870	Congenital malformation syndromes predominantly affecting facial appearance

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Prior authorization requests for CRO for congenital conditions that are not outlined in this section may be considered by the TMHP Medical Director on an individual basis with documentation of medical necessity. Additional devices beyond the once-per-lifetime benefit may be considered for prior authorization with documentation of all of the following:

- The initial device was obtained to treat synostotic plagiocephaly as a result of craniosynostosis, or non-synostotic plagiocephaly, brachycephaly, asymmetric brachycephaly, or dolichocephaly.
- Treatment with the device has been effective, but the client has not yet met the treatment goal.
- The new device is needed due to growth.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for an additional CRO.

The completed CCP Prior Authorization Form, which includes the DME must be signed and dated by the prescribing physician familiar with the client's condition. The completed CCP Prior Authorization Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept by the physician in the client's medical record.

2.2.19.4 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Standers, Standing Frames, Braces, and Parapodiums)

2.2.19.4.1 Services, Benefits, and Limitations

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, require prior authorization. A THKAO may be considered if the client requires assistance to stand and remain standing.

Parapodium

A parapodium is used to help clients with neuromuscular diseases or conditions resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free. It helps develop a sense of balance and aids in learning functional movements such as standing with the hands free. A parapodium acts as an exoskeleton, providing side struts and chest, hip, knee, and foot bracing.

A parapodium may be considered for reimbursement for one of the following levels:

- Level One: Small Parapodium—The client has a maximum axillary height of 35 inches and a maximum weight of 55 pounds (normal age range is 1 through 10 years of age).
- Level Two: Medium parapodium—The client has a maximum axillary height of 41 inches and a maximum weight of 77 pounds (normal age range is 5 through 12 years of age).
- Level Three: Large parapodium—The client has a maximum axillary height of 45 inches and a maximum weight of 115 pounds (normal age range is 10 through 16 years of age). Labor for parapodium assembly may be prior authorized.

Procedure code E0638 must be submitted with one of the following modifiers:

- UA-Standing frame/table system, one position (e.g., upright, supine, or prone stander), any size, including pediatric, with or without wheels. Medicaid level of care 10, as defined by each state

  Note: *Use modifier UA to identify an upright or prone system stander.*

- UB-Standing frame/table system, one position (e.g., upright, supine, or prone stander), any size, including pediatric, with or without wheels. Medicaid level of care 11, as defined by each state

  Note: *Use modifier UB to identify a supine stander.*

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Standing Frame or Brace

A standing frame or brace is used to help very young clients, who are 12 months of age and older, who have good head control in the upright position and who have a neuromuscular disease or condition resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free.

Providers must use procedure code E0638 for a standing frame or brace.

Vertical or Dynamic Stander

A vertical stander or dynamic stander is used to initiate standing for clients who cannot maintain a good standing posture or may never be able to stand independently. A vertical stander is used to develop weight bearing through the legs in order to decrease demineralization and to promote better body awareness. Documentation for these standers must address medical necessity for the standers to be mobile.

Providers must use procedure code E0642 for the purchase of a dynamic stander.

2.2.19.4.2 Prior Authorization and Documentation Requirements

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, requires prior authorization.

THKAO may be considered for clients who are CCP-eligible and who require assistance to stand and remain standing when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition.

Prior authorization may be considered for the THKAOs with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory status
- Anticipated benefits of the equipment
- Frequency and amount of time of a standing program
- Anticipated length of time the client will require this equipment
- Client's height, weight, and age
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

2.2.20 Prosthetic Services

2.2.20.1 Services, Benefits, and Limitations

External prostheses are a benefit of Texas Medicaid when provided by a licensed prosthetist or licensed prosthetist/orthotist through CCP for clients who are birth through 20 years of age.

The following prostheses and related services may be reimbursed when medical necessity criteria are met:

- Lower limb
- Upper limb
- Craniofacial
- External breast
- Repair, replacements, and modifications
- Prosthetic training
- Accessories to prostheses

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Prosthetic training by a physical or occupational therapist for a lower limb prosthesis or an upper extremity prosthesis is a benefit for clients who have not worn one previously or for a prolonged period or who are receiving a different type.

Refer to: Section 5, "Children's Therapy Services Clients birth through 20 years of age" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*).

To be considered for reimbursement, prostheses must be dispensed, fabricated, or modified by a licensed prosthetist or licensed prosthetist/orthotist enrolled with Medicare and CCP.

The date of service for a custom-made or custom-fitted prosthesis is the date the supplier places an order for the equipment and incurs a liability for the equipment. The custom-made or custom-fitted prosthesis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for a prosthetic device and not reimbursed separately:

- Evaluation of the residual limb and gait
- Measurement, casting, or fitting of the prosthesis
- Cost of base component parts and labor contained in the base procedure code description
- Repairs due to normal wear and tear during the 90 days following delivery
- Adjustments or modifications of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the client's functional ability

In general, base codes do not represent a complete device. To include the additional components necessary for a complete device, providers may bill additional components with a code that is used in addition to a base code. Addition codes may also be used to indicate modifications to a device. The values assigned to the additional codes do not represent the actual value of the component or modification, but only the difference between the total value and the value of the base code. As a result, reimbursement of an addition does not involve subtraction of any amounts from the base code allowance.

2.2.20.1.1 Noncovered Prosthetic Services

Prosthetic devices prescribed by a chiropractor are not a benefit of Texas Medicaid.

A vacuum-assisted socket system (procedure code L5781 or L5782), which is a specialized vacuum pump, is considered experimental and investigational, and is not a benefit of Texas Medicaid.

Myoelectric hand prostheses for conditions other than the absence of forearm(s) and hand(s) are considered experimental and investigational and are not a benefit of Texas Medicaid.

A prosthetic device customized with enhanced features is not considered medically necessary if ADLs can be met with a standard prosthetic device.

Accessories that are not required for the effective use of a prosthetic device are not considered medically necessary.

2.2.20.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all prosthetic devices.

A completed CCP Prior Authorization Form requesting the prosthesis must be signed and dated by a physician familiar with the client before requesting prior authorization for all prostheses. The completed CCP Prior Authorization Form must include the procedure codes and numerical quantities for services

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requested. A copy of the completed, signed, and dated form must be maintained by the prosthesis provider in the client's medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

To complete the prior authorization process by paper, the prosthesis provider must fax or mail the completed CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client's medical record at the provider's place of business.

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

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the client meets the following general indications for the requested device:

- The prosthesis replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the limb, and identification of the specific limb that is being replaced by the prosthesis.
- The prosthesis is required for ADLs or for rehabilitation purposes, and identification of the ADLs or rehabilitation purpose for which the prosthesis is required.

The provider must keep the following written documentation in the client's medical record:

- The prescription for the device.
  - Prosthetic devices must be prescribed by a physician (M.D. or D.O.).
  - The prescription must be dated prior to or on the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device. (A retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service or device.)
- The specific make, model, and serial number of the prosthetic components.
- The treatment plan outlining the therapy program prescribed by the treating physician, including expected goals with the use of the prosthesis.
- A statement submitted by the physician that indicates that the client or client's family or caregiver demonstrates willingness to comply with the therapy program.

Prior authorization is valid for a maximum period of six months from the prescription signature date.

At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

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The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.2.20.2.1 Lower-Limb Prostheses

Lower limb prostheses include, but are not limited to, the following:

- Partial foot, ankle, and knee disarticulation sockets
- Above-knee short prostheses
- Hip and knee disarticulation prostheses
- Postsurgical prostheses
- Preparatory prostheses
- Additions to lower extremity prostheses
- Replacement sockets

A basic lower limb prosthesis consists of the following:

- A socket or connection between the residual limb and the prosthesis
- A suspension mechanism attaching the socket to the prosthesis
- A knee joint that provides support during stance, smooth control during the swing phase, and unrestricted motion for sitting and kneeling
- An exoskeleton or endoskeleton pylon (tube or shell) that attaches the socket to the terminal device
- A terminal device (foot)

In addition to the general indication requirements, the following additional documentation is also required for all lower limb prostheses:

- Written documentation of the client's current and potential functional levels. A functional level is defined as a measurement of the capacity and potential of the individuals to accomplish their expected post-rehabilitation daily function. The potential functional ability is based on reasonable expectations of the treating physician and the prosthetist and includes, but is not limited to, the following:
  - The client's history, including prior use of a prosthesis if applicable
  - The client's current condition, including the status of the residual limb and any coexisting medical conditions
  - The client's motivation to ambulate and ability to achieve independent transfers or ambulation with the use of a lower limb prosthesis
- The following functional modifiers and levels have been defined by the Centers for Medicare & Medicaid Services (CMS):

Functional Level	Functional Modifier	Description
Level 0	K0	Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance quality of life or mobility.
Level 1	K1	Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator

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Functional Level	Functional Modifier	Description
Level 2	K2	Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.
Level 3	K3	Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
Level 4	K4	Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high-impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

A client whose functional level is zero (0) is not a candidate for a prosthetic device; the device is not considered medically necessary.

Advanced knee, ankle, and foot prostheses procedure codes must be submitted with the appropriate functional modifier in the table above.

Microprocessor-Controlled Lower Limb Prostheses

Microprocessor-controlled lower limb prostheses (e.g., Otto Bock C-Leg, Intelligent Prosthesis, or Ossur Rheo Knee) will be considered for prior authorization for clients who have a transfemoral amputation from a nonvascular cause, such as trauma or tumor and a functional level of 3 or above, and who meet the following criteria:

- The individual has adequate cardiovascular reserve and cognitive learning ability to master the higher level of technology and to allow for faster than normal walking speed.
- The individual demonstrates the ability to ambulate at a faster than baseline rate using a standard prosthetic application with a swing and stance control knee.
- The individual has a demonstrated need for long-distance ambulation at variable rates (greater than 400 yards) on a daily basis. Use of the limb in the home or for basic community ambulation is not sufficient to justify provision of the computerized limb instead of standard limb applications.
- The individual has a demonstrated need for regular ambulation on uneven terrain or for regular use on stairs. Use of the limb for limited stair climbing in the home or employment environment is not sufficient evidence for prescription of this device over standard prosthetic application.

The licensed prosthetist or licensed prosthetist/orthotist providing the device must be trained in the fitting and programming of the microprocessor-controlled prosthetic device.

Foot Prostheses

The following foot prostheses will be considered for prior authorization for clients whose documented functional level is 1 or above:

- A solid ankle-cushion heel (SACH) foot
- An external keel SACH foot or single axis ankle/foot

A flexible-keel foot or multi-axial ankle/foot will be considered for prior authorization for clients whose documented functional level is 2 or above.

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A flex foot system, energy storing foot, multiaxial ankle/foot, dynamic response, or flex-walk system or equivalent will be considered for prior authorization for clients whose documented functional level is 3 or above.

A prosthetic shoe will be considered for prior authorization if it is an integral part of a prosthesis for clients with a partial foot amputation.

Ankle Prosthesis

An axial rotation unit will be considered for prior authorization for clients whose documented functional level is 2 or above.

Knee Prosthesis

A single-axis, constant-friction knee and other basic knee systems will be considered for prior authorization for clients whose documented functional level is 1 or above. A fluid, pneumatic, or electronic knee prosthesis will be considered for prior authorization for clients whose documented functional level is 3 or above. A high-activity knee control frame will be considered for prior authorization for clients whose documented functional level is 4.

Prosthetic Substitutions or Additions for Below-Knee Prostheses

Prosthetic substitutions or additions (procedure codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980) are not considered medically necessary when an initial below-knee prosthesis (procedure code L5500) or a preparatory below-knee prosthesis (procedure codes L5510, L5520, L5530, or L5540) is provided.

Prosthetic substitutions or additions (procedure codes L5620, L5629, L5645, L5646, L5670, L5676, L5704, and L5962) are not considered medically necessary when a below-knee preparatory, prefabricated prosthesis (procedure code L5535) is provided.

Sockets

Prior authorization for test (diagnostic) sockets for an individual prosthesis is limited to a quantity of two test sockets. Prior authorization for same-socket inserts for an individual prosthesis is also limited to a quantity of two. Requests for test sockets or same-socket inserts beyond these limitations must include documentation of medical necessity that supports the need for the additional sockets.

2.2.20.2.2 Upper-Limb Prostheses

Upper limb prostheses include, but are not limited to, the following:

- Partial hand prostheses
- Wrist and elbow disarticulation prostheses
- Shoulder and interscapular thoracic prostheses
- Immediate postsurgical or early fitting prostheses
- Preparatory prostheses
- Terminal devices
- Replacement sockets
- Inner sockets-externally powered
- Electric hand, wrist, and elbow prostheses

Upper limb prostheses will be considered for prior authorization with documentation of all of the general indication requirements. The additional criteria in the following sections apply for specific prosthetic devices.

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Myoelectric Upper Limb Prostheses

A myoelectric upper limb prosthetic device is considered medically necessary when all of the following criteria have been met:

- The client has sufficient neurological, myocutaneous, and cognitive function to operate the prosthesis effectively.
- The client has an amputation or missing limb at the wrist or above (e.g., forearm, elbow, and so on).
- The client is free of comorbidities that could interfere with maintaining function of the prostheses (e.g., neuromuscular disease).
- The client retains sufficient microvolt threshold in the residual limb to allow proper function of the prostheses.
- Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the patient in performing ADLs.
- The client does not function in an environment that would inhibit function of the prosthesis (e.g., a wet environment or a situation involving electrical discharges that would affect the prosthesis).

2.2.20.2.3 External Breast Prostheses

External breast prostheses will be considered for prior authorization for clients who have congenital absence of a breast or who have had a mastectomy.

2.2.20.2.4 Craniofacial Prostheses

Craniofacial prostheses include, but are not limited to, external nasal, ear, and facial prostheses.

Craniofacial prostheses will be considered for prior authorization with documentation that the device is necessary to correct an absence or deformity of the affected body part.

2.2.20.2.5 Related Services

Accessories to Prostheses

Accessories to prostheses, such as stump stockings and harnesses will be considered for prior authorization when they are essential to the effective use of the prosthetic device.

Repairs, Replacements, and Modifications to Prostheses

Repairs due to normal wear and tear will be considered for prior authorization after 90 days from the date of delivery of the initial prosthesis, when the repair is:

- Necessary to make the equipment functional.
- More cost-effective than the replacement of the prosthetic device.

Providers must include documentation that supports medical necessity when they request prior authorization.

Additional information from the provider may be requested to determine cost-effectiveness.

Replacement of prosthetic equipment will be considered for coverage when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate and the measures to be taken to prevent re-occurrence must be submitted with the prior authorization request.

Socket replacements will be considered for prior authorization with documentation of functional or physiological need, including, but not limited to, changes in the residual limb, functional need changes, or irreparable damage or wear due to excessive weight or prosthetic demands of very active amputees.

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Children typically require new prosthetic devices every 12 to 18 months, although the actual lifespan of a device depends on the child's rate of skeletal growth. Prosthetic devices for children must accommodate growth and other physiological changes.

Components and systems that allow for growth or increase the lifespan of the prosthesis may include the following:

- Growth-oriented suspension systems and modifications
- Use of modular systems
- Use of flexible sockets
- Use of removable sockets (slip or triple-wall sockets)
- Use of distal pads
- Modification of socket liners
- Increasing or decreasing sock thickness

Modifications due to growth or change in medical status will be considered for prior authorization with documentation of medical necessity.

Medical necessity for requested components or additions to the prosthesis is based on the client's current functional ability and the expected functional potential as defined by the prosthetist and the ordering physician.

2.2.21 Phototherapy Devices

Phototherapy devices are not a benefit of Title XIX Home Health Services. Phototherapy devices are a benefit of Texas Medicaid through CCP for clients who are birth through 20 years of age.

2.2.21.1 Services, Benefits, and Limitations

The rental of phototherapy devices (procedure code E0202) for use in the home are a benefit of Texas Medicaid for low-risk infants.

Low-risk infants are 35 or more weeks gestation at birth, without comorbidity, and with a total serum bilirubin (TSB) level within the following ranges:

Infant's Gestation at Birth	TSB for infant 0-24 hours of age*	TSB for infant 25-48 hours of age*	TSB for infant 49-72 hours of age*	TSB for infant older than 72 hours of age*
35–37 weeks	3–7	7–13	10–15	13–18
38 weeks or greater	6–11	12–15	15–18	18–21

*** Infant age when TSB level is drawn.**
TSB levels are expressed in milligrams per deciliter (mg/dl).

The DME provider must perform routine maintenance and provide instructions to the parent or guardian on the safe use of the phototherapy device. Rental of a phototherapy device is reimbursed as a daily global fee and is limited to one per day, per client, any provider.

Providers may not bill for those days the phototherapy device is at the client's home and is not in use.

Skilled nursing (SN) visits for clients requiring phototherapy services may be reimbursed separately through Title XIX Home Health Services for nonroutine clinical teaching and assessment. Routine laboratory specimens are obtained during the SN visit, and may only be considered when the alternative to obtaining the specimen is to transport the client by ambulance.

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If a client who is receiving PDN services requires phototherapy, instructions in the use of the equipment must be part of the existing PDN authorized hours. SN visits will not be allowed on the same day as PDN services.

In accordance with American Academy of Pediatrics (AAP) guidelines, providers must conduct ongoing assessments for risk of severe hyperbilirubinemia for all infants who receive home phototherapy.

Initiation of home phototherapy for medium- and high-risk infants is not a benefit of Texas Medicaid. As defined by the AAP, medium- and high-risk infants should be considered for more extensive initial treatment in an inpatient setting. Medium- and high-risk infants include, but are not limited to, those who have one of the following known risk factors:

- Acidosis
- Albumin less than 3.0 g/dl
- Asphyxia
- Glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Isoimmune hemolytic disease (blood group incompatibility)
- Jaundice within the first 24 hours
- Sepsis
- Significant lethargy
- Temperature instability

2.2.21.2 Prior Authorization and Documentation Requirements

Home phototherapy devices require prior authorization and are provided only for the days that are medically necessary.

For low-risk infants, prior authorization will be considered for phototherapy services that begin in the home.

For stabilized infants who began phototherapy treatment during their hospitalization and have been discharged from the hospital, prior authorization will be considered for the continuation of phototherapy services in the home. Initial prior authorization may be given for a maximum of seven days of home phototherapy. A new CCP Prior Authorization Request Form must be submitted to request more than seven days of home phototherapy.

The following documentation is required to support medical necessity when requesting home phototherapy services:

- A diagnostic evaluation, which must include, but is not limited to, a normal history and physical exam, and normal laboratory values for the following, as medically indicated:
  - Complete blood count with differential
  - Platelets
  - Blood smear for red blood cell morphology
  - Reticulocyte count
  - Urinalysis
  - Maternal and infant blood typing
  - Coombs test
- TSB level (in mg/dl)

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- Gestational age
- Documentation of adequate infant hydration, as demonstrated by 4-6 wet diapers per day and 3-4 stools per day
- Documentation stating that infant weight loss does not exceed 10 percent of the infant's birth weight
- Physician's plan of care
- Anticipated number of days the client will need the phototherapy treatment
- Documentation of parental education regarding the importance of monitoring and follow-up

When requesting prior authorization for a hospitalized infant that requires continued home phototherapy, providers must submit documentation that indicates all pre-existing medium- or high-risk factors have resolved or stabilized.

Providers must submit the following additional documentation for prior authorization requests for previously hospitalized infants that require continued home phototherapy or for more than seven days of home phototherapy:

- TSB level greater than 13 mg/dl and trending downward. TSB levels less than 13 will require medical review to determine medical necessity.

  Note: *According to AAP guidelines, phototherapy may be discontinued when the TSB level falls below 13-14 mg/dl; however, exceptions to the guidelines may be considered. As a result, documentation must include the rationale for not discontinuing phototherapy when the TSB level drops below 13 mg/dl.*

- Birth weight and current weight demonstrating weight gain.

  Note: *According to AAP guidelines, breast-fed infants are expected to gain 15-30 grams per day (1/2-1 ounce per day) through the first 2-3 months of life.*

2.2.21.2.1 Retroactive Eligibility

Newborn babies may not have a Medicaid number at the time that services are ordered by the physician and provided by the supplier. In these cases, prior authorization may be given retroactively for services rendered between the start date and the date that the client's Medicaid number becomes available.

The provider is responsible for finding out the effective dates of client eligibility.

The provider has 95 days from the date on which the client's Medicaid number becomes available (add date) to obtain prior authorization for services that were already rendered.

2.2.22 Prothrombin Time/International Normalized Ratio (PT/INR) Home Testing Monitor

PT/INR home testing monitors are a benefit of Title XIX Home Health Services for clients who require chronic oral anticoagulation due to one of the following:

- Mechanical heart valve
- Chronic atrial fibrillation
- Venous thromboembolism (including both deep vein thrombosis [DVT] and pulmonary embolism)
- Ventricular assist device (VAD) awaiting a heart transplant

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The PT/INR home testing monitor is a portable, battery-operated instrument for the quantitative determination of PT/INR from whole blood obtained by finger-stick. This product is designed to aid in the management of high-risk clients who take oral anticoagulants.

Note: *For clients who are 20 years of age and younger and do not meet criteria for coverage through Title XIX Home Health Services, home PT/INR monitors and related testing supplies may be considered through CCP.*

Note: *For clients who are 21 years of age or older, requests for PT/INR monitors and related testing supplies that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

The following procedure codes are included in this benefit:

- Procedure code E1399 may be reimbursed for the rental or purchase of the monitor.
- Procedure code A9900 may be reimbursed for the related testing supplies.

Procedure codes E1399 and A9900 may be reimbursed to DME providers for services rendered in the home setting.

2.2.22.1 Prior Authorization

Prior authorization is required for the home PT/INR monitors and related testing supplies.

Prior authorization requests must be submitted within three business days of the date of service and must include documentation of medical necessity and a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form.

The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record.

The requesting provider may be asked for additional information to clarify or complete a request for the PT/INR monitor.

Prior authorization for the rental or purchase of a home PT/INR monitor and related testing supplies will be considered for clients who meet all the following criteria:

- The client is on anticoagulation therapy and has a current prescription for Warfarin or other oral anticoagulant.
- The client has been on anticoagulation therapy for at least three months prior to the request for the home PT/INR monitor.
- The client is required to self-test at least every two weeks.

Additionally, the client must have at least one of the following conditions documented in the request for prior authorization:

- Fluctuations of INR or PT/partial thromboplastin time (PTT) levels with titration greater than once per week in anticoagulation dosing with copies of laboratory reports and resultant medication changes.

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- A medical condition that limits physical movement, places the client under medical restrictions for isolation, or requires non-emergency ambulance transport for the purpose of obtaining laboratory specimens.
- Limited venous access that compromises the ability to obtain laboratory specimens for the adequate monitoring of anticoagulation therapy.

The prior authorization request will be evaluated upon receipt to determine whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

Note: *Skilled nursing (SN) visits will not be approved for the sole purpose of instructing the client on the use of the PT/INR home testing monitor. Any necessary instruction must be performed as part of the office visit with the prescribing provider.*

2.2.23 Respiratory Equipment and Supplies

Respiratory equipment and supplies may be provided in the home under Title XIX Home Health Services.

Respiratory equipment and supplies must be prescribed by a physician or an allowed practitioner, be FDA approved for the medical condition, and have federal financial participation available to be considered a medically necessary benefit. An eligible client must have compromised health status without the requested equipment or supplies.

Equipment provided for rental may be new or used. Equipment provided for purchase must be new and unused.

HHSC or its designee will determine whether respiratory equipment will be rented, purchased, or repaired based on the client's needs and expected duration of use.

Note: *When new unused equipment is initially provided for rental and is subsequently authorized for purchase, the provider is not required to replace the equipment.*

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts. Supplies needed for use with client-owned equipment may be purchased separately within the limitations.

Note: *For clients who are 20 years of age and younger, respiratory equipment and supplies that do not meet the criteria under Title XIX Home Health Services may be considered through the Texas Health Steps-Comprehensive Care Program (THSteps-CCP).*

Note: *For clients who are 21 years of age and older, respiratory equipment and supplies that do not meet the criteria under Title XIX Home Health Services may be considered under the Texas Medicaid Home Health-Durable Medical Equipment (DME) Exceptional Circumstances process. Respiratory equipment and supplies are available without prior authorization up to the stated quantity limitation, unless otherwise specified in this handbook. Prior authorization is required for quantities exceeding the limitation.*

2.2.23.1 Prior Authorization

Unless otherwise indicated, prior authorization is required for rental or purchase of respiratory equipment provided through Home Health services.

All miscellaneous procedure codes listed in this handbook require prior authorization.

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2.2.23.1.1 Initial Request

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form prescribing the DME and/or supplies must be signed and dated by a physician or an allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

A Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must be submitted for all DME services and supplies, unless the ordering physician or allowed practitioner is requesting the following:

- A continuous positive airway pressure (CPAP) or Bi-level positive airway pressure (BiPAP) and respiratory assist devices (RADs) are to be requested using a Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form.

  Note: *Home ventilators (procedure codes E0465, E0466, E0467, and E0468) requested with CPAP or RAD settings must also be submitted on the Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form with a letter of medical necessity explaining why CPAP or RAD is not medically appropriate for the client.*

- Oxygen Therapy is to be requested using a Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form.
- Secretion and mucus clearance device are to be requested using a Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request form or a Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices -Renewal Request form for secretion and mucus clearance devices.

  Note: *It is not necessary to submit a Title XIX form if one of the prior authorization forms listed above are submitted.*

The following prior authorization request forms with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record. The following forms will not be accepted beyond 90 days from the date of the ordering physician's signature:

- Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form
- Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form
- Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form
- Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request form
- Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices -Renewal Request form

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic method.

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To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the respiratory equipment and supplies.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies.

A determination as to whether the equipment will be rented, purchased, repaired, or modified will be made by HHSC or its designee based on the client's needs, duration of use, and age of the equipment.

Equipment that has been purchased may be considered for replacement when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report when appropriate and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

2.2.23.1.2 Respiratory Equipment for Clients not Meeting Required Criteria

Clients who are 20 years of age and younger

For clients who are 20 years of age and younger, respiratory equipment and supplies that do not meet the criteria under Title XIX Home Health Services may be considered through the Texas Health Steps-Comprehensive Care Program (THSteps-CCP).

Clients who are 21 years of age and older

For clients who are 21 years of age and older, respiratory equipment and supplies that do not meet the criteria under Title XIX Home Health Services may be considered through the Texas Medicaid Home Health-Durable Medical Equipment (DME) Exceptional Circumstances provision.

Refer to: Subsection 2.2.3, "Home Health DME and Supplies Exceptional Circumstances Provision" in this handbook for additional information about the Exceptional Circumstances provision.

Providers are expected to submit documentation for recertification requests as outlined in this handbook. If no specific documentation requirements are outlined, providers are to submit the following:

- A new prior authorization request form
- All of the initial request requirements
- A physician or an allowed practitioner attestation that the treatment has been effective and the client has been compliant with treatment

2.2.23.1.3 Repair to Client-Owned Equipment

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair.

HHSC or its designee reserves the right to request additional documentation about the need for repairs when there is evidence of abuse or neglect to equipment by the client, client's family, or caregiver. When there is documented proof of abuse or neglect, requests for repairs will not be prior authorized.

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Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity and must include all the following:

- The date of purchase
- The serial number of the current equipment (as applicable)
- The cause of the damage or need for repairs
- What steps the client or caregiver will take to prevent further damage if repairs are due to an accident
- When requested, the cost of purchasing new equipment as opposed to repairing current equipment

Temporary replacement of client-owned respiratory equipment during the repair may be considered for prior authorization for one month using procedure code K0462.

Labor for repair of client-owned respiratory equipment may be considered for prior authorization using procedure code K0739 up to a maximum of two hours per day (maximum quantity of 8 units).

Routine maintenance of rental equipment is the provider's responsibility.

2.2.23.2 Small Volume Nebulizers (SVN)

Small volume nebulizers (SVNs) (procedure code E0570) and related supplies (procedure codes A7003, A7004, and A7005) may be considered for purchase without prior authorization for the conditions listed below:

Condition
Bronchiectasis - Any type
Cystic Fibrosis (CF) with pulmonary manifestations
Pneumonia - Any type
Influenza
Bronchitis - Any type
Emphysema - Any type
Asthma - Any type
Chronic Obstructive Pulmonary Disease (COPD) - any type
Pneumoconiosis - Any type
Acute, Sub-acute or Chronic Respiratory conditions
Respiratory conditions due to radiation, smoke, unspecified and specified external agents
Abnormal Sputum
Other diseases of the of the trachea and bronchus
Tracheostomy Status
Attention to tracheostomy
HIV with pulmonary manifestations
Pneumocystosis
Complications of a specified or unspecified transplanted organ, bone marrow or stem cells
Primary Pulmonary Hypertension
Other Chronic Pulmonary Heart Disease

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Supporting documentation of medical necessity must be maintained in the client's medical record, which must be available on request and is subject to retrospective review including but not limited to the following:

- Completed Title XIX Form signed and dated by the client's prescribing physician or allowed practitioner
- Name of the medication(s) ordered for administration through the nebulizer treatments
- Frequency and duration of the need for the prescribed nebulizer treatments

SVN and related supplies may be considered for conditions not listed above with prior authorization when submitted with the following documentation of medical necessity:

- Completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner
- Justification supporting the use of an SVN to treat the client's diagnosis
- Name of the medication(s) ordered for administration through the nebulizer
- Frequency and duration of need for the prescribed nebulizer treatments

2.2.23.3 Ultrasonic Nebulizers (USNs)

An ultrasonic nebulizer (USN) or electronic aerosol generator (procedure code E0574) is an electrically powered device that uses a piezoelectric crystal to generate aerosol. This crystal transducer converts radio waves into high-frequency mechanical vibrations (sound).

Ultrasonic nebulizers are a benefit when medically necessary and may be considered for purchase with prior authorization.

2.2.23.3.1 Prior Authorization

Purchase of a USN may be considered medically necessary when submitted with all the following documentation:

- Client meets the criteria for a SVN
- Client requires equipment for delivery of one of the following:
  - Treprostinil to treat pulmonary arterial hypertension (PAH) when used to diminish symptoms associated with exercise
  - Tobramycin to treat cystic fibrosis (CF)

USN may also be considered medically necessary for conditions other than those listed only when all of the following criteria have been met:

- Client meets the criteria for a SVN
- Client's treating physician or allowed practitioner attests that the client has been compliant with other nebulizer and medication therapy
- Use of a SVN has failed to control the client's disease, such as preventing the client from utilizing the hospital or emergency room

2.2.23.4 Humidification Therapy and Heating Elements

Humidification involves adding water vapor and sometimes heat to the inspired gas. Humidification therapy and heating elements are provided using the following procedure codes:

Procedure Codes
Large Volume nebulizer jar (water jar)

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Procedure Codes			
A7007	A7017	E0575	E0580
Humidifiers			
E0550	E0561	E0562	
Other Supplies			
E0565	E1372	E0585	

2.2.23.4.1 Heating Elements

Heated humidifiers (procedure code E0562) and heated nebulizers (procedure code E0585) are used for clients with bypassed upper airways, clients receiving mechanical ventilatory support, and clients with high flow positive airway pressure devices. If heat is required for use with a large volume nebulizer (LVN), an immersion element (procedure code E1372) can be added.

2.2.23.4.2 Prior Authorization

Humidification therapy and heating elements may be considered for rental or purchase with prior authorization with documentation of medical necessity.

Indications for humidification and warming of inspired gases are humidifying dry medical gases and overcoming humidity deficit created when upper airway is bypassed.

Clinical signs and symptoms that may be an indication that airway humidification is medically necessary include the following:

- Dry, nonproductive cough
- Increased airway resistance
- Increased incidence of infection
- Increased work of breathing
- Complaint of substernal pain and airway dryness
- Thick, dehydrated secretions

Providers must specify the site of room air or oxygen delivery (e.g., nose or mouth, hypopharynx, trachea) and state how much heat and humidity is needed to mitigate the cold, dry gas delivered through the site.

Providers must submit a Title XIX form and all of the following documentation to obtain prior authorization for the monthly rental or purchase of humidification therapy or heating elements:

- Evidence that the client has a tracheostomy or tracheobronchial stent
- Evidence that the client has thick tenacious secretions not responsive to normal levels of humidification provided with routine humidifiers used with regulators or flow meters
- Evidence that the client is not currently renting a ventilator
- Evidence that the client is not currently renting a compressor for the delivery of humidification

Providers must specify the site of room air or oxygen delivery (e.g., nose or mouth, hypopharynx, trachea) and state how much heat and humidity is needed to mitigate the cold, dry gas delivered through the site.

2.2.23.5 Large Volume Nebulizer Jars (Water Jars) and Compressors

Large volume nebulizer jars (procedure codes A7007 and A7017) used with compressors in humidification systems are a benefit when medically necessary and may be considered for purchase without prior authorization.

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If heat is required, a heating element, such as an immersion element, can be added.

The autoclavable nebulizer (procedure code E0580 - glass or plastic) for use with a regulator or flow meter may be considered with prior authorization and documentation of medical necessity.

Equipment used with a large volume nebulizer to create a humidification system is a benefit when medically necessary with prior authorization.

A compressor (procedure code E0565) may be considered for rental or purchase with prior authorization. A compressor and heater (procedure code E0585), or large volume ultrasonic nebulizer (procedure code E0575) used to create the humidification systems when combined with a compressor are available for purchase and require prior authorization.

2.2.23.5.1 Prior Authorization

A large volume ultrasonic nebulizer and a nebulizer with compressor and heater may be considered for purchase with prior authorization when all the following criteria are met:

- The client has thick, tenacious secretions
- The client has one of the following medical conditions:
  - Cystic fibrosis
  - Bronchiectasis
  - A tracheostomy
  - A tracheobronchial stent

The compressor may also be considered when all of the following criteria are met:

- The compressor is needed for the administration of pentamidine using a filtered nebulizer
- The client has one of the following medical conditions:
  - HIV with pulmonary complications
  - Pneumocystosis
  - Complications of organ transplants

2.2.23.6 Intermittent Positive-Pressure Breathing (IPPB) Devices

IPPB is not the therapy of first choice for delivering aerosol or as a method of lung hyperinflation when other therapies can reliably meet the clinical objectives prescribed for the client. Prior authorization of an IPPB device (procedure code E0500) is available for rental or purchase and will be considered with documentation of ineffective response with use of other modalities such as treatment with a cough assist device.

Rental of the IPPB device includes all supplies, such as humidification and tubing.

In accordance with the American Association for Respiratory Care (AARC) recommendations, IPPB may be considered when one of the following indications is documented:

- The client has a need to improve lung expansion
- The need to deliver aerosol medication to a client when other methods of delivery have been unsuccessful

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2.2.23.6.1 Prior Authorization

IPPB requires prior authorization and may be considered with documentation of ineffective response to treatment when other modalities, such as a cough assist device, have failed, when prescribed in accordance with the AARC recommendations, and there is medical necessity to improve lung expansion due to one of the following:

- The presence of clinically significant pulmonary atelectasis when other forms of therapy have been unsuccessful or the client cannot cooperate with the treatment
- The inability to clear secretions adequately due to pathology that severely limits the client's ability to ventilate or cough effectively and failure to respond to other modes of treatment, including but not limited to:
- Neuromuscular disorders or kyphoscoliosis with associated decreases in lung volumes and capacities
- Presence of acute severe bronchospasm or exacerbated COPD that fails to respond to other therapy
- Deliver aerosol medication when other methods of delivery have been unsuccessful including, but not limited to:
- The client who has fatigue as a result of ventilatory muscle weakness such as neuromuscular disease, kyphoscoliosis, or spinal cord injury
- The clients with severe hyperinflation where IPPB may decrease dyspnea and discomfort during nebulized therapy

2.2.23.7 Controlled Dose Inhalation Drug Delivery Systems

A controlled dose inhalation drug delivery system (procedure code K0730) is a benefit when it is medically necessary to deliver the drug iloprost (e.g. Ventavis) and is restricted to clients with pulmonary artery hypertension. The controlled dose inhalation drug delivery system is available for purchase with prior authorization when medically necessary.

2.2.23.7.1 Prior Authorization

Prior authorization is required for purchase of a controlled dose inhalation drug delivery system when used with iloprost and may be considered when the client has a diagnosis of pulmonary artery hypertension and the pulmonary hypertension is not secondary to pulmonary venous hypertension or disorders of the respiratory system.

2.2.23.8 Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices (RAD) including Bi-Level PAP

Continuous positive airway pressure (CPAP) (procedure code E0601) and respiratory assist devices (RADs) (procedure code E0470) without set back up rate are available for rental or purchase with prior authorization.

RADs with set back up rate (procedure codes E0471 and E0472) are a benefit when medically necessary and may be considered for rental with prior authorization for clients requiring:

- Treatment of obstructive sleep apnea
- Restrictive thoracic disorders
- Severe chronic obstructive pulmonary disease
- Central sleep apnea
- Complex sleep apnea
- Hypoventilation syndrome

Note: *Other conditions may be considered based on medical necessity.*

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RADs with a set backup respiratory rate are available for rental, only when medically necessary.

Humidification devices (heated and non-heated) may be a benefit with prior authorization when medically necessary for rental or purchase for use with CPAP devices and RADs.

The following related supplies procedure codes are included in the CPAP and RAD rental and will not be reimbursed separately:

Procedure Codes									
A7029	A7030	A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038
A7039									

The following procedure codes will deny if billed in the same month by any provider as procedure code E0472:

Procedure Codes									
A7029	A7030	A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038
A7039									

2.2.23.8.1 Prior Authorization

CPAP devices (procedure code E0601) and RADs (procedure codes E0470, E0471, and E0472) require prior authorization. CPAP devices deliver a single, fixed pressure to the client during the night while sleeping. Some sleep breathing disorders do not benefit from CPAP and require treatment with RADs that are able to recognize the client's breathing patterns and adjust pressure during the respiratory cycle during sleep.

Note: *CPAP and RAD criteria are based on CMS coverage determinations.*

CPAP and RAD accessories (headgear, chin straps, face masks, nasal pillows, cushions, nasal interfaces, tubing and filters), when used with the following procedure codes and within the maximum allowed limits, do not require prior authorization with a fee-for-service history of a client-owned CPAP and RAD device:

Procedure Codes									
A7029	A7030	A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038
A7039									

Note: *RAD with backup rate used with an invasive interface (procedure codes E0471 and E0472) do require prior authorization. Supplies are included in the rental of procedure code E0472 and will not be authorized separately.*

In the case of a client-owned RAD with backup rate that is used with invasive interface (procedure code E0472) that was purchased as a result of a rental or purchased through another payer source, proof of ownership of the device is required for consideration of reimbursement of associated supplies and accessories. A statement from the treating physician or allowed practitioner providing the make and model of the client-owned device, submitted with the claims appeal, will meet this requirement if the claims history is not available.

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A CPAP device or a RAD without a set backup rate may be considered for an initial three month rental period with prior authorization. Following the initial three month rental period, if the CPAP or RAD without a set backup rate is effective, the device may be considered for purchase. Both devices may also be considered for continued rental with renewal at three month intervals up to 12 months.

A CPAP device and a RAD without a set backup rate will be considered purchased after 12 months of rental through the same provider and a request for purchase or further rental will not be considered.

A RAD with a set backup respiratory may be considered for an initial 3 month rental period with prior authorization and will be considered for rental only.

Humidification devices (heated or non-heated) for use with a CPAP or RAD device may be a benefit with prior authorization when medically necessary. Documentation submitted must support why humidification is medically necessary for use with positive pressure ventilation.

Prior authorization may be considered for initial and renewal requests for CPAP and RAD devices with submission of the Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form (new with each request) completed, signed and dated by the treating physician or allowed practitioner with the following sections completed:

- A and B for initial requests
- A and C for renewal requests

Additional documentation (e.g., titration sleep studies) as necessary to support the medical necessity of the service required as outlined below for the initial and renewal requests.

Initial Request for a Continuous Positive Airway Pressure (CPAP) System

The American Academy of Sleep Medicine (AASM) Guidelines state that it is clinically appropriate to treat clients who are 18 through 20 years of age using adult criteria.

A CPAP device (procedure code E0601) may be considered for an initial three-month rental period based on documentation supporting the medical necessity and appropriateness of the device. Documentation must include that the client has had a sleep study, lasting minimum of two hours, and at least one of the following criteria:

- For clients who are 17 years of age and younger, polysomnography results documenting an apnea-hypopnea index (AHI) greater than one event per hour may be used to establish medical necessity
- For clients who are 18 years of age and older, polysomnography results documenting an AHI or a respiratory disturbance index (RDI) greater than or equal to 15 events per hour
- For clients who are 18 years of age and older, an AHI or RDI greater than five events per hour with documentation of at least one of the following:
    - Excessive daytime sleepiness assessed by either the Epworth Sleepiness Scale (ESS) with a result greater than 10 or the Multiple Sleep Latency Test (MSLT) with a result less than 6
    - Symptoms of impaired cognition, mood disorders, or insomnia
    - Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg)
    - Ischemic heart disease or previous myocardial infarction
    - History of stroke
    - Greater than 20 episodes of oxygen desaturation to less than 85 percent during a full night sleep study
    - Any one episode of oxygen desaturation of less than 70 percent
    - Pulmonary hypertension

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CPAP may be medically necessary for the treatment of obstructive sleep apnea (OSA) in clients younger than 18 years of age when one of the following criteria is documented:

- Adenoidectomy or tonsillectomy is contraindicated
- Adenoidectomy or tonsillectomy is delayed
- Adenoidectomy or tonsillectomy has been unsuccessful in relieving symptoms of OSA

Documentation must be maintained in the client's medical record that the client or responsible caregiver has received instruction from the DME provider on the proper use and care of the device and supplies.

Renewal Request for a CPAP System

Prior authorization for purchase or an additional three month CPAP rental after the initial three-month rental period will be considered with all of the following documentation completed, signed, and dated by the client's treating physician or allowed practitioner:

- A new Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form
- Documentation of medical necessity supporting:
  - The client's continuous use of the equipment for a minimum of four hours per 24 hour period
  - The client's symptoms as documented by the treating physician or allowed practitioner are improved with use of the CPAP

Continued rental of CPAP may be considered for up to 12 months with renewal at 3 month intervals. A CPAP device will be considered purchased after 12 months of continuous rental through the same provider.

Initial Request for Respiratory Assist Devices (RADs), including BiPAP - with and without a Set Backup Respiratory Rate

A RAD with or without a set back up rate may be considered for prior authorization when the client has one of the following medical conditions as documented by a sleep study and meets criteria for medical necessity for the specific medical condition:

- Obstructive sleep apnea (OSA)
- Restrictive thoracic disorders (i.e., neuromuscular diseases or severe thoracic cage abnormalities)
- Severe COPD
- Central sleep apnea (CSA), complex sleep apnea (CompSA)
- Hypoventilation syndrome

Initial Request for RAD for the Treatment of Obstructive Sleep Apnea (OSA)

A RAD without backup may be considered for an initial three month trial period for the treatment of OSA with prior authorization and submission of all of the following:

- All the required documentation delineated on the Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form outlined in the section for CPAP
- The client meets the criteria for the initial CPAP rental
- The documentation supports that CPAP has been tried and one of the following is documented:
  - The client's treating physician or allowed practitioner verifies that a therapeutic trial of CPAP was conducted in the home or a facility setting and failed to be effective in treating the client's OSA
  - A CPAP device was found to be ineffective during the initial facility based or sleep laboratory titration trial testing

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If a CPAP device is tried and found ineffective during the initial facility-based titration or home trial, substitution of a RAD does not require a new face-to-face clinical evaluation or a new sleep test.

Initial Request for RAD for the Treatment of Restrictive Thoracic Medical Conditions

A RAD without a set backup rate requires prior authorization and may be considered for the treatment of thoracic medical conditions when all of the following are met:

- The client is diagnosed with a neuromuscular disorder (e.g., Duchenne muscular dystrophy, ALS, spinal cord injuries) or the client has a diagnosis of a severe thoracic cage abnormality (e.g., severe chest wall deformities) negatively impacting the client's respiratory effort
- Significant respiratory insufficiency is documented by one of the following:
  - An arterial blood gas (ABG) PaCO2 greater than or equal to 45 mm Hg, obtained while awake and breathing the client's routinely prescribed fraction of inspired oxygen concentration (FiO2)
  - Sleep oximetry demonstrates oxygen saturation less than or equal to 88 percent for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours), obtained while client is breathing his or her routinely prescribed FiO2

Note: *FIO2 is the concentration of oxygen prescribed for routine use by the client. For example, if the client does not normally use supplemental oxygen, their prescribed oxygen is room air (FiO2 of 21 percent).*

For clients who have been diagnosed with a neuromuscular disorder only, documentation must support one of the following:

- Maximal inspiratory pressure less than 60 cm H20
- Forced vital capacity less than 50 percent of predicted volume

A RAD with a set backup rate requires prior authorization and may be considered for the treatment of thoracic medical conditions when all of the following are met:

- The client meets the criteria for use of the RAD without a backup rate for the treatment of a thoracic medical condition
- The ordering physician or allowed practitioner certifies to all of the following:
  - Client has tried a RAD without a backup rate for at least 60 days
  - The client was compliant in the use of the device (using the device on average 4 or more hours in a 24 hour day)
  - The desired therapeutic respiratory response was not achieved with the RAD without a set backup rate

Initial Request for RAD for the Treatment of Severe Chronic Obstructive Pulmonary Disease (COPD)

A RAD without a backup rate may be considered for the treatment of severe COPD, with prior authorization, when all of the following criteria are met:

- An arterial blood gas PaCO2 less than 52 mm Hg, obtained while awake and when the client is either using 2 LPM of oxygen or the client's prescribed FIO2 (the blood gas should be drawn while the client is using whichever concentration of oxygen is the higher of the two)
- Sleep oximetry demonstrates oxygen saturation less than or equal to 88 percent for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours), obtained while breathing oxygen at 2 LPM or the client's prescribed FIO2 (whichever is higher)
- Prior to initiating therapy, documentation of sleep apnea and that treatment with CPAP has been considered with an explanation of why it was ruled out

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To rule out the use of a CPAP, formal sleep testing is not required if there is sufficient information in the medical record submitted with the request to demonstrate that the client does not suffer from some form of sleep apnea (obstructive sleep apnea (OSA), CSA, or CompSA) as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation).

A RAD with a backup feature will be considered with prior authorization for severe COPD when the all of the following criteria are met:

- The client meets the criteria for use of the RAD without a backup rate for COPD
- The ordering physician or allowed practitioner certifies to all of the following:
  - Client has tried a RAD without a backup rate for at least 60 days
  - The client was compliant in the use of the device (using on average 4 or more hours in a 24 hour day)
  - The desired therapeutic respiratory response was not achieved with the RAD without a set backup rate

Initial Request for RAD for the Treatment of Central Sleep Apnea (CSA) or Complex Sleep Apnea (CompSA)

CSA or CompSA is characterized by the development of central apneas or central hypopneas during pressure titrations performed in a sleep lab titration study for CPAP or RAD without a backup rate.

A RAD without a backup rate will be considered with prior authorization for the treatment of CSA or CompSA when a facility based polysomnogram is performed and supports all of the following:

- The client has a diagnosis of CSA or CompSA
- The sleep study documents one of the following:
  - The sum total of central hypopneas plus central apneas is greater than 50 percent of the total apneas and hypopneas rate
  - A central hypopnea/apnea rate index greater than 5 events per hour; and significant improvement of the sleep-associated hypoventilation while breathing the clients prescribed FiO2
  - Documentation ruling out CPAP as effective therapy if either OSA or CSA is a component of the initially observed sleep associated hypoventilation

A RAD with a backup rate will be considered with prior authorization for the treatment of CSA or CompSA when all of the following are met:

- The client meets the criteria for use of the RAD without a backup rate for the treatment of CSA or CompSA
- The ordering physician or allowed practitioner certifies to all of the following:
  - Client has tried a RAD without a backup rate for at least 60 days
  - The client was compliant in the use of the device (using on average 4 or more hours in a 24 hour day)
  - The desired therapeutic respiratory response was not achieved with the RAD without a set backup rate

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Initial Request for RAD for the Treatment of Hypoventilation Syndrome

A RAD without a backup rate may be considered for treatment of hypoventilation syndrome with prior authorization when all of the following criteria are met:

- An initial arterial blood gas PaCO2, obtained while awake with the client breathing their prescribed FIO2, greater than or equal to 45 mm Hg
- Spirometry shows a forced expired volume in 1 sec (FEV1) or the forced vital capacity (FVC) greater than or equal to 70 percent
- A facility-based polysomnogram demonstrates oxygen saturation less than or equal to 88 percent for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours) not caused by obstructive upper airway events

A RAD with a set backup respiratory rate may be considered with prior authorization for the treatment of hypoventilation syndrome when one of the following are met:

- The client has hypoventilation syndrome as determined by a facility-based polysomnogram that demonstrates the desired respiratory therapeutic effects were not achieved with a RAD without a backup rate
- The client meets the criteria for RAD without a backup rate for hypoventilation syndrome, and the physician or allowed practitioner documents the desired respiratory therapeutic effects were not achieved with the RAD without a backup rate.

Renewal Request for RAD with or without a Backup Rate

Prior Authorization is required for renewal of a RAD with or without a backup rate.

Prior authorization for purchase of RAD without a set back up rate or continued rental of a RAD with or without a backup rate, after completion of the initial three-month rental period, may be considered with all of the following documentation completed, signed, and dated by the client's treating physician or allowed practitioner:

- A new Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form
- Attestation from the treating physician or allowed practitioner that states the client is continuing to use the equipment at a minimum of four hours in a 24 hour period
- Client symptoms are improved as documented by the client's treating physician or allowed practitioner

When recertifying a RAD with or without a set backup rate for significant respiratory insufficiency, documentation of a capillary blood gas (CBG) demonstrating a PaCO2 greater than or equal to 45 mm Hg, obtained while awake and breathing the client's routinely prescribed FiO2 may be submitted in lieu of an ABG.

2.2.23.9 Mechanical Ventilation

Invasive and noninvasive ventilators (procedure codes E0465, E0466, E0467, and E0468) are considered for rental only with prior authorization and documentation of medical necessity indicating a clinical need for mechanical ventilation.

Mechanical ventilation may be considered for the treatment of, but not limited to:

- Neuromuscular or musculoskeletal diseases and conditions affecting the respiratory muscles
- Thoracic restrictive diseases
- Chronic respiratory failure
- The following procedure codes will deny if billed in the same month by any provider as procedure codes E0465 and E0466:

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Procedure Codes									
A4481	A4483	A4611	A4612	A4613	A4618				

The following procedure codes will deny if billed in the same month by any provider as procedure code E0467:

Procedure Codes									
A4216	A4217	A4481	A4483	A4605	A4611	A4612	A4613	A4618	A4619
A4624	A4628	A7000	A7002	A7003	A7004	A7005	A7006	A7007	A7012
A7013	A7014	A7015	A7017	A7025	A7026	A7027	A7028	A7029	A7030
A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038	A7039	A7046
A7525	E0424	E0431	E0433	E0434	E0439	E0441	E0442	E0443	E0444
E0465	E0466	E0470	E0471	E0472	E0482	E0483	E0561	E0562	E0565
E0570	E0585	E0600	E0601	E1372	E1390	K0738			

Any of the following procedure codes will deny if billed with E0468:

Procedure Codes									
A4216	A4217	A4481	A4483	A4611	A4612	A4613	A4618	A7027	A7028
A7029	A7030	A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038
A7039	A7046	E0465	E0466	E0470	E0471	E0472	E0482	E0561	E0562
E0601									

2.2.23.9.1 Prior Authorization

All ventilators and related equipment require prior authorization.

The DME provider is responsible for ensuring that there is a contingency plan to manage interruptions in the use of equipment such as emergency situations and mechanical failures that would be life threatening for the client. Acceptable plans include input from the client's treating practitioner that takes into account the severity of the client's medical condition and time constraints in providing emergency support.

A ventilator may be considered for an initial three-month rental period. Following the initial three-month rental period, if the ventilator was effective, it may be considered for ongoing six-month rental periods.

A home ventilator with an invasive or noninvasive interface (procedure codes E0465, E0466, E0467, and E0468) is not intended for use as a CPAP or RAD; however, a home ventilator may be considered when medically necessary. A home ventilator requested with CPAP or RAD settings must be submitted on the Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form with a letter of medical necessity explaining why a CPAP or RAD is not medically appropriate for the client.

Prior authorization may be considered for initial and renewal requests for mechanical ventilators with submission of all of the following:

- A completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner (new with each request)
- Attestation from the treating physician or allowed practitioner that the mechanical ventilator is medically necessary and the client is compliant with the use of the equipment

The completed Title XIX Form must specify all ventilator settings and must be maintained by the DME provider and the treating physician, or allowed practitioner, in the client's medical record.

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The monthly ventilator rental includes all ventilator related supplies regardless of the client's duration of use, whether 24 hours per day or less, including, but not limited to:

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- Humidification systems including supplies and solutions (e.g., sterile or distilled water)
- In-line compressors and related supplies
- Replacement ventilator
- Tracheostomy tube filters and humidification devices, such as heat moisture exchangers (procedure code A4483)

Note: *A replacement ventilator is a replacement for the primary ventilator due to mechanical or other malfunction and is considered a part of the rental agreement and is not authorized separately from the primary ventilator request.*

Oxygen rental is not considered a ventilator supply and may be considered for separate prior authorization.

Refer to: Subsection 2.2.23.12, "Oxygen Therapy" in this handbook for more information.

Heated or non-heated humidification requires a separate prior authorization for rental or purchase for client owned ventilators. Documentation submitted must support why it is medically necessary for the use with the ventilation.

Refer to: Subsection 2.2.23.4, "Humidification Therapy and Heating Elements" in this handbook for more information.

When prescribed by a treating physician or allowed practitioner and medically necessary for clients who require mechanical ventilation, the following devices will be prior authorized for rental:

- A home ventilator that uses an invasive interface, such as a tracheostomy tube (procedure code E0465)
- A home ventilator that uses a non-invasive interface, such as a mask or chest shell (procedure code E0466)
- A multifunction respiratory device (procedure code E0467)
- A dual-function respiratory device (procedure code E0468)

Rental of a chest shell (cuirass or "clam shell") (procedure code E0457) and chest wrap (procedure code E0459) for use with a mechanical ventilator is limited to up to three months.

A dual-function respiratory device home ventilator (procedure code E0468) may be prior authorized for rental for those clients who require mechanical ventilation with documentation that also meets the medical necessity criteria for a cough augmentation device.

Purchase of a chest shell (cuirass or "clam shell") may be prior authorized for purchase following the initial three-month rental period of the mechanical ventilator. The prescribing physician or allowed practitioner must include the predicted length of treatment and the client's compliance with the equipment.

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2.2.23.10 Back-Up Mechanical Ventilator

A back-up ventilator is defined as an identical or similar device used to meet the same medical needs as the primary ventilator for the client, but provided in the home as a precaution in case of malfunction of the primary ventilator.

Requests for a back-up ventilator in the home must meet both the following criteria to be considered medically necessary:

- The client cannot maintain spontaneous ventilations for four or more consecutive hours.
- The client lives in an area where a replacement ventilator cannot be provided within two hours.

Prior authorization requests for a back-up ventilator must include all of the following documentation:

- The amount of time the client is able to maintain spontaneous ventilation.
- The distance and/or delivery time of a replacement ventilator to the clients home.

All requests for a back-up ventilator in the home must be sent to the TMHP for Medical Director for review.

2.2.23.11 Secretion and Mucus Clearance Devices

Secretion and mucus clearance devices are a benefit when medically necessary, and are typically needed by clients diagnosed with cystic fibrosis (CF), chronic bronchitis, bronchiectasis, and ciliary dyskinesia syndromes, some forms of asthma, neuromuscular degenerative disorders, post-operative atelectasis, or thoracic wall defects.

Secretion and mucus clearance devices may be considered when documentation clearly shows the client has one of the following indications for this form of therapy as described by the AARC in the Clinical Practices Guidelines for Postural Drainage Therapy:

- Evidence of retained secretions
- Evidence that the client is having difficulty with the secretion clearance
- Presence of atelectasis caused by mucus plugging

The following secretion and mucus clearance devices or procedures do not require prior authorization:

- Incentive spirometers (procedure code A9284)
- Mucous clearance valved chamber (oscillating positive expiratory pressure (PEP), such as the Flutter Valve) (procedure code S8185)
- Moisture exchangers (procedure code A4483) only when used for mechanically ventilated clients who own their ventilator
- Tracheostoma filters, such as Thermovent T (procedure code A4481) for clients with a tracheotomy who are not mechanically ventilated

The following secretion and mucus clearance devices require prior authorization:

- Insufflation-exsufflation devices (e.g. Cough Assist, Cofflator) (procedure code E0482)
- Electrical percussors (procedure code E0480)
- The high-frequency chest wall oscillation (HFCWO) system with full anterior and/or posterior thoracic region receiving simultaneous external oscillation (procedure code E0483)
- Percussion cup (procedure code E1399)
- Intermittent positive pressure breathing (IPPB) devices (procedure code E0500)

Procedure codes A7025 and A7026 will deny if billed in the same month by any provider as rental of procedure code E0483.

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2.2.23.11.1 Prior Authorization

Prior authorization requests for the rental or purchase of secretion and mucus clearance devices require submission of a Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request form or a Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices -Renewal Request form completed, signed, and dated by the client's treating physician or allowed practitioner unless otherwise specified.

Clients requiring more than one secretion and mucus clearance device must have a pulmonologist or allowed practitioner specialized in pulmonology as the treating provider who submits a signed and dated letter of medical necessity (LMN) on the physician's letterhead stating the need of two devices.

Percussion Cups

Percussion cups, used when performing chest physiotherapy, may be medically necessary to loosen thick, mucus secretions, assist respiration, and prevent infections and require prior authorization. Percussion cups should be requested using the miscellaneous DME procedure code E1399.

Electrical Percussor

An electrical percussor (procedure code E0480) may be considered for rental or purchase with documentation of medical necessity including a description of all previous courses of therapy (such as manual percussion and postural drainage (P&PD) or valved devices) and why they did not adequately assist the client in airway mucus clearance.

Cough Augmentation Device (e.g., mechanical insufflation-exsufflation or cough assist machine)

A cough augmentation device (procedure code E0482) may be considered for prior authorization for rental only for those clients who have chronic pulmonary disease or neuromuscular disorders (including spinal cord injury) that affect the respiratory musculature, causing a weak, ineffectual, or absent cough.

Prior authorization of a cough augmentation device may be considered for an initial three-month rental period with all of the following documentation completed, signed, and dated by the client's treating physician or allowed practitioner:

- Diagnosis and background history including, as applicable, recent illnesses, complications, medications used, history of recent hospitalizations, and results of pulmonary function studies (if applicable) due to diagnosis related complications
- History of school, work, or extracurricular activity absences or other clinical evidence supporting natural deterioration to the level of requiring the use of a cough augmentation device to clear the airways, such as a weak, ineffective cough as demonstrated by pulmonary function studies (PFTs)
- Medical reasons why the client, parent, guardian, or caregiver cannot perform chest physiotherapy, or why such therapies were previously not effective

Requests for prior authorization recertification must include documentation by the client's treating physician or allowed practitioner that the client is compliant with the use of the equipment and that the treatment is effective.

High-Frequency Chest Wall Oscillation (HFCWO) System

A high-frequency chest wall oscillation (HFCWO) system with full anterior and/or posterior thoracic region receiving simultaneous external oscillation (procedure code E0483) will not be prior authorized as first line treatment. The client must have trialed other percussion and postural drainage therapy, such as electric percussor or cough augmentation device, for a minimum of three months before a request for a HFCWO system will be considered for prior authorization.

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A request for a HFCWO system may be considered for prior authorization for rental or purchase when submitted with documentation addressing why prior therapy was ineffective and documentation of one of the following conditions.

- Bronchiectasis when it is confirmed by CT scan and characterized by either a continuous daily productive cough for 6 months or frequent exacerbations of pulmonary infections (i.e., more than 2 times per year) requiring antibiotic therapy
- Cystic fibrosis or other documented chronic supperative endobronchitis
- Chronic neuromuscular disorder affecting the client's ability to cough or clear respiratory secretions
- Weak ineffective or absent cough caused by chronic pulmonary disease or a neuromuscular disorder

Rental of the HFCWO System

An initial three-month rental may be prior authorized for the HFCWO system with hose and vest (procedure code E0483) when submitted with the following documentation of medical necessity that is completed, signed, and dated by the client's treating physician or allowed practitioner:

- A Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices form (Initial or Renewal Request) form
- Client history of a chronic respiratory illness with exacerbation or change in baseline respiratory condition in the past 6 months, including extra nebulizer treatments for respiratory secretions, I.V. antibiotics, and hospitalizations
- Client history of school, work, or extracurricular activity absences due to diagnosis related symptoms, or pulmonary function testing in (PFTs) in past 6 months, if applicable
- Other appropriate (age, ability, skill) modes of chest physiotherapy (such as percussion and postural drainage therapy or mechanical device) that have been trialed by the client, parent, guardian, or caregiver for a minimum of three months before the HFCWO request and the reasons the trialed therapy was ineffective or contraindicated
- Documentation that any previous use of an HFCWO device did not result in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or an exacerbation of seizure activity

If at the end of the initial three-month rental a determination of purchase cannot be made, an additional three month-rental may be considered for prior authorization when the request is submitted with the above documentation and documentation of compliance with ordered therapy.

Purchase of the HFCWO System

If at the end of the initial three-month rental, the HFCWO system (procedure code E0483) is documented to be effective, purchase of the system may be considered for prior authorization when submitted with all the following required documentation:

- A physician or allowed practitioner's statement of the HFCWO system trial in a clinic, hospital, or the home setting documenting:
  - The results of the HFCWO system therapy
  - The effectiveness and tolerance of the system that includes evidence of vest tolerance
  - An explanation of the trial outcome
- The treating physician or allowed practitioner's description and assessment of the effectiveness and tolerance of the system that includes the client's diagnosis and the following background history:
  - Respiratory related complications and evidence of a decrease in these complications

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  - Medications used, including IV antibiotic therapy with dosage, frequency and duration, including evidence of decreased respiratory-related medication use
  - Recent hospitalizations related to the client's respiratory condition and evidence of shorter hospital length(s) of stay
  - Evidence of decreased hospitalizations
  - Evidence of fewer school, work, or extracurricular activity absences due to a diagnostic related condition or other clinical evidence supporting natural deterioration to the level of requiring the use of a HFCWO system to clear the airways, such as a weak, ineffective cough as demonstrated by pulmonary function studies (PFTs)
  - Evidence of the frequency and compliance graphs for the 3-month period showing the frequency prescribed by the physician or allowed practitioner for each day and use of the system at least 50 percent of the time
- A statement from the treating physician or allowed practitioner that the previous use of the HFCWO device has not resulted in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or exacerbation of seizure activity.

A HFCWO system purchase will be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer. Requests for a vest replacement (procedure code A7025) must include documentation that supports the client can no longer wear the vest due to changes in the client's condition such as changes in height, weight, or skin abrasions.

2.2.23.12 Oxygen Therapy

Devices used for in-home oxygen therapy including stationary oxygen concentrators (procedure code E1390), compressed gas (procedure code E0424), liquid oxygen (procedure code E0439), portable compressed gas cylinder (procedure code E0431), or liquid oxygen reservoir (procedure code E0433) systems are a benefit when medically necessary and require prior authorization.

Oxygen system rental includes, but is not be limited to:

- Oxygen concentrator or oxygen tanks
- Regulator
- Flow meter
- Humidifier
- Cannula or mask
- Tubing

Oxygen system supplies, including but not limited to a cannula or mask, refills, and tubing do not require prior authorization for client owned equipment.

Devices used for in-home oxygen therapy may be considered for the treatment of hypoxemia which may be the result of, but not limited to:

- Bronchopulmonary dysplasia or other respiratory diagnoses due to prematurity
- Respiratory failure or insufficiency; musculoskeletal weakness, such as that caused by Duchenne's muscular dystrophy or spinal muscle atrophy
- Diagnosis of cluster headaches
- Severe lung disease, such as COPD, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, or widespread pulmonary neoplasm

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Humidification during oxygen therapy may be a benefit with prior authorization and is provided as a component of the oxygen therapy rental. Humidification during oxygen delivery with client-owned equipment may be a benefit for rental or purchase with prior authorization when medically necessary.

The following procedure codes will deny if billed in the same month by any provider as procedure codes E0424, E0431, E0433, E0434, E0439, E1390, and K0738:

Procedure Codes									
A4615	A4616	A4617	A4619	A4620	E0441	E0442	E0443	E0444	E0447
E0580	E1353	E1355							

2.2.23.12.1 Prior Authorization

Oxygen therapy criteria are based on AARC, American Thoracic Society, and British Thoracic Society Treatment Guidelines. Oxygen therapy related supplies, other than humidification, do not require prior authorization for client owned equipment. Humidification during oxygen delivery with client-owned equipment may be a benefit for rental or purchase with prior authorization when medically necessary.

All oxygen therapy equipment requires prior authorization and prior authorization may be considered for monthly rental only. A completed Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form completed, signed, and dated by a the client's treating physician or allowed practitioner must be submitted.

Prescribing providers must maintain an original, completed, signed, and dated Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form in the client's medical record. The DME provider must maintain a copy of the complete, signed, and dated in the client's record.

Stationary oxygen concentrators are the preferred oxygen therapy home delivery system. If other types of oxygen therapy home delivery systems are required, documentation of medical necessity to support an exception, such as frequent interruptions in electrical service or medical necessity for a higher oxygen concentration than can be obtained with a concentrator, must be provided. The other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks).
- Liquid oxygen reservoir systems.

Multiple oxygen types (e.g., liquid and gas) will not be authorized concurrently.

Initial Oxygen Therapy Medical Necessity Certification

Oxygen ordered for 'as needed' or 'PRN' use does not provide a basis to determine if intermittent oxygen is reasonable and medically necessary for the client. Documentation must support the need for intermittent use of oxygen.

Prior authorization of home oxygen therapy for an initial three month rental period may be considered with submission of all of the following documentation in addition to the request:

- Evidence from the client's treating physician or allowed practitioner of a determination that the client has severe lung disease or hypoxia-related symptoms that are expected to improve with oxygen therapy and the client's blood gas studies meet the criteria indicated below
- A Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form with Sections A and B that is completed, signed, and dated by the client's treating physician or allowed practitioner documenting the client's specific medical needs and the testing performed to determine the need for oxygen therapy including all of the following criteria:
  - The client's medical diagnosis requiring oxygen therapy
  - The oxygen flow rate

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    - An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12 hours per day), and duration of need (e.g., 3 months)
- A qualifying blood gas assessment may be supported by the results of either pulse oximetry or an arterial blood gas and includes all of the following:
    - Date of the testing
    - Results of the testing
- If the blood gas assessment occurred during the client's inpatient hospital stay, a blood gas performed no more than two days before discharge is acceptable.
- If a blood gas is obtained while the client is at home, the assessment must be performed while the client is in a stable chronic state (i.e., not during a period of acute illness or an exacerbation of their underlying disease) within the 30 day period prior to the request for service.

Oxygen therapy coverage is available under one of the three group categories outlined below, if the client has an eligible condition as described above.

Group I Oxygen Therapy Category

Group I - Prior authorization may be considered for clients of any age with significant hypoxemia with documentation of any of the following:

- An arterial pO2 (partial pressure of oxygen) equal to or less than 55 mm Hg or an arterial oxygen saturation equal to or less than 88 percent, taken at rest, breathing room air
- An arterial pO2 equal to or less than 55 mm Hg or arterial oxygen saturation at or below 88 percent, taken during sleep and lasting for at least 5 continuous minutes for clients who have a pO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake
- A decrease in arterial pO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation of more than 5 percent, for at least 5 continuous minutes taken during sleep with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia)
- An arterial pO2 equal to or less than 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a member who demonstrates a pO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, supplemental oxygen may be provided for use during exercise if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air

Group I Oxygen Therapy for Clients who are 20 Years of Age and Younger

Prior authorization may be considered for clients 20 years of age and younger when evidenced by any of the above or the following documentation:

- A neonate, and premature infant of any age who have not reached their 40th week of gestational maturity with an arterial pO2 of less than 60 mmHg or an arterial oxygen saturation level is less than 92 percent
- An infant with chronic neonatal lung disease with an arterial oxygen saturation equal to or less than 92 percent
- Other medical conditions that may be considered with supporting documentation include, but are not limited to:
    - Infants with bronchopulmonary dysplasia
    - Infants with apnea of prematurity, or recurrent cyanotic apneic episodes

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- Children with severe pulmonary hypotension
- Children who have sickle cell anemia with respiratory conditions
- Infants or children who have idiopathic pulmonary hypertension with sleep associated desaturations or a documented need for an emergent use of oxygen

Oxygen Saturation	pO2 in mm HG	Required Parameters	Clients/Comments
Less than or equal to 88 percent	Less than or equal to 55	At rest on room air	Infants, children and adults
Less than or equal to 88 percent	Less than or equal to 55	For greater than or equal to 5 minutes during sleep, when "at rest" criteria not met	Infants, children and adults
Less than or equal to 88 percent	Less than or equal to 55	During exercise, when criteria for "at rest" is not met Tests provided must document the following results: At rest on room air Exercising without oxygen Exercising with oxygen	Infants, children and adults If only criteria - documentation from physician or allowed practitioner: client's hypoxemia improved with use of O2 with exercise
Decrease of greater than 5 percent	Decrease of greater than 10 mm HG	For greater than 5 minutes taken during sleep and Client has signs or symptoms attributable to hypoxemia	Infants, children and adults
Less than 92 percent	Less than 60	At rest on room air	Neonates, premature infants who are < than their 40 week gestational maturity
Less than or equal to 92 percent		At rest on room air Chronic neonatal lung disease	Infants and children
Greater than or equal to 89 percent	Greater than or equal to 56	Documentation from physician or allowed practitioner supporting the medical need for the oxygen therapy due to medical conditions requiring different parameters	Clients of any age

Intermittent acute oxygen therapy at home is not routinely recommended for seizures as there is no evidence that it reduces seizure duration, reduces harm from prolonged seizures, or improves quality of life for the child or family.

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Group II Oxygen Therapy Category

Group II-Prior authorization may be considered for clients of any age whose arterial pO2 is 56-59 mm Hg or whose arterial blood oxygen saturation is 89 percent with documentation of any of the following:

- Dependent edema suggesting congestive heart failure (CHF)
- Cor pulmonale (pulmonary hypertension)
- Erythrocythemia with a hematocrit greater than 56 percent

Group III Oxygen Therapy Category

Group III-Prior authorization may be considered for clients with a diagnosis of cluster headaches with documentation of all of the following:

- Neurological evaluation with diagnosis of cluster headache
- Documentation of failed medication therapy

For clients whose only diagnosis is OSA, documentation must support the client's oxygen sleep desaturation was not corrected with use of CPAP or other RADs.

Oxygen Therapy Recertification

Prior authorization of oxygen therapy rental after an initial three-month rental period may be considered for periods of six month at a time with the submission of all of the following documentation:

- A new Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form with Sections A and B completed, signed, and dated by the client's treating physician or allowed practitioner
- Evidence of a continued need for oxygen therapy
- Evidence from the client's treating physician or allowed practitioner of the client's compliance with the oxygen therapy
- A new arterial blood gas assessment using either pulse oximetry or arterial blood gases
- Evidence that the client meets the criteria for any of the above Groups (I, II, or III) for oxygen therapy

If the above criteria for oxygen therapy are not met medical necessity for recertification of oxygen therapy will be considered by a medical director with documentation from the treating physician or allowed practitioner supporting the client's need for oxygen therapy.

Stationary Oxygen Systems

Rental of a stationary oxygen system includes, but is not limited to, the nasal cannula or mask, tubing, and a basic bubble humidification system.

The types of covered stationary oxygen delivery systems include:

- Oxygen concentrators
- Compressed oxygen gas cylinder systems
- Liquid oxygen cylinder systems

Portable Oxygen Systems

Portable oxygen therapy may be considered for prior authorization when medical necessity documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside of the home environment.

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Portable oxygen systems will not be considered for prior authorization for travel outside of the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.

The types of covered portable oxygen and portable oxygen related delivery systems include:

- Portable tanks for compressed oxygen gas cylinder systems
- Portable tanks for liquid oxygen cylinder systems
- Home compressor attachment used on an oxygen compressor to fill oxygen tanks
- Portable gaseous oxygen system home compressor

2.2.23.13 Cardiorespiratory Monitor (CRM)

A cardiorespiratory monitor (CRM) (procedure codes E0618 and E0619) for purchase or rental may be a benefit when medically necessary and may be considered for clients who require moment-to-moment cardiac and respiratory monitoring due to potential for sudden unexpected deterioration. For infants who are four months of age and younger, a CRM with recording feature (procedure code E0619) may be considered for rental without prior authorization for a maximum of two months. Prior authorization is required for clients who are 5 months of age and older.

> ***Note:*** *The American Academy of Pediatrics (AAP) recommends that infant monitoring using an infant CRM should not be used as a strategy to prevent sudden infant death syndrome (SIDS).*

Procedure codes A4556 and A4557 will deny if billed in the same month by any provider as procedure codes E0618 and E0619.

2.2.23.13.1 Prior Authorization

For infants who are four months of age and younger, a CRM with recording feature (procedure code E0619) may be considered for rental without prior authorization for a maximum of two months with documentation of one of the following conditions:

- Central apnea (respiratory control disorders)
- Cardiac rhythm issues

A completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner must be maintained in the client's medical record.

If a two-month rental has expired for infants who are 4 months of age and younger and continued CRM is medically necessary, a submitted prior authorization request on a completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner (new with each request) must include the following:

- The client has on-going, documented cardiorespiratory episodes (e.g. apnea or dysrhythmia)
- A physician or allowed practitioner interpretation, signed and dated by the physician or allowed practitioner, of the most recent two-month's CRM data recorded downloads

A CRM with or without recording feature (procedure code E0618 or E0619) may be considered for prior authorization for rental or purchase for clients who are 5 months of age and older when submitted with a completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner (new with each request) for one of the following conditions:

- An episode of apparent life-threatening event (ALTE) in an infant who is 12 months of age or younger
- Symptomatic central apnea
- Technology dependence such as:

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- Mechanical ventilation
- Tracheostomy with a critical airway obstruction
- Assisted ventilation dependence
- Cardiac dysrhythmia with significant risk of morbidity or mortality

2.2.23.14 Tracheostomy Tubes and Related Supplies

Tracheostomy tubes (procedure codes A7520, A7521, and A7522) are medically necessary for clients with a tracheostomy and are available for purchase with prior authorization.

Tracheostomy supplies, including inner cannulas, are available for purchase when medically necessary without prior authorization within the stated benefit limits.

A tracheostomy speaking valve is considered a medically necessary accessory that enhances the function of the tracheostomy and is available for purchase without prior authorization when requested within the stated benefit limits.

A tracheostomy speaking valve (procedure code L8501) is available for purchase and is limited to one per six months without prior authorization.

2.2.23.14.1 Prior Authorization

For the initial tracheostomy tube request, three tubes may be considered for prior authorization in the first month of service (two the same size and one smaller for emergencies).

For the next five months of the initial prior authorization period and for subsequent requests, one tracheostomy tube will be prior authorized per month.

More than one tracheostomy tube per month may be considered on a case-by-case basis with medical documentation supporting why the tracheostomy tube must be changed more frequently in order to meet the client's medical needs.

Requesting tracheostomy supplies above the defined limitation

Tracheostomy supplies requests for clients 20 years of age and younger that exceed the defined limits require prior authorization with documentation supporting the medical need of the quantity requested and may be considered under the Comprehensive Care Program and must be requested on a CCP Prior Authorization Request Form.

Tracheostomy supplies requests for clients who are 21 years of age and older that exceed the defined limits require prior authorization with documentation supporting the medical need of the quantity requested and may be considered by a medical director with documentation of medical necessity and must be requested on a Title XIX Form.

Modifiers for Tracheostomy Tubes

When requesting prior authorization for non-customized or non-specialized tracheostomy tubes without specialized functions, providers must submit the most appropriate procedure code with no modifier.

When requesting prior authorization for specialized but non-customized tracheostomy tubes with specialized functions, providers submit the request with modifier U1.

When requesting prior authorization for customized tracheostomy tubes, providers must submit the request with modifier U2.

With the use of either modifier U1 or U2, the following documentation is required:

- A physician or allowed practitioner statement of the reason the client cannot use a standard tracheostomy tube

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- The manufacturer's information on the specialized functions of the tracheostomy tube or the order form describing the customization of the tracheostomy tube

Manufacturer's retail or invoice pricing information is required when using modifier U2.

Tracheostomy Tube Inner Cannula and Required Modifier

Clients with a tracheostomy tube with a reusable inner cannula (procedure code A4623) are allowed one reusable inner cannula per month without prior authorization.

Requests for more than one reusable inner cannula per month require prior authorization and medical documentation from the client's physician or allowed practitioner to support the need for more than one reusable inner cannula per month.

Clients with a tracheostomy tube with a disposable inner cannula (procedure code A4623 with modifier U3) are allowed 31 disposable inner cannulas per month without prior authorization. Request for more than 31 disposable inner cannulas per month require prior authorization and documentation from the client's treating physician or allowed practitioner to support the medical need for more than 31 disposable inner cannulas per month.

Custom tracheostomy tubes are manufactured with reusable inner cannulas. The reusable inner cannulas are included in the prior authorization for any custom tracheostomy tube authorized.

2.2.23.15 Suction Machines and Related Supplies

A suction machine (procedure code E0600) may be considered for purchase with prior authorization if medically necessary for clients who have difficulty raising and clearing secretions. Suction supplies (suction canisters, suction tubing, tracheal suction catheters, and oropharyngeal suction catheters) (procedure codes A4605, A4624, A4628, A7000, and A7002) are medically necessary for use with a suction machine. These supplies are available, if medically necessary, for purchase without prior authorization, up to the stated benefit limits unless otherwise indicated. Only one type of tracheal suction catheter is allowed per month.

In most cases in the home setting, sterile suction catheters (procedure codes A4605 and A4624) and sterile saline for suctioning (procedure code A4216) are considered medically necessary only for tracheostomy suctioning. Sterile saline for tracheal suctioning (procedure code A4216) does not require prior authorization when requested within the stated benefit limits.

Procedure code A4605 will deny if billed in the same month by any provider as procedure code A4624.

2.2.23.15.1 Prior Authorization

Suction machines, suction canisters, suction tubing, tracheal suction tubes, and oropharyngeal suction catheters are a benefit with documented medical need to have oral, nasopharyngeal, or tracheal suctioning performed. Suction supplies do not require prior authorization within the stated benefit limits.

Suction canister filters are limited to one every two months with prior authorization and should be requested using the miscellaneous DME procedure code A9900. Suction equipment and supplies requests for clients who are 20 years of age and younger that exceed the allowed limits require prior authorization with documentation supporting the medical need of the quantity requested, may be considered under Comprehensive Care Program, and must be requested on a CCP Prior Authorization Request Form.

Suction equipment and supplies requests for clients who are 21 years of age and older that exceed the allowed limits require prior authorization with documentation supporting the medical need of the quantity requested and may be considered by a medical director with documentation of medical necessity supporting the medical need of the quantity requested and must be requested on a Title XIX Form.

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2.2.23.16 Other Respiratory Supplies

Other respiratory supplies are a benefit when medically necessary and are available without prior authorization up to the stated quantity limitation unless otherwise indicated:

- Non-sterile (clean) respiratory supplies are considered standard of care and are clinically appropriate in the home setting
- Sterile respiratory supplies are a benefit with prior authorization when medically necessary and documentation clearly demonstrates that the client's medical needs cannot be met with non-sterile (clean) supplies

2.2.23.16.1 Prior Authorization

Respiratory supplies are included in the rental of the respiratory equipment and will not be prior authorized separately, but may be prior authorized for equipment that is owned by the client.

To request prior authorization for respiratory supplies for use with client-owned equipment, the following documentation must be provided by the client's treating physician or allowed practitioner:

- A completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner (new with each request)
- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status
- The prescribed respiratory care regimen, to include frequency, duration, and supplies needed
- Treatment for infection, if present
- Quantity of disposable supplies prescribed per month by the physician or allowed practitioner
- Medical justification for the quantity and type of supply requested

2.2.23.17 Bag Valve Mask (BVM) Resuscitator

A bag valve mask (BVM) resuscitator or handheld resuscitation bag for a ventilator-dependent client (procedure code S8999) is commonly used when the client is temporarily removed from mechanical ventilation. A BVM for a ventilator dependent client may be a benefit for purchase when medically necessary without prior authorization.

A BVM for a non-ventilator client with or without a tracheotomy and with an appropriately sized face mask when appropriate who requires manual respiratory assistance due to inadequate or no breathing may be a benefit when medically necessary and requires prior authorization using the miscellaneous DME procedure code E1399 and will be reviewed by a medical director.

2.2.23.18 Short Term Pulse Oximetry Services, Benefits, and Limitations

A pulse oximeter (procedure code E0445) may be rented for short term use for no more than one calendar month in a six calendar month period. The short term rental of a pulse oximeter may be a benefit when medically necessary and does not require prior authorization for clients with one of the following conditions:

- Weaning the client from home oxygen
- Change in the client's condition that requires an adjustment in the liter flow of their home oxygen treatment
- To determine the client's appropriate home oxygen liter flow for ambulation, exercise, or sleep
- To determine the client's appropriate home oxygen liter flow for those who have neuromuscular disease involving the respiratory muscles, with chronic lung disease, or with severe cardiopulmonary disease.

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2.2.23.19 Long Term Pulse Oximetry Services, Benefits, and Limitations

Long term pulse oximetry (procedure code E0445 with modifier U4) may be a benefit of Texas Medicaid through the Comprehensive Care Program (CCP) with prior authorization. Long-term rental and purchase of a pulse oximeter is a benefit for clients who are birth through 20 years of age. A pulse oximeter for long-term use is defined as equipment rented for more than one calendar month in a six-month period. Long-term pulse oximetry is limited to clients eligible for CCP who qualify for medically necessary services beyond the limits of the home health benefit.

A long-term pulse oximeter must be a device that:

- Is a bedside or tabletop device.
- Provides continuous oxygen saturation monitoring.
- Requires use of wired probes.
- Has battery and alternating current (A/C) capability.

2.2.23.19.1 Long Term Pulse Oximeter Prior Authorization

Prior Authorization for Clients 21 Years of Age and Older

Pulse oximetry that is medically necessary for more than one calendar month in a six calendar month period requires prior authorization and will be considered for clients 21 years of age and older by a medical director when submitted with a complete Title XIX form, signed and dated by the treating physician or allowed practitioner and with documentation of medical necessity, such as:

- When weaning from a ventilator or oxygen and an earlier weaning attempt was unsuccessful that includes why it was unsuccessful
- Documentation of changes in the client's condition since the failed weaning attempt

Prior Authorization for Clients Birth through 20 Years of Age

Prior authorization is required for rental or purchase of a long-term pulse oximeter (procedure code E0445 with modifier U4) for clients who are birth through 20 years of age. HHSC or its designee will determine whether the long term pulse oximeter equipment will be rented, purchased, or repaired based on the client's needs and expected duration of use. Only new, unused equipment will be purchased.

The prior authorization request must include the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by a physician or an allowed practitioner that includes the procedure codes and quantities for the services requested
- Documentation of the cause of the oxygen lability
- Documentation that a caregiver or medical healthcare provider is present who has been trained in use of the oximeter and how to respond to readings in a medically safe and appropriate manner, and the client meets one of the following criteria:
    - Client is oxygen or ventilator dependent and has respiratory system instability as noted in the documentation
    - Client experiences respiratory complications that require equipment that has oxygen saturation monitoring capabilities

A long-term pulse oximeter may be prior authorized for monthly rental up to a maximum of six months. Recertification for an additional six-month period may be considered for a maximum of six additional months.

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A long-term pulse oximeter will be considered purchased and owned by the client when the total monthly payments equal the purchase cost for the equipment. Prior authorization for purchase or continued rental of the long-term pulse oximeter at the end of a 12-month rental period will not be considered. A long-term pulse oximeter may be prior authorized for purchase when a purchase is determined to be more cost effective than leasing the device with supplies.

Long-term pulse oximeter equipment that has been purchased is anticipated to last a minimum of five years. Replacement of equipment may also be considered for prior authorization when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with prior authorization request.

A long-term pulse oximeter used to monitor a client with a history of seizure activity is not routinely recommended for seizures as there is no evidence that it reduces seizure duration, reduces harm from prolonged seizures, or improves quality of life for the child or family.

Pulse Oximetry Supplies

Pulse oximeter probes for client-owned equipment do not require prior authorization and are limited as follows:

- Disposable pulse oximeter probes (procedure code A4606) are limited to four per month
- Reusable pulse oximeter sensor probes (procedure code A4606 with modifier U5) are limited to one every six months

Procedure code A4606 and procedure code A4606 with modifier U5 will deny if billed in the same month by any provider as procedure code E0445.

Prior authorization may be considered for quantities greater than four per month with documentation supporting medical necessity.

Pulse oximeter probes (procedure code A4606 [disposable] or A4606 [reusable] with modifier U5) are included in the pulse oximeter equipment rental. Pulse oximeter probes will be denied if billed with rental of pulse oximeter equipment (procedure code E0445 or E0445 with modifier U4) in the same month of service by any provider.

The rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

2.2.23.20 Procedure Codes and Limitations for Respiratory Equipment and Supplies

Procedure Code	Maximum Limitations	Requires Prior Authorization
A4216	60 per calendar month	No
A4481	31 per calendar month	No
A4483	15 per calendar month	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4556	15 per calendar month	No
A4557	2 per calendar month	No
A4605	10 per calendar month Only 1 type of tracheal catheter is allowed per month. A4605 will deny as part of A4624 if billed in same month.	No
A4606	4 per calendar month	Included in pulse oximeter rental, No prior authorization for client-owned equipment if within policy limit

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Procedure Code	Maximum Limitations	Requires Prior Authorization
A4606 with modifier U5	1 per 6 calendar months	Included in pulse oximeter rental, No prior authorization for client-owned equipment if within policy limit
A4611	1 per 5 rolling years	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4612	1 per 5 rolling years	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4613	1 per 5 rolling years	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4614	1 per 6 calendar months	No
A4615	2 per calendar month	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4616	4 per calendar year	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4617	2 per calendar month	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4618	4 per calendar month	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4619	2 per calendar month	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4620	2 per calendar months	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4623	1 per calendar month	No
A4623 with modifier U3	31 per month	No
A4624	85 per calendar month Only 1 type of tracheal catheter is allowed per month	No
A4627	1 per 6 calendar months	No
A4628	2 per calendar month	No
A4629	30 per calendar month	No
A7000	10 per calendar month	No
A7002	8 per calendar month	No
A7003	2 per calendar month	No
A7004	2 per calendar month	No
A7005	1 per 6 calendar months	No
A7006	1 per calendar month	No
A7007	2 per calendar month	No

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Procedure Code	Maximum Limitations	Requires Prior Authorization
A7009	1 per calendar year	No
A7010	1 per 2 calendar months	No
A7012	2 per calendar month	No
A7013	2 per calendar month	No
A7014	1 per 3 calendar months	No
A7015	1 per calendar month	No
A7016	2 per calendar year	No
A7017	1 per 3 rolling years	No
A7018	4 per calendar month	No
A7025	1 per lifetime	Yes
A7026	1 per 6 calendar months	No
A7027	1 per 3 calendar months	No
A7028	1 per calendar month	No
A7029	2 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7030	1 per 3 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7031	1 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7032	2 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7033	2 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7034	1 per 3 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7035	1 per 6 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7036	1 per 6 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7037	1 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7038	2 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7039	1 per 6 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7520	1 per calendar month	Yes

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Procedure Code	Maximum Limitations	Requires Prior Authorization
A7520 with modifier U1	1 per calendar month	Yes
A7520 with modifier U2	1 per calendar month	Yes
A7521	1 per calendar month	Yes
A7521 with modifier U1	1 per calendar month	Yes
A7521 with modifier U2	1 per calendar month	Yes
A7522	4 per calendar year	Yes
A7523	1 per 2 years	No
A7525	4 per calendar month	No
A7526	20 per calendar month	No
A9900	As needed	Yes
A9284	1 per 6 calendar months	No
E0424 (Rental)	1 per calendar month	Yes
E0431 (Rental)	1 per calendar month	Yes
E0433 (Rental)	1 per calendar month	Yes
E0434 (Rental)	1 per calendar month	Yes
E0439 (Rental)	1 per calendar month	Yes
E0441	1 per calendar month	Yes
E0442	1 per calendar month	Yes
E0443	1 per calendar month	Yes
E0444	1 per calendar month	Yes
E0447	1 per calendar month	Yes
E0445 (Rental)	1 per 6 calendar months	Yes
E0457 (Purchase)	1 per 5 rolling years	Yes
E0457 (Rental)	1 per calendar month	Yes
E0459 (Purchase)	1 per lifetime	Yes
E0459 (Rental)	1 per calendar month	Yes
E0465 (Rental)	1 per calendar month	Yes
E0466 (Rental)	1 per calendar month	Yes
E0467 (Rental)	1 per calendar month	Yes
E0468 (Rental)	1 per calendar month	Yes
E0470 (Purchase)	1 per 5 rolling years	Yes
E0470 (Rental)	1 per calendar month	Yes
E0471 (Rental)	1 per calendar month	Yes
E0472 (Rental)	1 per calendar month	Yes
E0480 (Purchase)	1 per rolling 5 years	Yes
E0480 (Rental)	1 per calendar month	Yes
E0482 (Rental)	1 per calendar month	Yes

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Procedure Code	Maximum Limitations	Requires Prior Authorization
E0483 (Purchase)	1 per lifetime	Yes
E0483 (Rental)	1 per calendar month	Yes
E0500 (Rental)	1 per calendar month	Yes
E0500	1 per 5 rolling years	Yes
E0550 (Rental)	1 per calendar month	Yes
E0550 (Purchase)	1 per 3 rolling years	Yes
E0561 (Purchase)	1 per 5 rolling years	Yes
E0561 (Rental)	1 per calendar month	Yes
E0562 (Purchase)	1 per 5 rolling years	Yes
E0562 (Rental)	1 per calendar month	Yes
E0565 (Purchase)	1 per 5 rolling years	Yes
E0565 (Rental)	1 per calendar month	Yes
E0570 (Purchase)	1 per 5 rolling years	No for conditions listed in policy. Yes for conditions not listed in policy.
E0574 (Purchase)	1 per 5 rolling years	Yes
E0575 (Purchase)	1 per 5 rolling years	Yes
E0580 (Purchase)	1 per 3 rolling years	Yes Included in O2 rental.
E0580 (Rental)	1 per calendar month	Yes Included in O2 rental.
E0585 (Purchase)	1 per 3 rolling years	Yes
E0600 (Purchase)	1 per 5 rolling years	Yes
E0601 (Purchase)	1 per 5 rolling years	Yes
E0601 (Rental)	1 per calendar month	Yes
E0618 (Purchase)	1 per 5 rolling years	Yes
E0618 (Rental)	1 per calendar month	Yes
E0619 (Purchase)	1 per 5 rolling years	Yes Exception: No prior authorization required for maximum 2 months for infants birth through 4 months of age
E0619 (Rental)	1 per calendar month	Yes
E1353 (Purchase)	1 per rolling year	No. Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
E1355 (Purchase)	1 per 3 rolling years	No. Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
E1372 (Purchase)	1 per 3 rolling years	Yes
E1390 (Rental)	1 per calendar month	Yes
E1399 (Rental)	As needed	Yes
E1399 (Purchase)	As needed	Yes
K0462 (Rental)	1 per calendar month	Yes

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Procedure Code	Maximum Limitations	Requires Prior Authorization
K0730 (Purchase)	1 per 5 rolling years	Yes
K0738 (Rental)	1 per calendar month	Yes
K0739	2 hours per day	Yes
L8501	1 per 6 calendar months	No
S8101	1 per 6 calendar months	No
S8185 (Purchase)	1 per 5 rolling Years	No
S8189 (Purchase)	As needed	Yes
S8999 (Purchase)	1 per calendar year	No

2.2.23.21 Services that are not a Benefit

The following are not a benefit of Title XIX Home Health Services:

- Respiratory equipment or supplies requested primarily for the convenience of the caregiver
- Rental of:
  - Mucus clearance valved chamber
  - Medication small volume nebulizer
  - Intrapulmonary percussive ventilation (IPV) system
  - Ultrasonic nebulizers
  - Oxygen supplies for rented equipment
  - Intermittent or spot-check pulse oximetry
- Purchase of:
  - Bi-level PAP with set backup respiratory rate
  - Intrapulmonary percussive ventilation (IPV)
  - Ventilators
  - Pulse oximeter as a Home Health benefit
  - Intermittent or spot-check pulse oximetry
  - Long term (greater than 1 calendar month) pulse oximeter is not a benefit of Home Health services.

Note: *Clients 20 years of age and younger who qualify for medically necessary services beyond the limits of the short-term pulse oximeter benefit may request those long-term pulse oximeter services through the Comprehensive Care Program (CCP).*

The following items are not a benefit of Title XIX Home Health Services because they either have no federal financial participation (FFP) available, are considered environmental equipment, or are considered ineffective or detrimental and as such are not considered medically necessary:

- Cool mist humidifiers
- Room air humidifiers
- Vaporizers
- Dehumidifiers
- Air conditioners

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- Back-up generators

Sterile water is not medically necessary for humidifiers in the home setting and is therefore not a benefit.

2.2.24 Special Needs Car Seats and Travel Restraints

2.2.24.1 Special Needs Car Seats

A special needs car seat may be considered for reimbursement with prior authorization for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt.

A special needs car seat must have a top tether installed. The top tether is essential for proper use of the car seat. The installer is reimbursed for the installation by the manufacturer.

Providers must use procedure code E1399 for a special needs car seat.

Car seat accessories available from the manufacturer may be considered for reimbursement with prior authorization when medically necessary for correct positioning.

A stroller base for a special needs car seat is not a benefit of Texas Medicaid.

A special needs car seat may be considered for reimbursement with prior authorization for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt. Consideration must be given to the manufacturer's weight and height limitations and must reflect allowances for at least 12 months of growth.

The provider must maintain a statement that has been signed and dated by the client's parent or legal guardian in the client's medical record that states the following:

- A top tether has been installed in the vehicle in which the client will be transported, by a manufacturer-trained vendor.
- Training in the correct use of the car seat has been provided by a manufacturer-trained vendor.
- The client's parent or legal guardian has received instruction and has demonstrated the correct use of the car seat to a manufacturer-trained vendor.

To request prior authorization for a special needs car seat or accessories, the following documentation must be provided:

- The client's weight must be at least 40 pounds, or the client's height must be at least 40 inches.
- Supporting documentation must include the following and must be submitted for prior authorization:
    - Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status.
    - A description of the client's postural condition specifically including head and trunk control (or lack of control) and why a booster chair or seatbelt will not meet the client's needs (the car seat must be able to support the head if head control is poor).
    - The expected long-term need for the special needs car seat.
    - A copy of the manufacturer's certification for the installer's training to insert the specified car seat.

A request for a client who does not meet the criteria may be considered on a case-by-case basis on review by HHSC or its designee.

2.2.24.2 Travel Safety Restraints

Providers must use procedure code E0700 for the purchase of travel safety restraints, such as ankle and wrist belts.

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A travel safety restraint and ankle or wrist belts may be considered for reimbursement through CCP without prior authorization for clients with a medical condition requiring them to be transported in either a prone or supine position. The DME provider and the prescribing physician or allowed practitioner familiar with the client must maintain documentation in the client's medical record supporting the medical necessity of the travel safety restraint.

2.2.25 Subcutaneous Injection Ports

A subcutaneous injection port is a sterile medication delivery device through which medications prescribed by a physician or allowed practitioner can be injected directly into the subcutaneous tissue using a standard syringe and needle, an injection pen, or other manual injection device. The device can be used for multiple subcutaneous injections for a period of up to 72 hours, thereby avoiding repeated needle punctures of the skin. The device cannot be used with an injection pump.

A subcutaneous injection port, such as the *I-Port* or *Insuflon*, is a benefit of Texas Medicaid as a Title XIX Home Health service with prior authorization. Claims for a subcutaneous injection port must be submitted with procedure code A4211 and modifier U4.

Texas Medicaid may reimburse the device for clients who require multiple daily injections of medications prescribed by a physician or allowed practitioner and who meet the medical necessity criteria.

The subcutaneous injection port is not a benefit of Texas Medicaid as an item of convenience or for clients who are already receiving the medication through an ambulatory infusion pump. The device is considered an item of convenience if the client does not meet the criteria for medical necessity.

Note: *For clients who are 20 years of age or younger and do not meet criteria for coverage through Title XIX Home Health Services may be considered through the Texas Health Steps Comprehensive Care Program (THSteps-CCP).*

Note: *For clients who are 21 years of age or older, requests that do not meet the criteria for coverage through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health - Durable Medical Equipment (DME) Exceptional Circumstances process.*

2.2.25.1 Prior Authorization

Prior authorization is required for a subcutaneous injection port. Initial prior authorizations will be issued for a trial period of up to 3 months. Prior authorizations that are issued after the successful completion of the initial trial period may be issued for a period of up to 6 months. Prior authorizations for subcutaneous injection ports are limited to a quantity of 10 individual ports per month. Additional ports will be considered for prior authorization with documentation of medical necessity.

2.2.25.2 Documentation Requirements

The initial request for prior authorization must include documentation that indicates the client meets the following criteria for medical necessity:

- The client has a medical condition that requires multiple (i.e., two or more) subcutaneous, self-administered injections on a daily basis and has a current prescription for the injectable medication. Documentation must indicate the specific medical condition that is being treated, the name of the injectable medication, and the dosage and frequency of the injections.

  Note: *"Self-administered" includes those injections administered by the client through a subcutaneous injection or by the caregiver to the client through a subcutaneous injection.*

- The client or the caregiver has been unsuccessful with the self-administration of injections using a standard needle and syringe because the client demonstrates trypanophobia (i.e., severe needle phobia), as evidenced by documented physical or psychological symptoms. Documented symptoms may include, but are not limited to, the following:

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Condition	Possible Exhibited Symptoms
Vaso-vagal trypanophobia	Physical symptoms such as changes in blood pressure, syncope, sweating, nausea, pallor, and tinnitus
Associate trypanophobia	Psychological symptoms such as extreme anxiety, insomnia, and panic attacks
Resistive trypanophobia	Signs and symptoms such as combativeness, elevated heart rate, high blood pressure, and violent resistance to procedures involving needles or injections

The prescribing provider must include with the prior authorization request a written statement of medical necessity that identifies the client as an appropriate candidate for the subcutaneous injection port device. The physician or allowed practitioner's statement or medical record documentation that is submitted with the prior authorization request must indicate the following:

- The client or caregiver has received instruction during an office visit on the proper placement and use of the device, with successful return demonstration. (Prior authorization requests for skilled nursing visits for the sole purpose of client instruction on the use of the subcutaneous injection port device will not be approved. Necessary instruction must be performed as part of the office visit with the prescribing provider.)
- The client has no known allergies or sensitivities to adhesives, silicone, or similar materials.
- The client has no skin infection at potential injection sites.
- The client's most recent lab results related to the medical condition requiring treatment with daily subcutaneous injections must also be submitted with the prior authorization request. Lab results may include, but are not limited to, hemoglobin A1c (HbA1c) levels for clients with insulin dependent diabetes mellitus (IDDM) and partial thromboplastin time (PTT) for clients who are receiving anticoagulant therapy.

Requests for the renewal of the prior authorization after the initial trial period has ended must include documentation of the following:

- Ongoing signs and symptoms associated with the client's trypanophobia.
- Improved compliance with the injection regimen prescribed by the physician or allowed practitioner.
- Successful use of the device with no persistent pattern of the client's dislodging the device during the initial trial period.
- Results of relevant lab tests performed upon completion of the initial trial period, including, but not limited to, HbA1c levels for clients with IDDM and PTT for clients who are receiving anticoagulant therapy.

Note: *For clients with IDDM, if the HbA1c level has not declined with use of the subcutaneous injection port, additional documentation must be submitted by the physician or allowed practitioner who documents the clinical determination about the lack of significant improvement in the HbA1c level. The renewal of the prior authorization will not be approved without this information.*

2.2.26 Total Parenteral Nutrition (TPN) Solutions

2.2.26.1 Services, Benefits, and Limitations for Clients Birth through 20 Years of Age

In-home TPN for clients who are birth through 20 years of age may be considered through CCP. Eligible clients may receive short-term or long-term nutritional support when oral or enteral intake are unable to maintain adequate nutrition. Covered services must be medically necessary and prescribed by the physician or allowed practitioner.

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Parenteral nutrition solution, supplies, and infusion pumps services may be reimbursed with the following procedure codes:

Procedure Codes									
Solution Procedure Codes									
B4164	B4168	B4172	B4176	B4178	B4180	B4185	B4187	B4189	B4193
B4197	B4199	B4216	B5000	B5100	B5200				
Supply Procedure Codes									
B4220	B4222	B4224	B9999						
Infusion Pump Procedure Codes									
B9004	B9006								

Note: *Procedure code B4187 is a benefit for clients who are birth through 18 years of age.*

2.2.26.2 Prior Authorization and Documentation Requirements for Clients Birth through age 20

Prior authorization is required for TPN solutions, lipids, supply kits, and infusion pumps that are provided through CCP for clients birth through 20 years of age. Renewal of the prior authorization will be considered on the basis of medical necessity.

TPN solutions, lipids, supply kits, and infusion pumps will be considered with prior authorization when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following:

- Conditions that result in a loss of function of the gastrointestinal (GI) tract and the inability to obtain adequate nutrition by the enteral route, such as:
  - Infections of the pancreas, intestines, or other body organs that result in a loss of GI function
  - Inflammatory bowel disease
  - Necrotizing enterocolitis
  - Malnutrition
  - Trauma
  - Overwhelming systemic infections
  - Serious burns
- Conditions that result in an inability of the bowel to absorb nutrition, such as:
  - Extensive bowel resection
  - Severe, advanced bowel disease. Examples include short bowel syndrome (SBS), chronicintestinal pseudo-obstruction (CIPS), Hirshprungs disease (HD), Crohn's disease, and ulcerative colitis
  - Prematurity
  - Leukemias
  - Congenital gastrointestinal anomalies
  - Acquired immunodeficiency syndrome

To facilitate determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and supplies requested.

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Prior authorization requests for TPN must include the following information:

- Medical condition for which TPN is necessary
- Documentation of any trials with oral and enteral feedings
- Percent of daily nutritional needs from TPN
- A copy of the TPN formula or prescription that includes amino acids and lipids and is signed and dated by the physician or allowed practitioner
- A copy of the most recent laboratory results that includes potassium, calcium, liver function studies, and albumin

Note: *Conditions or durations of need that are not listed above may be considered by HHSC or its designee with documentation of medical necessity.*

The requesting provider may be asked for additional information to clarify or complete a request for TPN services.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for TPN and related services.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the TPN services.

2.2.26.3 Services, Benefits, and Limitations for Clients 21 years of age and older

In-home TPN for clients who are 21 years of age and older may be considered through home health services. Eligible clients may receive long-term nutritional support when oral or enteral intake are unable to maintain adequate nutrition. "Long-term nutritional support" refers to treatment lasting 30 days or longer. Covered services must be medically necessary and prescribed by the physician or allowed practitioner.

Conditions that may require TPN include, but are not limited to the following:

- Bowel disease or disorder
- Cancer
- AIDS
- Coma
- Burns
- Peritonitis

Note: *Conditions or a duration of need not listed above may be considered by HHSC or its designee with documentation of medical necessity.*

TPN services are not a benefit when oral or enteral intake will maintain adequate nutrition.

Parenteral nutrition solution services may be reimbursed using the following procedure codes:

Procedure Codes									
B4164	B4168	B4172	B4176	B4178	B4180	B4185	B4189	B4193	B4197
B4199	B4216	B5000	B5100	B5200					

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2.2.26.4 Prior Authorization and Documentation Requirements for Clients who are 21 Years of Age and Older

TPN solutions, lipids, supply kits, and infusion pumps must be prior authorized. Renewal of the prior authorization will be considered on the basis of medical necessity.

The administration of intravenous fluids and electrolytes cannot be billed as in-home TPN.

Claims for TPN must contain the 9-character prior authorization number in Block 23. Providers must consult with their vendor for the location of this field in the electronic claims format. The prescribing physician or allowed practitioner's name and NPI must be in Block 17 and 17a or in the appropriate field of the provider's electronic software.

Requests for prior authorization must include the following information:

- Medical condition necessitating the need for TPN and long-term nutritional support.
- Documentation of any trials with oral or enteral feedings.
- Percent of daily nutritional needs from TPN.
- A copy of the TPN formula or prescription, including amino acids and lipids, signed and dated by the physician or allowed practitioner.
- A copy of the most recent laboratory results (to include potassium, calcium, liver function studies and albumin).

The requesting provider may be asked for additional information to clarify or complete a request for TPN services.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the TPN services.

2.2.26.5 Infusion Pumps and Supplies (All Ages)

Parenteral nutrition supplies may be reimbursed using procedure codes B4220, B4222, B4224, and B9999.

Prior authorization requests for miscellaneous procedure code B9999 must include the following:

- A detailed description of the requested item or supply.
- Documentation supporting the medical necessity for the requested item or supply.

Prior authorization requests for a portable parenteral nutrition infusion pump (procedure code B9004) must also include documentation of medical necessity demonstrating that:

- The client requires continuous feedings
- Feeding intervals exceed the time that the client must be away from home to:
  - Attend school or work.
  - Participate in extensive, physician- or allowed practitioner-ordered outpatient therapies.
  - Attend frequent, multiple medical appointments.

Prior authorization for parenteral nutrition infusion pumps will be limited to one portable pump (procedure code B9004) or one stationary pump (procedure code B9006) at any one time, unless medical necessity for two infusion pumps is established. Supporting documentation for the additional pump must be included with the prior authorization request.

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The infusion pump may be rented once a month or purchased once every five years.

2.2.26.6 Backpack or Carrying Case (All Ages)

A backpack or carrying case for a portable parenteral nutrition infusion pump may be a benefit of Home Health Services, when medically necessary and prior authorized, using procedure code B9999.

Prior authorization requests for miscellaneous procedure code B9999 must include the following:

- A detailed description of the requested item or supply.
- Documentation supporting the medical necessity for the requested item or supply.

Requests for a carrying case or backpack for the portable infusion pump will be considered for prior authorization under miscellaneous code B9999, for clients who meet the medical necessity criteria for the portable pump as outlined above. The following additional criteria apply:

- The client is ambulatory, or uses a wheelchair which will not support the use of a portable pump by other means, such as an intravenous (IV) pole.
- The portable enteral feeding pump is client-owned.

2.2.26.7 Reimbursement and Claims (All Ages)

No more than a one-week supply of solutions and additives may be reimbursed if the solutions and additives are shipped and not used because of the client's loss of eligibility, change in treatment, or inpatient hospitalization. Any days that the client is an inpatient in a hospital or other medical facility or institution must be excluded from the daily billing. Payment for partial months will be prorated based upon the actual days of administration. The administration of intravenous fluids and electrolytes cannot be billed as in-home TPN.

Claims for TPN must contain the 9-character prior authorization number in Block 23. Providers must consult with their vendor for the location of this field in the electronic claims format. The prescribing physician or allowed practitioner's name and NPI must be in Block 17 and 17a or in the appropriate field of the provider's electronic software.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the TPN services.

2.2.27 Vitamin and Mineral Products

Vitamin and mineral products prescribed or ordered by a physician or allowed practitioner to treat various conditions are a benefit of Texas Medicaid through CCP for clients who are 20 years of age and younger. Vitamin and mineral products must be submitted with procedure code A9152 or A9153, the appropriate modifier, and the corresponding National Drug Code. Units must be based on the quantity dispensed, for up to a 30-day supply.

> ***Note:*** *It is acceptable for providers to bill in excess of a 30-day supply when billing for liquid formulations due to variances in container size.*

For purposes of billing, one unit is equal to one dose. The total billable units are equal to the total doses requested on the prior authorization.

Providers must dispense the most cost-effective product prescribed in accordance with a prescription from a licensed physician or allowed practitioner. Organic products will not be reimbursed unless medical documentation is provided to substantiate the need for that formulation.

The following vitamin and mineral products may be a benefit when submitted with the corresponding procedure code and state-identified modifier:

Vitamin or Mineral	Procedure Code	State-Identified Modifier
Beta-carotene	A9152	U1

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Vitamin or Mineral	Procedure Code	State-Identified Modifier
Vitamin A (retinol)	A9152	U1
Biotin	A9152	U2
Boric acid	A9152	U3
Copper	A9152	U3
Iodine	A9152	U3
Phosphorus	A9152	U3
Zinc	A9152	U3
Calcium	A9152	U4
Chloride	A9152	U5
Iron	A9152	U6
Magnesium	A9152	U7
Vitamin B1 (thiamin)	A9152	U8
Vitamin B2 (riboflavin)	A9152	U8
Vitamin B3 (niacin)	A9152	U8
Vitamin B5 (pantothenic acid)	A9152	U8
Vitamin B6 (pyridoxine, pyridoxal 5-phosphate)	A9152	U8
Vitamin B9 (folic acid)	A9152	U8
Vitamin B12 (cyanocobalamin)	A9152	U8
Vitamin C (ascorbic acid)	A9152	U9
Vitamin D (ergocalciferol)	A9152	UA
Vitamin E (tocopherols)	A9152	UB
Vitamin K (phytonadione)	A9152	UC
Multiminerals	A9153	U1
Multivitamins	A9153	U2
Trace elements	A9153	U3
Miscellaneous	A9152 or A9153	UD

Note: *Claims for multivitamins with any combination of additives must be submitted with modifier U2.*

Vitamin and mineral products may be indicated for, but are not limited to, treatment of the following conditions:

Vitamin or Mineral	Condition
Beta-carotene	Vitamin A deficiency
	Cystic fibrosis
	Disorders of porphyrin metabolism
	Intestinal malabsorption
Biotin	Biotin deficiency
	Biotinidase deficiency
	Carnitine deficiency

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Vitamin or Mineral	Condition
Boric acid	Recalcitrant vulva vaginitis
Calcium	Calcium deficiency
	Disorders of calcium metabolism
	Chronic renal disease
	Pituitary dwarfism, isolated growth hormone deficiency
	Hypocalcemia and hypomagnesaemia of the newborn
	Intestinal disaccharidase deficiencies and disaccharide malabsorption
	Allergic gastroenteritis and colitis
	Hypocalcemia due to use of Depo-Provera contraceptive injection
Chloride	Hypochloremia
	Hypercapnia with mixed acid-base disorder
	Bronchopulmonary dysplasia
Copper	Disorders of copper metabolism
Iodine	Iodine deficiency
	Simple and unspecified goiter and nontoxic nodular goiter
Iron	Disorders of iron metabolism
	Iron deficiency anemia
	Sideroachrestic anemia
Magnesium	Magnesium deficiency
	Hypoparathyroidism
Phosphorus	Disorders of phosphorus metabolism
Vitamin A (retinol)	Vitamin A deficiency
	Intestinal malabsorption
	Disorders of the biliary tract
	Cystic fibrosis
Vitamin B1 (thiamin)	Vitamin B1 deficiency
	Disturbances of branched-chain amino-acid metabolism (e.g., maple syrup urine disease)
	Disorders of mitochondrial metabolism
	Wernicke-Korsakoff syndrome
Vitamin B2 (riboflavin)	Vitamin B2 deficiency
	Disorders of fatty acid oxidation
	Riboflavin deficiency, ariboflavinosis
	Disorders of mitochondrial metabolism
Vitamin B3 (niacin)	Vitamin B3 deficiency
	Disorders of lipid metabolism, (e.g., pure hypercholesterolemia)
Vitamin B5 (pantothenic acid)	Vitamin B5 deficiency
Vitamin B6 (pyridoxine, pyridoxal 5-phosphate)	Vitamin B6 deficiency
	Sideroblastic anemia

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Vitamin or Mineral	Condition
Vitamin B9 (folic acid)	Vitamin B9 deficiency
	Folate-deficiency anemia
	Combined B12 and folate-deficiency anemia
	Disorders of mitochondrial metabolism
	Sickle-cell disease
	Pernicious anemia
Vitamin B12 (cyanocobalamin)	Vitamin B12 deficiency
	Disturbances of sulphur-bearing amino-acid metabolism (e.g., homocystinuria and disturbances of metabolism of methionine)
	Pernicious anemia
	Combined B12 and folate-deficiency anemia
Vitamin C (ascorbic acid)	Vitamin C deficiency
	Anemia due to disorders of glutathione metabolism
	Disorders of mitochondrial metabolism
Vitamin D (ergocalciferol)	Vitamin D deficiency
	Galactosemia
	Glycogenosis
	Disorders of magnesium metabolism
	Intestinal malabsorption
	Chronic renal disease
	Cystic fibrosis
	Disorders of phosphorus metabolism
	Hypocalcemia
	Disorders of the biliary tract
	Hypoparathyroidism
	Intestinal disaccharidase deficiencies and disaccharide malabsorption
	Allergic gastroenteritis and colitis
Vitamin E (tocopherols)	Vitamin E deficiency
	Inflammatory bowel disease (e.g., Crohn's, granulomatous enteritis, and ulcerative colitis)
	Disorders of mitochondrial metabolism
	Chronic liver disease
	Intestinal malabsorption
	Disorders of the biliary tract
	Cystic fibrosis

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Vitamin or Mineral	Condition
Vitamin K (phytonadione)	Vitamin K deficiency
	Congenital deficiency of other clotting factors
	Hypoprothrombinemia of the newborn
	Hemorrhagic disease of the newborn
	Intestinal malabsorption
	Acquired coagulation factor deficiency
	Cystic fibrosis
	Disorders of the biliary tract
	Chronic liver disease
Zinc	Zinc deficiency
	Wilson's disease
	Acrodermatitis enteropathica
Multi-minerals	Other and unspecified protein-calorie malnutrition
Multi-vitamins	Cystic fibrosis
	Other and unspecified protein-calorie malnutrition
Trace elements	Mineral deficiency

Prior authorization for vitamin and mineral products must be requested using the CCP Prior Authorization Request Form. Requests for prior authorizations must be submitted and approved before the date of dispensing the vitamin or mineral products. Prior authorization requests for vitamin and mineral products that are initiated before the date of the physician or allowed practitioner's order will not be approved.

The following documentation must be submitted with the prior authorization request:

- A physician's or allowed practitioner's prescription with the name of the vitamin or mineral product, dosage, frequency, duration, and route of administration
- The MSRP or average wholesale price (AWP), whichever is applicable, or the provider's documented invoice price
- The calculated price per dose
- Documentation that supports the medical necessity of the requested vitamin or mineral

The following sample tables, taken from the CCP Prior Authorization Request Form, are examples of the information that is required to submit a request for vitamin and mineral products:

- Example 1: Vitamin D

HCPCS Code	Brief Description of Requested Services	Retail Price
A9152 UA	Vitamin D (ergocalciferol) 10 ml bottle (8000 units/ml)	$40.00/bottle
	Dose: 400 units (0.05 ml)	$0.20/dose
	Route: PO	
	Frequency: QD	
Note: HCPCS codes and descriptions must be provided.		

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- Example 2: Multivitamin Tablets

HCPCS Code	Brief Description of Requested Services	Retail Price
A9153 U2	Centrum Kids (80 tablets/bottle)	$8.99/bottle
	Dose: 1 tablet	$0.11/dose
	Route: PO	
	Frequency: QD	
Note: HCPCS codes and descriptions must be provided.		

Prior authorization requests for products, conditions, or quantities other than those described in the "Benefits" section of this handbook will be considered on a case-by-case basis after review by the medical director. Providers must submit documentation that the prescribed products are for a medically accepted indication. Documentation must include one of the following:

- FDA approval
- The use is supported by one or more citations that are included or approved for inclusion in the following compendia:
  - The American Hospital Formulary Service Drug Information
  - The United States Pharmacopoeia-Drug Information (or its successor publications)
  - The DRUGDEX Information System
  - Two articles from major medical peer-reviewed literature that demonstrate validated, uncontested data for the use of the agent in a specific medical condition that is safe and effective

Prior authorization of vitamin and mineral products may be granted for up to six months, and for a quantity up to a 30-day supply.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

Note: *Quantities in excess of these limitations may be considered when requesting liquid formulations due to variances in container size.*

Requests for additional vitamin and mineral products must be submitted before the current authorized period expires, but no more than 30 days before the expiration.

2.2.28 Wound Care Supplies or Systems

Wound care equipment and supplies may be a benefit under Texas Medicaid Title XIX Home Health services.

To be considered a Home Health benefit, all of the following criteria must be met:

- The client must be eligible for home health benefits.
- The criteria listed in this handbook for the requested equipment and supplies must be met.
- The equipment and supplies requested must be medically necessary.
- Federal financial participation must be available.
- The requested equipment and supplies must be safe and appropriate for use in the home.

This handbook addresses wound care equipment and supplies provided to the client by a Durable Medical Equipment (DME) provider in the home and outpatient hospital setting.

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Wound care equipment and supplies are designed to assist in healing of wounds in conjunction with an individualized wound care regimen prescribed by a provider familiar with the client.

Comprehensive wound care regimens include but are not limited to:

- Maintenance of a clean, moist bed of granulation tissue
- Debridement to remove devitalized tissue
- Any necessary treatment to resolve infection
- Optimization of nutrition, circulation, ambulation, and chronic disease management

Providers are to consider the clinical efficacy of the wound care product, the client's functional status, as well as the measurable signs of effective wound management when ordering products to treat wounds. Measurable signs of wound management include, but are not limited to:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate
- A decrease in amount of necrotic tissue
- Improved infection status

Wounds are defined as acute or chronic:

- Acute wounds progress through the normal stages of wound healing and show definite signs of healing within four weeks
- Chronic wounds do not progress normally through the stages of healing (often getting "stalled" in one phase) and do not show evidence of healing within four weeks

Skin ulcers represent the majority of chronic wounds. Skin ulcers include but are not limited to:

- Venous ulcers (also known as venous insufficiency ulcers or stasis ulcers)
- Arterial ulcers
- Diabetic ulcers
- Pressure injuries or pressure ulcers

2.2.28.1 Wound Care Supplies

Medically necessary wound care equipment and supplies include, but are not limited to, cleansing agents, wound packing, dressings and coverings, compression garments, and negative pressure wound therapy (NPWT) systems.

Cleansers

Wound cleansing helps create an optimal healing environment and decreases the potential for infection. Cleansing agents and methods vary based on effectiveness and individual client needs. Wound cleansing agents may include, but are not limited to:

- Normal Saline
- Commercial wound cleansers
- Povidone Iodine
- Hydrogen peroxide
- Sodium Hypochlorite

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Dressings

A dressing is a wet or dry, sterile or non-sterile, pad or compress that is designed to be in direct contact with the wound. A dressing is applied to promote healing and protect the wound from further harm. Dressings and related supplies may include, but are not limited to:

- Wound packing and fillers
- Gauze, impregnated or non-impregnated, sterile or non-sterile
- Dry dressings
- Collagen dressings
- Alginate or other fiber gelling dressings
- Composite dressings
- Antimicrobials
- Foam dressings
- Contact layers and transparent films
- Hydrocolloid, Hydrofiber, and Hydrogel dressings
- Specialty absorptive dressings
- Compression dressings and wraps
- Tape to secure dressings

Compression

Compression dressings, wraps or stockings apply pressure to body parts to control edema and aid circulation by redirecting blood centrally. Below the knee and above the knee compression stockings may be benefits for Texas Medicaid clients. Compression dressings or stockings may be used, but not limited to the following indications:

- Edema in Pregnancy
- Postural Hypotension
- Lymphedema
- Treatment of any of the following complications of chronic venous insufficiency:
  - Venous edema
  - Stasis Ulcers
  - Varicose veins (not including spider veins)
  - Lipodermatosclerosis

Custom burn compression garments may be a benefit with prior authorization and documentation supporting medical necessity.

2.2.28.2 Negative-Pressure Wound Therapy (NPWT) System

An NPWT system provides and maintains a moist wound environment and protects the wound during the healing process.

An NPWT system consists of a cell foam dressing that is placed in the wound bed, a suction catheter tip, an adhesive drape to cover the wound, suction tubing, and a computerized electric vacuum pump. An NPWT system uses continuous or intermittent sub-atmospheric pressure to remove excess interstitial

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fluid and remove growth factor inhibitors. The removal of inhibitors allows the growth factor to stimulate cell proliferation and migration. Removal of excess fluid also helps decrease periwound induration.

Drainage from the wound is collected in a canister. Typically, each wound dressing is changed two to three times per week. NPWT is often referred to as a "wound-vac."

NPWT may be considered for clients with wounds including but not limited to:

- Pressure
- Arterial
- Venous stasis
- Diabetic ulcers
- Post-surgical wound dehiscence; non-adhering skin grafts; or surgical flaps required for covering such wounds

Prior authorization is not required for the initial 90 days of NPWT. Prior authorization is required for continued therapy after the initial 90 days, with the submission of the Wound Care Equipment and Supplies Order Form.

Providers must submit the required documentation for the NPWT system for any prior authorization periods after the initial 90 days of treatment. All documentation required for prior authorization must be maintained in the client's medical record with the prescribing provider.

2.2.28.3 Exclusions

The following services are not a benefit of Texas Medicaid:

- Wound care supplies for use in the office or outpatient setting
- Equipment and supplies for stand-by or back-up use
- Topical or portable hyperbaric oxygen chambers (procedure code A4575) that are placed directly over the wound and provide higher concentrations of oxygen to the damaged tissue
- Non-contact normothermic wound therapy (NNWT) systems and associated supplies (procedure codes A6000, E0231, E0232)
- Rental or purchase of an electrical stimulation or electromagnetic wound treatment device (procedure code E0769), for use by the client or caregiver in the home setting
- Contact or non-contact ultrasound treatment for wounds
- Electrochemical low-dose tissue oxygenation systems
- Metabolically and non-metabolically active skin equivalents used in wound care are not reimbursed in the home setting
- Procedure code A6545 billed without AW modifier

2.2.28.4 Authorization Requirements

Requests for medically necessary wound care equipment or supplies for any eligible client that does not meet criteria as outlined in this handbook for requests for supplies above the defined limitations will be considered through the comprehensive care program. These requests require prior authorization with documentation supporting the medical necessity of the equipment and the quantity requested.

Note: *For clients who are 21 years of age or older, requests for wound care equipment and supplies that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health - Durable Medical Equipment (DME) Exceptional Circumstances process.*

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A completed Wound Care Equipment and Supplies Order Form prescribing the DME and/or supplies must be signed and dated by a physician or allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Wound Care Equipment and Supplies Order Form must include the procedure codes and quantities for services requested.

The completed Wound Care Equipment and Supplies Order Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department. To complete the prior authorization process electronically, the DME provider must submit the prior authorization requirements through any approved electronic methods.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the wound care supplies or wound care system.

Unless otherwise specified, wound care equipment and supplies are available without prior authorization up to the stated quantity limitations. Prior authorization is required for any quantities exceeding the limitations.

Prior authorization or additional documentation is required for:

- Quantities of wound care supplies exceeding the quantity limits listed in the Procedure Codes and Limitations table.
- Disposable wound suction (procedure code A9272). Submitted documentation must include justification addressing why no other wound care equipment and supplies will meet the client's need.
- Continued use of negative pressure wound therapy (NPWT) for more than 90 days requires documentation outlined in NPWT Greater than 90 Days section of this handbook.
- Compression burn garments require documentation of an appropriate diagnosis and evidence of medical necessity. These requests will be reviewed by the medical director.

Prior Authorization is required for the following procedure codes:

Procedure Codes								
A6215	A6260	A6501	A6503	A6504	A6505	A6506	A6507	A6508
A6509	A6510	A6511	A6512	A6513	A6515	A6516	A6517	A6518
A6519	A6549	A6611	A9272	T1999				

2.2.28.5 Documentation Requirements

Information from the following four categories must be submitted anytime that prior authorization is required. If prior authorization is not required, this documentation must be maintained in the client's medical record and is subject to retrospective review.

Category 1: Medical History and Compliance

A comprehensive treatment plan, including the prescribed wound care and management planned for the client including, but not limited to:

- Any medical diagnosis or chronic condition that effects wound healing

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- History of previous wound care treatments and outcomes with dates, including therapies initiated in a hospital or Skilled Nursing Facility (SNF)
- Continued management of unresolved compliance issues (i.e., missed medical appointments, refusing dressing changes, repositioning, smoking, poor nutritional intake or choices)
- Whether a family member/friend/caregiver agrees to be available to assist the client

Category 2: Wound Care Interventions

Relevant information related to the current wound, including:

- Any mechanical, surgical, enzymatic or autolytic tissue debridement (if performed)
- Treatment for infection (if present)

Category 3: Wound Description & Details

Detailed description of the wound including:

- Dates of previous and current assessments
- The measurements at the initiation of wound care and the current measurements, including length, width, depth and any undermining or tunneling
- Wound color
- Amount, quality, quantity, and odor of drainage (if present)
- Presence of granulation or eschar (if appropriate)
- The currently prescribed wound care regimen, to include types of dressings, frequency of dressing changes and supplies needed for each dressing change
- Frequency client will be seen by a licensed medical professional to assess wound healing and current wound treatment regimen

Category 4: Contraindications

Absence of the following contraindications:

- Untreated osteomyelitis within the vicinity of the wound
- Wound ischemia
- Gangrene
- Presence in the wound of necrotic tissue with eschar (if debridement has not been attempted)
- Cancer present in the wound or around the margins
- Presence of a fistula to an organ or body cavity within the vicinity of the wound
- Documentation explaining the appropriateness of wound care is required if any of the above contra-indications are present

The requesting DME provider may be asked for additional information to clarify or complete a request for the wound care equipment or supplies including but not limited to:

- Overall health status of clients whose wounds are not progressing through the normal stages of healing, including but not limited to:
  - Albumin or pre-albumin (within 30 days)
  - Hemoglobin A1C (within 30 days)
  - Use of pressure reducing surfaces, repositioning, and encouraged ambulation

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All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

Reauthorization will be considered based on medical necessity, with a new prior authorization request.

NPWT Greater than 90 Days

NPWT may be considered beyond the initial 90-day treatment period for additional 30 day treatment periods with prior authorization justifying continued use.

For NPWT of greater than 90 days, providers must submit justification for continued use of NPWT including:

- The measurements at the initiation of NPWT and the current measurements, including length, width, depth and any undermining or tunneling

Additionally, providers must make note if any of the following contraindications are present:

- No measurable improvement of wound status occurring over the prior 90-day period.
- The wound care equipment or supplies are no longer being used by the client as prescribed.

NPWT Supplies

NPWT supplies are limited to a maximum of:

- 15 dressing kits or supplies (procedure code A6550) per wound per month; unless documentation supports that the wound size requires more than one dressing kit for each dressing change or if the provider has ordered more frequent dressing changes.
- 10 disposable canisters (procedure code A7000) per month; unless documentation provided indicates medical necessity for additional canisters.

2.2.28.6 Reimbursement and Billing Guidelines

Wound care equipment and supplies addressed in this section are reimbursed only when provided as a Title XIX Home Health Benefit. Supplies provided in an outpatient setting, such as a wound care clinic, are part of the facility fee and are not reimbursed separately.

Providers should only bill for one month of supplies at a time, even though prior authorization may be granted for up to six months.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

Procedure code A6545 must be billed with modifier AW, claims will deny if billed without the modifier.

Providers are reimbursed for items addressed in this section by the lesser of:

- The providers billed charges
- The published fee determined by HHSC

Manual price is determined by HHSC, which is based on:

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

If manual pricing is used, the provider must request prior authorization and submit documentation of one of the following:

- The MSRP or AWP, whichever is applicable.

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- The provider's documented invoice cost.

DME Certification

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any equipment or appliance delivered to a client. The certification form must include the name of the item, the date the client received the equipment or appliance, and the dated signatures of the provider and the client or primary caregiver. This signed and dated form must be maintained by the DME provider in the client's medical record.

The DME Certification and Receipt Form must be submitted for DME claims and appeals when:

- A single item meets or exceeds a billed amount of $2,500.00
- Multiple items submitted on the same date of service meet or exceed a total billed amount of $2,500.00

Claims submitted without the DME Certification and Receipt Form will be denied.

Clients who receive DME meeting or exceeding a total billed amount of $2,500.00 may be contacted to verify receipt of the equipment. If receipt of the equipment cannot be verified, the claim payment is eligible for recoupment.

2.2.28.7 Wound Care Procedures and Limitations

The procedure codes listed in the following table do not require prior authorization when requested within allowable limits.

Note: *Quantities that exceed the limitations identified in the table will require prior authorization with documentation supporting medical necessity.*

Procedure Code	Limitation
A4213	30 per month
A4216	60 per month
A4217	10 per month
A4244	4 per month
A4246	4 per month
A4247	1 per month
A4320	15 per month
A4322	30 per month
A4364	8 per month
A4450	100 per month
A4452	100 per month
A4455	4 per month
A4456	60 per month
A4461	30 per month
A4465	4 per month
A4490	4 per year
A4495	4 per year
A4500	4 per year
A4510	4 per year
A4927	1 per month

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Procedure Code	Limitation
A5120	50 per month
A5121	30 per month
A5122	15 per month
A5126	40 per month
A6010	10 per month
A6011	30 per month
A6021	10 per month
A6022	10 per month
A6023	2 per month
A6024	4 per month
A6025	15 per month
A6196	30 per month
A6197	15 per month
A6198	4 per month
A6199	15 per month
A6203	30 per month
A6204	30 per month
A6205	10 per month
A6206	60 per month
A6207	30 per month
A6208	4 per month
A6209	30 per month
A6210	15 per month
A6211	4 per month
A6212	30 per month
A6213	30 per month
A6214	10 per month
A6216	200 per month
A6217	200 per month
A6218	15 per month
A6219	120 per month
A6220	30 per month
A6221	15 per month
A6222	60 per month
A6223	60 per month
A6224	60 per month
A6228	120 per month
A6229	30 per month
A6230	15 per month
A6231	60 per month

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Procedure Code	Limitation
A6232	30 per month
A6233	10 per month
A6234	30 per month
A6235	15 per month
A6236	10 per month
A6237	30 per month
A6238	10 per month
A6239	15 per month
A6240	8 per month
A6241	15 per month
A6242	30 per month
A6243	15 per month
A6244	4 per month
A6245	30 per month
A6246	30 per month
A6247	10 per month
A6248	8 per month
A6251	60 per month
A6252	30 per month
A6253	15 per month
A6254	60 per month
A6255	30 per month
A6256	15 per month
A6257	30 per month
A6258	30 per month
A6259	15 per month
A6261	8 per month
A6262	8 per month
A6266	120 per month
A6402	200 per month
A6403	100 per month
A6404	15 per month
A6407	60 per month
A6410	30 per month
A6411	30 per month
A6412	30 per month
A6441	60 per month
A6442	120 per month
A6443	120 per month
A6444	120 per month

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Procedure Code	Limitation
A6445	120 per month
A6446	120 per month
A6447	120 per month
A6448	30 per month
A6449	60 per month
A6450	30 per month
A6451	30 per month
A6452	60 per month
A6453	30 per month
A6454	60 per month
A6455	30 per month
A6456	60 per month
A6457	60 per month
A6530	16 per year
A6531	16 per year
A6532	16 per year
A6533	16 per year
A6534	16 per year
A6535	16 per year
A6536	16 per year
A6537	16 per year
A6538	16 per year
A6539	16 per year
A6540	16 per year
A6541	16 per year
A6544	4 per year
A6545-AW	8 per year
A6550	15 per month
A7000	10 per month
E2402	1 per month

The procedure codes in the following table require prior authorization.

Note: *Providers must provide appropriate documentation of medical necessity and documentation for the quantity requested.*

Procedure Code	Limitation
A6215	As Needed
A6260	As Needed
A6501	As Needed
A6503	As Needed
A6504	As Needed

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Procedure Code	Limitation
A6505	As Needed
A6506	As Needed
A6507	As Needed
A6508	As Needed
A6509	As Needed
A6510	As Needed
A6511	As Needed
A6512	As Needed
A6513	As Needed
A6549	As Needed
A9272	As Needed
T1999	As Needed

2.2.29 Limitations and Exclusions

Payment cannot be made for any service, supply or equipment for which FFP is not available. For clients who are 20 years of age and younger and who are eligible to receive THSteps services, refer to Subsection 2.2, "Services, Benefits, Limitations and Prior Authorization" in this handbook to find which of these items are a benefit for CCP.

Home Health Services does not cover the following:

- Adaptive strollers, travel seats, push chairs, and car seats
- Administration of non-FDA-approved medications/treatments or the supplies and equipment used for administration
- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers
- Any services, equipment, or supplies furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services or supplies furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services or supplies furnished without prior approval by TMHP, except as listed
- Any supplies or equipment used in a physician's office, or inserted by a physician (e.g., low profile gastrostomy tube)
- Apnea monitors
- Blood products (the administration or the supplies and equipment used to administer blood products)
- Cardiac telemetry monitoring
- Chemotherapy administration or the supplies and equipment used to administer chemotherapy
- Diapers and wipes for clients who are 3 years of age and younger
- Dynamic orthotic cranioplasty (DOC)
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, heater/air conditioner filters, space heaters, fans, water purification systems, vacuum cleaners, treatments for dust mites, rodents, and insects

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- Home whirlpool baths, spas, home exercisers/gym equipment, hemodialysis equipment, safety wall rails, toys/therapy equipment
- IPV
- Nutritional counseling
- Orthotics, braces, prosthetics including but not limited to voice prosthetic, and artificial larynx
- Parapodiums
- Personal protective equipment (such as gloves, masks, gowns, and sharps containers) for use by a health-care provider, including but not limited to an RN, LVN, or attendant in the home setting
- Pneumocardiograms
- Seat lift chairs
- Shipping, freight, delivery travel time
- Structural changes to homes, domiciles, or other living arrangements
- Vehicle mechanical or structural modifications, such as wheelchair lifts

Refer to: Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2.30 Procedure Codes That Do Not Require Prior Authorization

The procedure codes listed in the following table do not require prior authorization for clients who are receiving services under Home Health Services. Although prior authorization is not required, providers must retain a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form for these clients. For medical supplies not requiring prior authorization, a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form may be valid for a maximum of six months unless the physician or allowed practitioner indicates the duration of need is less. If the physician or allowed practitioner indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form is required at the end of the duration of need. It is expected that reasonable, medically necessary amounts will be provided.

The use of these services is subject to retrospective review. This is not an all inclusive list.

Procedure Codes									
Nebulizer Supplies/Equipment*									
E0570	E0575	E0580	S8101						
Incontinence Supplies**									
A4310	A4311	A4312	A4313	A4314	A4315	A4316	A4320	A4321	A4322
A4326	A4327	A4328	A4330	A4331	A4333	A4334	A4335	A4338	A4340
A4344	A4346	A4351	A4352	A4353	A4354	A4355	A4356	A4357	A4358
A4402	A4554	A5102	A5105	A5112	A5113	A5114	A5120	A5121	A5122
A5131	A5200								
Inhaler Equipment									
A4614	A4627								

*** Prior authorization is required for certain diagnoses and if limitations are exceeded. Refer to subsection 2.2.23.2, "Small Volume Nebulizers (SVN)" in this handbook.**

**** Prior authorization is required for some procedure codes if the maximum limitation is exceeded. Refer to subsection 2.2.15.9, "Incontinence Procedure Codes with Limitations" in this handbook.**

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2.3 Other or Special Provisions

2.3.1 Medicaid Relationship to Medicare

2.3.1.1 Possible Medicare Clients

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is entitled to receive. Home health providers must follow these guidelines:

- Clients who are 64 years of age and younger without Medicare Part A or B:
  - If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of the Home Health Services Program.
- Clients who are 65 years of age and older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
  - In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.
  - If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days from the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

2.3.1.2 Benefits for Medicare and Medicaid Clients

For eligible Medicare/Medicaid clients, Medicare is the primary payer and providers must bill Medicare before submitting a claim to Medicaid. Medicaid pays the Medicare deductible on Part B claims for qualified home health clients.

Home health service prior authorizations may be given for HHA services, certain medical supplies, equipment, or appliances suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) who does not qualify for home health services under Medicare because SN care, PT, or OT are not a part of the client's care.
- When the medical supplies, equipment, or appliances are denied by Medicare Part B and are a benefit of Home Health Services.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third party resources or other insurance.

Note: *If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization. Texas Medicaid will only pay the deductible and coinsurance according to current payment guidelines on the electronic crossover claim.*

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

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2.3.1.3 Medicare and Medicaid Prior Authorization

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN.

Note: *For MQMB clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states "not medically necessary." Medicaid only will consider prior authorization requests if the Medicare denial states "not a benefit" of Medicare.*

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Texas Medicaid is only responsible for premiums, coinsurance, or deductibles on these clients according to payment guidelines. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

To ensure Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of home health services for clients.

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN. Fax a copy of the original Medicare MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.

Note: *Claims for STAR+PLUS MQMB clients (those with Medicare and Medicaid) must always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.*

When the client is 65 years of age and older or appears otherwise eligible for Medicare such as blind and disabled, but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a "pending status" for Medicare determination is 90 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Section 3, "Home Health Skilled Nursing and Home Health Aide Services" in the *Home Health Nursing and Private Duty Nursing Services Handbook* (*Vol. 2, Provider Handbooks*).

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Providers must use only type of bill (TOB) 321 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and result in claim denial.

Home Health services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS 1450 paper claim form, providers must include all required information on the claim, as TMHP does not key information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. The prior authorization number must appear on the UB-04 CMS-1450 claim in Block 63 and in Block 23 of the CMS-1500 claim. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.

2.4.2 Reimbursement

DME and expendable medical supplies are reimbursed in accordance with 1 TAC §355.8023. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126.

DME and expendable supplies, other than nutritional products, that have no established fee, are subject to manual pricing at the documented MSRP less 18 percent or the provider's documented invoice cost.

Nutritional products that have no established fee are subject to manual pricing at the documented AWP less 10.5 percent or at the provider's documented invoice cost.

For reimbursement, providers must note the following:

- Claims are approved or denied according to the eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of 1 month for supplies according to the billing requirements.
- DME/supplies must be provided by either a Medicaid enrolled home health agency's Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both must enroll and bill using the NPI enrolled as a DME supplier. File these services on a CMS-1500 claim form.

  Note: *Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a benefit of Home Health Services. These services may be considered a benefit for clients who qualify for CCP.*

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

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Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

2.4.3 Home Health Agency Reimbursement for DME Services

Home health agencies are reimbursed for DME and medical supplies in accordance with 1 TAC §355.8023. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126. DME and medical supplies, other than nutritional products, that have no established fee are subject to manual pricing at the documented MSRP less 18 percent or the provider's documented invoice cost.

2.4.4 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies home health services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that "a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for home health services care services and may not establish or review a plan of treatment."

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency's assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or 5 percent of the agency's total operating expenses, whichever is less.

When providing CCP services and general home health services, the provider must file these on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number, and must send them to the appropriate address.

Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing services. Documentation must be sent to TMHP Provider Enrollment at the address indicated in subsection A.11, "Written Communication With TMHP" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

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3 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

4 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

5 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form
CCP Prior Authorization Request Form
DME Certification and Receipt Form
External Insulin Pump Prior Authorization Form
Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form Instructions
Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form
Home Health Plan of Care (POC) Instructions
Home Health Plan of Care (POC)
Home Health Prior Authorization Checklist
Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP)

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Forms
Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form
Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices—Initial Request form
Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices -Renewal Request form
Texas Medicaid Provider Surety Bond and Instructions
Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services)
Wound Care Equipment and Supplies Order Form

6 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Home Health Services DME/Medical Supplies

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GYNECOLOGICAL, OBSTETRICS, AND FAMILY PLANNING TITLE XIX SERVICES HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human Services

GYNECOLOGICAL, OBSTETRICS, AND FAMILY PLANNING TITLE XIX SERVICES

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1 General Information

The information in this handbook is intended for gynecological, obstetrics, and Texas Medicaid Title XIX family planning providers. The handbook provides information about Texas Medicaid's benefits, policies, and procedures that are applicable to these service providers.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: The *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about providing services to Texas Medicaid/Texas Health Steps (THSteps) clients.

"Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

"Texas Medicaid Administration" in the *Preliminary Information* (*Vol. 1, General Information*).

The *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*) for information about women's health services.

The *Health and Human Services Commission Family Planning Program Services Handbook* (*Vol. 2, Provider Handbooks*) for information about Health and Human Services Commission (HHSC) programs that provide family planning services.

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, providers can refer to the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in the Medicaid Managed Care Handbook.

Refer to: Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

1.1 Family Planning Overview

TMHP processes family planning claims and encounters for two different funding sources:

- The HHSC Family Planning program funding for HHSC-contracted providers
- The Title XIX family planning funding for Texas Medicaid providers

HHSC awards contracts to agencies across Texas to provide services to low-income individuals who may not qualify for Texas Medicaid services. These awards are granted through a competitive procurement process. HHSC contracts with a variety of providers, including local health departments, universities, medical schools, private nonprofit agencies, FQHCs, RHCs, and hospital districts. All HHSC-contracted providers must first be enrolled in Title XIX Texas Medicaid.

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Client eligibility requirements, reimbursement methodologies, client copayment guidelines, and covered services may differ for each funding source. Family planning funding cannot be used for elective abortion services.

- Title XIX funds are available for family planning services provided to Texas Medicaid clients. TMHP processes Title XIX claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.
- HHSC Family Planning Program contracts annually with family planning providers. TMHP processes claims and reimburses providers for services to eligible clients according to the individually granted funds.
- Funds are also available for women's health and family planning services provided to Healthy Texas Women (HTW) clients. TMHP processes HTW claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.

1.1.1 Guidelines for Family Planning Providers

The following guidelines apply for all family planning services:

- Family planning services may be provided by a physician or under the direction of a physician, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by a registered nurse (RN), physicians assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or certified nurse midwife (CNM).
- Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.
- Texas Medicaid clients, including limited care clients, are allowed to choose any enrolled family planning service provider.
- Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate.
- Family planning clients must be allowed the freedom to accept or reject services without coercion.
- Only family planning clients may consent to the provision of family planning services. Counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult.
- Sterilization services cannot be provided to any person who is 20 years of age or younger. For more information, HHSC providers may refer to the HHSC website at www.healthytexaswomen.org.

1.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.

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- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Medicaid Title XIX Family Planning Services

2.1 Title XIX Provider Enrollment

Physician, FQHC, and RHC providers may provide Title XIX family planning services for Texas Medicaid clients under the provider's Texas Medicaid provider number. No additional enrollment is required to provide Title XIX family planning services.

Refer to: Subsection 7.1, "Provider Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about physician provider enrollment.

Subsection 4.1, "Enrollment" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about FQHC provider enrollment.

Subsection 8.1, "Enrollment" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about RHC provider enrollment.

Family planning agencies must apply for enrollment with TMHP. To be enrolled in Texas Medicaid, family planning agencies must meet the following requirements:

- Complete an agency enrollment application.
- Ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician in accordance with the Texas Medical Board or Texas BON.
- Have a medical director who is a physician currently licensed to practice medicine in Texas, and submit a current copy of the medical director's physician license.
- Have an established record of performance in the provision of both medical and educational counseling of family planning services as verified through client records, established clinic hours, and clinic site locations.
- Provide family planning services in accordance with HHSC standards of client care for family planning agencies.
- Be approved for family planning services by the HHSC Family Planning Program.

Note: *An RHC can also apply for enrollment as a family planning agency.*

The effective date for participation is the date an approved provider agreement with Medicaid is established.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 6.3.6, "Benefit Code" in the *Section 6: Claims Filing* (*Vol. 2, Provider Handbooks*) for more information about benefit codes.

2.2 Services, Benefits, Limitations, and Prior Authorization

This section includes information on family planning services funded through Title XIX Medicaid.

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Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Title XIX services include:

- Family planning annual exams
- Other family planning office or outpatient visits
- Laboratory services
- Radiology services
- Contraceptive devices and related procedures
- Drugs and supplies
- Medical counseling and education
- Sterilization and sterilization-related procedures (i.e., tubal implants, tubal ligation, vasectomy, and anesthesia for sterilization)

Providers must use one of the following diagnosis codes in conjunction with all family planning procedures and services:

Diagnosis Codes							
Z30011	Z30013	Z30014	Z30015	Z30016	Z30017	Z30018	Z3002
Z3009	Z302	Z3040	Z3041	Z3042	Z30430	Z30431	Z30432
Z30433	Z3044	Z3045	Z3046	Z3049	Z308	Z309	Z9851
Z9852							

One of the diagnosis codes in this table must be included in Block 24 E of the CMS-1500 claim form referencing the appropriate procedure code. The choice of diagnosis code must be based on the type of family planning service performed.

Note: *Title XIX family planning services are exempt from the limited program and rules.*

2.2.1 Family Planning Annual Exams

An annual family planning exam consists of a comprehensive health history and physical examination, which includes the following:

- Medical laboratory evaluations as indicated
- An assessment of the client's problems and needs
- The implementation of an appropriate contraceptive management plan

Family planning providers must bill the most appropriate evaluation and management (E/M) visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP and a family planning diagnosis code:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

Important: *Only the annual family planning examination requires modifier FP. All other family planning office visits do not. One annual family planning examination is allowed per year. Claims filed incorrectly may be denied.*

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The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

Billing Criteria	Frequency
New patient: Most appropriate E/M procedure code with modifier FP and a family planning diagnosis code	One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group
Established patient: Most appropriate E/M procedure code with modifier FP and a family planning diagnosis code	Once a year*
*** The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.**	

An annual family planning examination (billed with modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit.

If another condition requiring an E/M office visit beyond the required components for the annual examination is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client's condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

2.2.1.1 FQHC Reimbursement for Family Planning Annual Exams

To receive their encounter rate for the annual family planning examination, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous table in subsection 2.2.1, "Family Planning Annual Exams" in this handbook.

The annual exam is allowed once per fiscal year, per client, per provider. Two additional family planning office or outpatient visits may be reimbursed to the FQHC within the same year for the same client.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

2.2.2 Other Family Planning Office or Outpatient Visits

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

New and established patient E/M services for general family planning visits (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) may be provided via a telemedicine service delivered using synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit.

New and established patient E/M services delivered using synchronous audiovisual technology must be billed using the 95 modifier.

Refer to: The *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about E/M services and The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for restrictions for services delivered using synchronous audiovisual technology.

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Documentation requirements for a telemedicine service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the service delivery method when provided via telemedicine.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine documentation requirements, including requirements for informed consent.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

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

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

Title XIX family planning providers must use one of the following procedure codes based on the complexity of the visit with a family planning diagnosis for other family planning office or outpatient visits:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

Important: *Family planning E/M office and outpatient visits should not be billed with modifier FP. Claims filed incorrectly may be denied.*

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for each type of visit:

Billing Criteria	**Frequency**
New patient: Most appropriate E/M procedure code with a family planning diagnosis code	One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group
Established patient: Most appropriate E/M procedure code with a family planning diagnosis code	As needed*
*** The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.**	

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

A general family planning office or outpatient visit (billed without modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client's condition required a significant, separately

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identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

2.2.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits

FQHCs may be reimbursed for three family planning encounters per year, per client, same provider, regardless of the reason for the encounter. The three encounters may include any combination of general family planning, annual family planning exams, or services. Procedure codes J7296, J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an intrauterine device (IUD) or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

A family planning diagnosis code must be billed along with the most appropriate informational procedure codes for the services that were rendered. Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

Refer to: Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about FQHC services.

2.2.2.2 RHC Reimbursement for Other Family Planning Office or Outpatient Visits

RHC's may receive an encounter rate when submitting claims with procedure code T1015, in addition to a flat "add on" fee for a LARC device (procedure codes J7296, J7297, J7298, J7300, J7301, and J7307).

Refer to: Subsection 8.2.1.4, "Family Planning Services" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about family planning services performed by an RHC.

2.2.3 Laboratory Procedures

All family planning laboratory services must be billed with a family planning diagnosis code.

2.2.3.1 Clinical Laboratory Improvement Amendments (CLIA) Requirement

All providers of laboratory services must comply with the rules and regulations of the CLIA. Providers who are not in compliance with CLIA will not be reimbursed for laboratory services. Only the office or lab that holds the appropriate CLIA certificate and that actually performs the laboratory test procedure may be reimbursed for the procedure.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.3.2 Medical Record Documentation

Medicaid family planning service providers must document in the client's medical record the medical necessity of all ordered laboratory services. The medical record documentation must also reference an appropriate diagnosis.

2.2.3.3 Lab Specimen Handling and Testing

Any test specimen sent to a laboratory may be reimbursed to the laboratory that performs the test and not to the referring family planning provider.

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If the provider that obtains the specimen does not perform the laboratory procedure, the provider that obtains the specimen may be reimbursed one lab handling fee per day, per client, using procedure code 99000 and a family planning diagnosis code for the handling or conveyance of the specimen from the provider's office to a laboratory. More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.

Handling fees are not paid for Pap smears or cultures. The appropriate procedure code may be reimbursed for Pap smear interpretations when billed with modifier SU indicating that the screening and interpretation were actually performed in the office.

2.2.3.4 Providing Information to the Reference Laboratory

When sending any specimen, including Pap smears, to the reference laboratory, the family planning provider must provide the reference laboratory with the client's name, address, Texas Medicaid number, and a family planning diagnosis so the laboratory may bill Texas Medicaid for its family planning lab services.

2.2.4 Radiology Services

Procedure codes 74000, 74010, and 76830 may be reimbursed for services performed for the purpose of localization of an IUD.

2.2.5 External Contraceptives, Long Acting Reversible Contraceptives (LARCs), and Related Procedures

2.2.5.1 External Contraceptives

Procedure codes A4261 (cervical cap) and A4266 (diaphragm) may be reimbursed separately from the fitting and instruction (procedure code 57170).

Procedure codes A4261 and A4266 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30012	Z30018	Z3009	Z302	Z3040	Z3041	Z3042
Z30431	Z30432	Z3049	Z308	Z309	Z641		

2.2.5.2 Long Acting Reversible Contraception: Intrauterine Devices

2.2.5.2.1 Insertion of the LARC IUD

The IUD and the insertion of the IUD may be reimbursed using procedure code J7296, J7297, J7298, J7300, J7301, and 58300.

Procedure codes J7296, J7297, J7298, J7300, and J7301 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis codes							
Z30011	Z30013	Z30014	Z30018	Z3002	Z3009	Z302	Z3040
Z3041	Z3042	Z30430	Z30431	Z30432	Z30433	Z3049	Z308
Z309	Z9851	Z9852					

2.2.5.2.2 Removal of the LARC IUD

Procedure code 58301 may be reimbursed when an IUD is extracted from the uterine cavity. An office visit will not be reimbursed when billed on the same date of service as procedure code 58301.

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When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD removal procedure code or the IUD replacement procedure code, the following reimbursement may apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- The removal or the replacement of the IUD will be denied.

2.2.5.3 Long Acting Reversible Contraception: Implantable Contraceptive Capsules

The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Procedure code 11981 may be reimbursed for the insertion of the contraceptive capsule when it is billed with a family planning diagnosis code.

Procedure code 11983 may be reimbursed for the removal with reinsertion of the contraceptive capsule when it is billed with a family planning diagnosis code. Progesterone-containing subdermal contraceptive capsules (Norplant) were previously used for birth control. Although subdermal contraceptive capsules are no longer approved by the Food and Drug Administration (FDA), the removal of the implanted contraceptive capsule may be considered for reimbursement with procedure code 11976 or 11982.

2.2.5.4 Immediate Postpartum Insertion of LARCs: IUDs and Implantable Contraceptive Capsules

Procedure codes for LARCs may be reimbursed in addition to the hospital Diagnosis related group (DRG) payment when insertion is performed immediately postpartum. "Immediately postpartum" refers to the following:

- Insertion within 10–15 minutes of placental delivery for IUDs
- Insertion prior to discharge for implantable contraceptive capsules.

Medicaid MCOs must adopt claim processing procedures to reimburse hospital and facility providers for immediate postpartum LARC devices in addition to the rate for delivery services.

For claims submitted to TMHP, hospital and facility providers must submit an outpatient claim with the appropriate procedure code for the contraceptive device in addition to the inpatient claim for the delivery services.

For claims submitted to a Texas Medicaid managed care organization (MCO), providers must follow the MCO's claim processing procedures for reimbursement of immediate postpartum LARC devices in addition to the rate for delivery services.

2.2.6 Contraceptive Drugs, Supplies, and Prophylactics

The following procedure codes may be reimbursed for contraceptive drugs, supplies, and prophylactics:

Procedure Codes								
A4267	A4268	A4269	J1050	J3490*	J7294	J7295	J7304	S4993
96372								
*** Procedure code J3490 may be reimbursed when a prescription medication to treat a genital infection is provided to the client.**								

Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

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Procedure code J1050 (no modifier) may be reimbursed for services rendered to male and female clients of any age for other indications as appropriate. Providers must bill the appropriate quantity based on the amount used in milligrams (mg).

For Texas Medicaid Title XIX services, procedure code J1050 is not diagnosis-restricted. For Title XIX family planning services, procedure code J1050 must be billed with a valid family planning diagnosis code.

Procedure codes A4268, A4269, and S4993 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30012	Z30018	Z3009	Z302	Z3040	Z3041	Z3042
Z30431	Z30432	Z3049	Z308	Z309	Z641		

Procedure code A9150 is not reimbursed through Title XIX Medicaid for the medication to treat a monilia infection. The drug is available through the Texas Vendor Drug Program with a prescription.

Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Refer to: Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

2.2.6.1 Prescriptions and Dispensing Medication

Family planning agencies may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill accordingly.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP for Texas Medicaid fee-for-service clients. Only family planning agencies may be reimbursed for dispensing family planning drugs and supplies. Family planning agencies may be reimbursed for dispensing up to a 1-year supply of contraceptives in a 12-month period using procedure code J7294, J7295, J7304, or S4993. The appropriate family planning diagnosis code must be included on the claim.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

Title XIX clients may have prescriptions filled at the clinic pharmacy or at another pharmacy. Pharmacies under the Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule for up to a six-month supply.

2.2.6.2 Pharmacy Benefit for Long-Acting Reversible Contraception Products

Certain LARC products are available as a pharmacy benefit of Family Planning and are available through a limited number of specialty pharmacies that work with LARC manufacturers. Providers can refer to the Long-Acting Reversible Contraception Products section of the Outpatient Drug Services Handbook for additional information, including a list of covered products and participating specialty pharmacies.

2.2.6.3 Medroxyprogesterone Acetate (Depo-Provera)

Medroxyprogesterone acetate injectable suspension (Depo-Provera) has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate given at 90-day intervals has been proven to be a long-term method of preventing pregnancy. Medroxyprogesterone acetate injectable suspension is reimbursed by Texas Medicaid to providers of family planning services. Medroxyprogesterone acetate must be billed using procedure code J1050 with modifier U1 and a valid family planning diagnosis codes.

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2.2.6.4 Injection Administration

Injection administration billed by a provider is reimbursed separately from the medication. If billed without procedure code J1050 and modifier U1, procedure code 96372 must be billed with a family planning diagnosis and a description of the medication in the Remarks field of the claim. Injection administration is not payable to outpatient hospitals.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for a list of family planning diagnosis codes.

2.2.7 Medical Counseling and Education

Procedure code H1010 for the instruction in natural family planning methods may be reimbursed once per day, per person or per couple, when billed by any provider with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30018	Z3002	Z3009	Z302	Z3040	Z3041	Z3042
Z30430	Z30431	Z30432	Z30433	Z3049	Z308	Z309	Z9851
Z9852							

Procedure code H1010 is intended to instruct a couple or an individual in methods of natural family planning. Two sessions (one per client) may be billed for separate, individual sessions, or one session may be billed for counseling and education if provided in a joint session. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.

2.2.8 Sterilization and Sterilization-Related Procedures

For a complete list of Title XIX sterilization procedures, providers can refer to the Texas Medicaid fee schedules located on the TMHP website at public.tmhp.com/FeeSchedules/Default.aspx.

2.2.8.1 Sterilization Consent

Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: *The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not sterilization consent.*

Refer to: Sterilization Consent Form (English) on the TMHP website at www.tmhp.com.

Sterilization Consent Form (Spanish) on the TMHP website at www.tmhp.com.

Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.

2.2.8.2 Anesthesia for Sterilization

Procedure codes 00840, 00851, and 00940 may be reimbursed for anesthesia for sterilization services in accordance with standard anesthesia billing requirements. Providers must include a valid family planning diagnosis code on the claim.

Refer to: Subsection 6.2.5.2, "Anesthesia" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about anesthesia modifiers.

2.2.8.3 Occlusive Sterilization Device

Procedure code A4264 may be reimbursed for the occlusive sterilization system (micro-insert), and may be reimbursed separately from the surgery (procedure code 58565) to place the device.

Providers must bill procedure code A4264 on the same date of service by the same provider as the occlusive sterilization system (micro-insert).

Procedure code 58565 is considered bilateral and is limited to once per lifetime, any provider.

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2.2.8.4 Tubal Ligation

Procedure code 58600, 58615, 58670, or 58671 may be reimbursed for tubal ligations.

2.2.8.5 Vasectomy

Procedure code 55250 may be reimbursed for any sterilization procedure that is performed on a male by a family planning agency. This procedure code may be reimbursed as a global fee to include preoperative, intra-operative, and postoperative services by all parties involved. Vasectomies are considered to be permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the client, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

2.2.8.6 Facility Fees for Sterilization

Hospital-based and freestanding ambulatory surgical centers (HASCs/ASCs) may be reimbursed for procedure code 55250, 58260, 58262, 58565, 58600, 58615, 58670, or 58671. An appropriate family planning diagnosis code must be billed when reporting facility fees for procedure codes 58565 or 58670.

Refer to: Ambulatory Surgical Center on the TMHP website at www.tmhp.com for a claim form example.

Subsection 6.2.13, "Gynecological and Reproductive Health and Family Planning Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional gynecological, reproductive health, and family planning services procedure codes that may be reimbursed to ASC and HASC providers.

2.2.9 Prior Authorization

Prior authorization is not required for family planning services, including sterilization and sterilization-related procedures.

2.2.10 Non-covered Services

2.2.10.1 Family Planning Services for Undocumented Aliens

Undocumented aliens are identified on the client eligibility card as having limited Medicaid eligibility by the classification of Type Program (TP) 30, 31, 34, and 35. Under Texas Medicaid, these clients are only eligible for emergency services, including emergency labor and delivery. Texas Medicaid emergency-only services do not cover Title XIX family planning services.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological and reproductive health services, and family planning services.

Gynecological and reproductive health services, and family planning services are subject to retrospective review and recoupment if documentation does not support the service billed.

Documentation requirements for a telemedicine service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the service delivery method when provided via a telemedicine service.

Refer to: Subsection 3.4, "Telemedicine Services" in the *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine documentation requirements, including requirements for informed consent.

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2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Providers may use the following claim forms to submit claims to TMHP:

Providers	Forms
Medicaid Fee-For-Service Claims Submitted to TMHP	
All family planning services provided by physicians, PAs, NPs, CNSs, CNMs, and family planning agencies who also contract with HHSC	2017 claim form or approved electronic format
Medicaid family planning providers who do not contract with HHSC	2017 claim form, CMS-1500 claim form, or approved electronic format of either form
Hospitals	UB-04 CMS-1450 claim form or approved electronic format
FQHCs not contracted with HHSC	UB-04 CMS-1450, 2017 claim form, or approved electronic format of either form
FQHC also contracts with HHSC	2017 claim form or approved electronic format

The following applies when filing claims:

- All claims and Sterilization Consent Forms submitted by family planning agencies must be submitted with benefit code FP3.
- Family planning services billed by RHCs must include modifier AJ, AM, SA, or U7. These services must be billed using the appropriate national place of service (72) for an RHC setting.
- When completing a 2017, CMS-1500, or UB-04 CMS-1450 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.
- All claims must be filed within approved filing deadlines.
- Denied claims may be appealed.

Providers may copy 2017 Claim Form on the TMHP website at www.tmhp.com.

Providers may purchase CMS-1500 and UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

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Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.9, "Family Planning Claim Form (Paper Billing)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.9.1, "2017 Claim Form" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5.4, "CMS-1500 Instruction Table" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.6.3, "UB-04 CMS-1450 Instruction Table" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about filing deadlines.

"Section 7: Appeals" (*Vol. 1, General Information*) for information about appealing claims.

Blocks that are not referenced are not required for processing by TMHP and may be left blank.

RHCs must use their National Provider Identifier (NPI), the appropriate benefit code as applicable, and the appropriate modifier and place of service as outlined in this section.

2.4.1.1 Family Planning and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client's confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.

2.4.2 Billing Procedures for Non-Family-Planning Services Provided During a Family Planning Visit (Title XIX Only)

When a non-family-planning service is provided during a family planning visit or the client is offered family planning services during a medical visit, the following billing process must be used:

- A family planning clinic must bill for non-family-planning services using the performing provider's NPI and taxonomy code. The clinic NPI and taxonomy code is used to bill family planning services only.
- The performing provider must bill both family planning services and non-family-planning services, using the correct NPI and taxonomy code.
- The FQHC must bill both family planning services and non-family-planning services, using the correct NPI and taxonomy code.
- An RHC may bill a rural health encounter for a non-family-planning medical condition or use the physician's or NP's NPI and taxonomy code to bill for family planning services. If the RHC also is enrolled as a family planning agency, the family planning services may be billed using the agency's family planning NPI and taxonomy code and the appropriate national place of service (72) for an RHC setting.

2.4.3 National Drug Code

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

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2.4.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

3 Breastfeeding Support Services

Breast pumps facilitate an infant's ability to receive their mother's own breast milk when it would be difficult to do so without equipment. Breast pump equipment is a benefit when provided by durable medical equipment (DME) suppliers and medical supply companies in the home. DME suppliers may deliver breast pump equipment to a client who is still in the hospital, but for claims purposes, the place of service should indicate the home setting.

Durable medical equipment (DME) is defined as medical equipment/appliances that are manufactured to withstand repeated use, ordered by a physician or an allowed practitioner for use in the home, and required to correct or ameliorate the client's disability, condition, or illness. Since there is no single authority (such as a federal agency) that confers the official status of "durable medical equipment" on any device or product, the Health and Human Services Commission (HHSC) retains the right to make such determinations with regard to DME provided by Texas Medicaid. DME provided by Texas Medicaid must either have a well-established history of efficacy, or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a Medicaid-eligible medical condition or functional disability.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or a clinical nurse specialist (CNS).*

A breast pump may be obtained under an eligible mother's Medicaid client number; however, if a mother is no longer eligible for Texas Medicaid and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number.

Any provider who is familiar with the mother's or infant's health may order a breast pump. The ordering provider may include, but is not limited to, obstetricians, gynecologists, neonatologists, and pediatricians. Providers in the hospital setting or the community setting may write the order for breast pump equipment.

DME providers are not precluded from releasing equipment to infants with a Medicaid pending status when they have an order from the direct care provider. A Medicaid identification number is typically assigned to an infant within 24 hours, but it may take longer. During this time, DME providers are expected to release equipment to the client as ordered by the direct care provider who is familiar with the infant.

Note: *For clients who are 21 years of age or older, requests for breast pumps that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Note: *Medicaid providers should supply breast pump equipment to qualifying clients. If clients do not meet criteria as outlined, mothers should also be informed that breast pumps may be available through the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC), contingent upon WIC's issuance criteria.*

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The American Academy of Pediatrics (AAP) recommends that infants exclusively breastfeed for the first six months and continue to breastfeed through 12 months of age or longer.

Breastfeeding refers to both the infant's feeding of breast milk directly from the breast as well as the feeding of mother's own expressed breast milk to the infant.

Breast milk provides unsurpassed nutrition and immune protections, influencing the growth and development of infants, and is a significant primary prevention strategy for improving infant health outcomes.

Breastfeeding is encouraged as a means to prevent various illnesses and conditions and to promote the health and wellness of mothers and infants. In some circumstances, breast pumps may be necessary for breastfeeding.

Breastfeeding reduces the infant's risk for illness, including ear infections, gastrointestinal and bacterial infections, respiratory infections, asthma, diabetes, obesity, and leukemia; and reduces the premature infant's risk of necrotizing enterocolitis. Breastfeeding also reduces the mother's risk of developing conditions including breast and ovarian cancers, diabetes, and cardiovascular disease. With proper breastfeeding support and management, breastfeeding may also be protective against post-partum depression.

Infant health can be directly impacted by the ability of the infant's mother to provide her own breast milk. Therefore, it is beneficial to enhance the opportunities for infants to receive their mother's milk through the use of equipment when needed.

The American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) advise that mothers who are infected with human immunodeficiency virus (HIV), Human T-lymphotropic virus (HTLV)-1, and HTLV-2 infection should not breastfeed as the virus may be passed to their infant.

All breast pumps must meet the following specifications:

- Comply, be registered, and be cleared with the Federal Drug Administration (FDA)
- Allow for pumping sessions to be efficiently completed within 30 minutes
- Be adaptable for several sizes of breast shields (flanges), including larger sizes, so as to accommodate different sizes of breasts and nipples
- Have an adjustable and wide-range of suction pressure at the breast shield during use, typically from 30 millimeters of mercury up to 250 millimeters of mercury (mm Hg)
- Have a mechanism or written guidelines to prevent or instruct the user from achieving a vacuum level over 250 mm Hg
- Be portable

The following breast pump procedure codes are a benefit of Texas Medicaid with the listed limitations:

Procedure Codes	Additional Information	Limitations
A4281, A4282, A4283, A4284, A4285, A4286, A4288	Breast pump parts for use with a pump that has been purchased. All parts must be submitted with modifier U8.	Each part - up to 2 times within 12 months from the breast pump date of purchase
E0602*	Purchase of a personal-use, manual breast pump	Once within 12 months from the date of birth
E0603*	Purchase of a personal-use, electric breast pump	
***Only one of these procedure codes may be reimbursed when submitted for the same date of service by any provider**		

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Procedure Codes	Additional Information	Limitations
E0604*	Rental of a multiple-user, hospital-grade electric breast pump	Initial 60-day rental, followed by up to three 90-day rentals within 12 months from the date of birth
***Only one of these procedure codes may be reimbursed when submitted for the same date of service by any provider**		

Modifier	Description
U8	U8 denotes the replacement of a part for durable medical equipment and must be used when submitting claims for any breast pump parts

The rental or purchase of a breast pump, as well as any replacements or parts, must be billed using the mother's Medicaid identification number, or if she is no longer eligible, using the infant's Medicaid identification number.

Personal-use breast pump is for use by only one individual. Personal-use pumps are not to be shared, or used by anyone other than the original owner. Use by more than one individual may pose a risk of cross-contamination, may result in infection or illness of mother and infant, and may void the equipment warranty.

A manual or electrical (AC and/or DC) personal-use breast pump may be considered for purchase only.

A multiple-user electric breast pump is also known as a hospital-grade electric breast pump. Hospital-grade electric breast pumps are designed for repeated uses throughout the pump's lifetime, by more than one woman and infant. The risk of cross-contamination is eliminated via a closed system. Pumped breast milk must not reach the motor. Hospital grade pumps are durable, heavy-duty breast pumps.

A hospital-grade breast pump may be considered for rental only.

Pump kits, which are specific to each breast pump manufacturer's requirements, provide the necessary supplies and accessories to allow expression of breast milk.

Procedure codes E0602 and E0603 will be denied when submitted within the same calendar month as procedure code E0604.

Procedure code E0602 will be denied when submitted within one year from procedure code E0603, any provider.

Claims for parts will not be reimbursed when billed for the same day as the purchase of breast pump equipment. Reimbursement is for purchase or rental, with documented medical necessity and prior authorization when appropriate, as outlined in this handbook.

Refer to: Subsection 2.3.2.3, "Breast Pump Claims Filing for MCO Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for more information related to breast pump coverage for newborns.

3.1 Breast Pump Kit Specifications

A breast pump kit is included in the purchase or rental of a breast pump, and is not separately reimbursed. Kits should include the following:

- Breast shields (flanges) that are adjustable and flexible, or flanges that are available in several different sizes if rigid, including larger sizes
- All accessories necessary for pumping two breasts simultaneously for electric pumps, or at least one breast manually for manual handle-squeeze pumps
- All parts necessary to easily convert an electric pump to a manual pump
- At least one extra set of membranes and valve replacements

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- At least one extra diaphragm replacement for closed-system pumps
- At least two collection bottles with spill-proof standard size caps, that are bisphenol-A (BPA) and DEHP-free
- Accessories and supplies must be compatible with the pump provided. Materials must be of durable quality for withstanding repeated boiling, washing, and pumping use.

3.2 Replacement Parts

Breast pump replacement parts (procedure codes A4281, A4282, A4283, A4284, and A4285) must be billed with modifier U8.

Replacement parts will be denied when submitted for the same date of service as a breast pump.

If the breast pump was not purchased by Texas Medicaid and requires replacement parts, the following documentation of a client-owned device must be submitted:

- Purchase date
- Serial number
- Purchasing entity of the device
- Copy of the receipt, if available

Note: *Parts for a hospital-grade electric breast pump (procedure code E0604), and routine servicing and all necessary repairs to ensure the unit remains functional for the client's needs, are included in the rental of the pump and is the responsibility of the DME supplier.*

Refer to: Subsection 6.4.1, "National Correct Coding Initiative (NCCI) Guidelines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about NCCI MUE guidelines.

3.3 Personal-Use Manual Breast Pump Medical Necessity Criteria

Manual breast pumps (procedure code E0602) are personal-use, hand-operated, handle-squeeze pumps that are appropriate for short-term or occasional uses related to, but not limited to, any of the following:

- Infrequent separation from infants; such as mothers who work or go to school part-time for less than 10 hours per week, and who do not meet criteria for electric or hospital-grade pumps.
- Resolving brief uncomplicated periods of plugged duct
- Short-term concerns of mild engorgement
- Flat, retracted, or inverted nipples, and the mother does not meet the criteria for electric or hospital-grade pumps
- Cracked or fissured nipples, and the mother does not meet the criteria for electric or hospital-grade pumps

Note: *Manual breast pumps are not recommended for pumping on a regular basis, or for attempting to establish a milk supply.*

3.3.1 Specifications

Manual breast pumps must include an independent milk collection bottle. The pump cylinder must not be the milk-collecting container.

3.4 Personal-Use Electric Breast Pump Medical Necessity

Electric Breast Pumps (procedure code E0603) have a motor and are electrically (AC and/or DC) operated. Personal-use double-collection electric breast pumps are recommended for their functionality and efficiency; they allow expression of breast milk from both breasts simultaneously.

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Personal use double-collection electric breast pumps are for mothers and infants who are breastfeeding with limited, minor, or no complications. Personal-use double-collection electric breast pumps are recommended for pumping and maintaining a milk supply related to, but not limited to, any of the following:

- Regular separation from infants; such as mothers returning to work or school for 10 or more hours per week
- Infants detained in the hospital, who do not meet the criteria for a multiple-user electric breast pump
- Significant breast engorgement
- Breast abscess
- Mastitis
- If the mother is to receive short-term treatment with medication or therapies that may be transmitted through breast milk, but she wishes to maintain her milk supply by pumping and discarding her milk in the interim

3.4.1 Specifications

Electric breast pumps must meet the following specifications:

- Be adaptable for simultaneous pumping of both breasts (double-collection)
- Have an adjustable suction pressure range necessary for preventing nipple trauma
- Automatically cycle with an adjustable variable cycling rate, typically 30 to 60 or more cycles per minute
- Include a battery option or adapter to be used as an alternate power source when electricity is not immediately available

Note: *Personal-use, single-collection electric pumps cannot simultaneously pump both breasts. Single-collection pumps are not recommended, as they are neither effective in maintaining a long-term milk supply nor efficient when pumping during short periods, such as work breaks. Double-collection breast pumps are the standard personal-use electric pump recommended by Texas Medicaid for breastfeeding infants and mothers.*

3.5 Hospital-Grade Electric Breast Pump Medical Necessity Criteria

Multiple-user, hospital-grade electric breast pumps (procedure code E0604) are heavy-duty, durable, closed-system pumps designed to be loaned multiple times throughout the pump's lifespan.

Rental of a multiple-user, hospital-grade electric breast pump is recommended for moderate to significant breastfeeding complications. Hospital-grade electric breast pumps are recommended for pumping related to, but not limited to, any of the following:

- Infants who cannot suck well, or have an uncoordinated swallow/suck reflex, due to respiratory disease or congenital disorder
- Infants diagnosed with failure to thrive, cardiac problems, or other special needs
- Infants who are chronically ill
- Infants of low birth-weight with increased nutritional needs
- Infants with severe feeding or digestive problems, as described by the provider in documentation
- Prematurity (less than 37 weeks gestation)
- Multiple births (e.g., twins, triplets, etc.)

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- Long-term separation of mother and infant due to hospitalization
- Mothers experiencing conditions affecting their milk production, or low-milk supply, as described in documentation by the prescribing provider familiar with the client
- Mothers needing to induce lactation for establishing their milk supply, but are unable to do so without a hospital-grade breast pump

Note: *A closed-system pump requires a personal-use milk collection pump kit, included in the rental, but to be kept by the individual and not for return with the pump.*

3.5.1 Specifications

Use of a hospital-grade breast pump may be covered when the use of a hospital-grade breast pump is determined to be medically necessary and appropriate, as documented by the provider.

A hospital-grade electric breast pump must meet the following specifications:

- Be adaptable for simultaneous pumping of both breasts with an adjustable suction for preventing nipple trauma
- Automatically cycle with adjustable or variable cycling that closely mimics the suckling action of an infant
- Electrical (AC and/or DC)
- Include an adapter to be used as an alternate power source when electricity is not immediately available
- Must not allow milk to contact the housing unit or internal pump-motor at any time when the multiple-user pump is used per manufacturer's instructions

3.6 Prior Authorization

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form prescribing the DME and/or supplies must be signed and dated by a physician or an allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department. To complete the prior authorization process electronically, the DME provider must submit the prior authorization requirements through any approved electronic methods.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation for medical necessity of the medical equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for breastfeeding equipment.

3.6.1 Replacement Parts

Prior authorization is not be required for up to 2 replacements of each part within 12 months from the breast pump's date of purchase.

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Prior authorization is required for parts that exceed the limitations outlined in this handbook.

Requests must be submitted with appropriate documentation to support the need for additional replacement parts. The following documentation must be included under "If applicable" in section B of the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form:

- The provider must attest that the mother continues to use the equipment for breastfeeding.
- The provider must indicate that the requested part is required for improved pumping efficiency (e.g., larger flanges), or is damaged or lost and affecting the function of the pump.

3.6.2 Personal-Use Manual or Electric Breast Pumps

Prior authorization is not required for the purchase of a manual or electric personal-use breast pump, within 12 months from the date of birth. Prior authorization is required for the replacement of a manual or electric personal-use breast pump due to damage or loss, within 12 months from the purchase date.

Requests for the replacement of a Texas Medicaid purchased personal-use breast pump (procedure code E0602 or E0603) must include the following documentation:

- A statement from the provider describing the loss or damage and what measures will be taken to prevent reoccurrence
- A copy of the police or fire report, when appropriate. The report must also be maintained in the client's medical record.

Note: *HHSC or its designee reserves the right to request additional documentation about the need for replacement when there is evidence of abuse or neglect to equipment by the client, client's family, or caregiver. Requests for replacement when there is documented proof of abuse or neglect will not be approved.*

3.6.3 Hospital-Grade Breast Pump

The initial 60-day rental of a hospital-grade pump does not require prior authorization.

The subsequent rental of a hospital-grade breast pump does require prior authorization. Subsequent rental requests may be considered for 90-day increments only. A maximum of 3 prior-authorized 90-day increments will be allowed within the 12 months following birth.

If an infant with medical necessity requires the extended rental of a hospital-grade electric breast pump, beyond these limitations, the claim may be considered for reimbursement upon appeal with documentation.

The prescribing provider familiar with the client must identify pumping as the mother's primary method for expressing her breast milk, and must include a statement that clearly describes the infant's medical necessity. Medically necessary conditions may include the following:

- Short-bowel syndrome
- Severe malabsorption syndromes
- Severe feeding intolerances or immunological deficiencies

Clients who no longer qualify for the continued rental of a hospital-grade breast pump may still qualify for the purchase of a breast pump as outlined in this handbook.

Purchase of a manual breast pump will not be reimbursed during the rental of a hospital-grade pump or if a personal-use electric breast pump was already purchased within the frequency limitations outlined in this handbook.

Purchase of a personal-use electric breast pump will not be reimbursed during the rental of a hospital-grade breast pump.

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A hospital-grade electric breast pump will be considered purchased and owned by the client when the monthly payments for rental, through the same provider, equals the purchase cost for the equipment.

The following is required:

- The DME provider must notify the client when the rental equipment is considered purchased due to an extended rental. Proof of ownership must be provided to the client by the DME provider.
- Proof of client ownership of the device is required for reimbursement of replacement parts
- A statement from the DME provider indicating the make and model of the client-owned device, along with proof of client ownership, must be submitted with claim appeals for reimbursement of parts.

A hospital-grade breast pump that has been purchased due to extended rental is anticipated to last the minimum time frame indicated by the manufacturer's warranty.

3.7 Documentation Requirements

Direct care providers must maintain the following documentation in the client's medical record:

- Client's specific medical necessity regarding the specific type of breast pump equipment ordered
- Anticipated duration of need regarding the circumstances or conditions related to the type of equipment ordered
- Infant's age (or gestational age, if premature)
- Documentation of the mother's intent to breastfeed

3.7.1 DME Certification Form

The DME Certification and Receipt Form must be submitted by DME claims and appeals when:

- A single item meets or exceeds a billed amount of $2,500
- Multiple items submitted on the same date of service meet or exceed a total billed amount of $2,500

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the following:

- Name of the item
- Date the client received the DME
- Date signature of the DME provider and the client or client's primary caregiver

The signed and dated form must be maintained by the DME provider in the client's record.

Claims submitted without the DME Certification and Receipt Form will be denied.

Clients who receive DME meeting or exceeding a total billed amount of $2,500 may be contacted to verify receipt of the equipment. If receipt of the equipment cannot be verified, the claim payment is eligible for recoupment.

3.8 Services that are not a Benefit

The following breastfeeding support services are not benefits of Texas Medicaid:

- Personal-use electric breast pumps that are only capable of single-collection pumping, one breast at a time
- Breastfeeding support services in the preconception or prenatal period
- Breastfeeding support services for infants who are not breastfeeding and the mother has no intent to breastfeed

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4 Obstetric Services

4.1 Services, Benefits, Limitations, and Prior Authorization

Antepartum care, antenatal surveillance, perinatal procedures, infant deliveries, and postpartum care are a benefit of Texas Medicaid.

Medicaid reimburses prenatal care, deliveries, and postpartum care as individual services. Providers may choose one of the following options for billing maternity services:

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

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

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and claims must be received by TMHP within 95 days of the date of service.

Medicaid may reimburse only one delivery or Cesarean section procedure code per client in a seven-month period; reimbursement includes multiple births. Delivering physicians who perform regional anesthesia or nerve block do not receive additional reimbursement because these charges are included in the reimbursement for the delivery except when it is decided a cesarean delivery is required following neuraxial labor analgesia. Procedure code 01967 may be reimbursed separately with cesarean procedure codes 59514, 59515, 59620 and 59622.

Refer to: Subsection 9.2.7.3, "Anesthesia for Labor and Delivery" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information related to anesthesia reimbursement.

Procedure code 99140 is not considered for reimbursement when submitted with diagnosis code O80 for a normal delivery or with diagnosis code O82 for a Cesarean delivery when one of these diagnosis codes is documented on the claim as the referenced diagnosis. The referenced diagnosis must indicate the complicating condition. An emergency is defined as a situation when delay in treatment of the client poses a significant health threat to a client's life, bodily organ, or body part.

Hospital admissions resulting from conditions or comorbidities complicating labor should be billed using the appropriate E/M procedure codes. These codes are not subject to the three-day pre-care period but are not payable on the date of delivery or the following six-week post-care period.

The procedure codes listed in the tables below may be reimbursed by Texas Medicaid. Providers can refer to the Texas Medicaid Static Fee Schedules and the Online Fee Look-up for rate and coverage information about specific procedure codes.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures. Medical record documentation must include assessment findings that substantiate the medical necessity for each diagnostic test performed.

4.1.1 Antepartum and Fetal Invasive Procedures

The following procedure codes may be submitted for antepartum and fetal invasive procedures:

Procedure Codes									
36460	59000	59001	59012	59015	59020	59025	59030	59050	59051

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Procedure Codes									
59070	59074	59076	82731	84112					

Antenatal surveillance includes fetal contraction stress test (procedure code 59020), fetal nonstress test (procedure code 59025), and fetal biophysical profile with or without nonstress testing (procedure code 76818 or 76819).

The American Congress of Obstetricians and Gynecologists (ACOG) states "because antepartum fetal surveillance results have not been definitively demonstrated to improve perinatal outcome, all indications for antepartum testing must be considered somewhat relative. In general, antepartum fetal surveillance has been employed in pregnancies in which the risk of antepartum fetal demise is increased." Accordingly, some of the conditions under which testing may be appropriate, include but are not limited to the following:

- Maternal conditions:
  - Antiphospholipid syndrome
  - Hyperthyroidism (poorly controlled)
  - Hemoglobinopathies (hemoglobin SS, SC, or S-thalassemia)
  - Cyanotic heart disease
  - Systemic lupus erythematosus
  - Chronic renal disease
  - Type I diabetes mellitus
  - Hypertensive disorders
- Pregnancy-related conditions:
  - Pregnancy-induced hypertension
  - Decreased fetal movement
  - Oligohydramnios
  - Polyhydramnios
  - Intrauterine growth restriction
  - Postterm pregnancy
  - Isoimmunization (moderate to severe)
  - Previous fetal demise (unexplained or recurrent risk)
  - Multiple gestation (with significant growth discrepancy)

Procedure codes 59020 and 59025 billed with revenue code 729 for outpatient facilities may be reimbursed on the same day by a different provider without appeal; however, if billed more than once per day by the same provider, it will be denied. The provider may appeal with documentation supporting the performance of the test more than once on the same day by the same provider.

A fetal fibronectin (fFN) enzyme immunoassay (procedure code 82731) may be considered for reimbursement through Texas Medicaid when performed between 22 0/7 and 34 6/7 weeks for women with risk factors for preterm labor with or without symptoms of preterm labor.

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Fetal intrauterine transfusion (procedure code 36460) and cordocentesis (procedure code 59012) are restricted to the diagnoses listed in the following table:

Diagnosis Codes							
O353XX0	O353XX1	O353XX2	O353XX3	O353XX4	O353XX5	O353XX9	O358XX0
O360110	O360111	O360112	O360113	O360114	O360115	O360119	O360120
O360121	O360122	O360123	O360124	O360125	O360129	O360130	O360131
O360132	O360133	O360134	O360135	O360139	O360190	O360191	O360192
O360193	O360194	O360195	O360199	O360910	O360911	O360912	O360913
O360914	O360915	O360919	O360920	O360921	O360922	O360923	O360924
O360925	O360929	O360930	O360931	O360932	O360933	O360934	O360935
O360939	O360990	O360991	O360992	O360993	O360994	O360995	O360999
O361110	O361111	O361112	O361113	O361114	O361115	O361119	O361120
O361121	O361122	O361123	O361124	O361125	O361129	O361130	O361131
O361132	O361133	O361134	O361135	O361139	O361190	O361191	O361192
O361193	O361194	O361195	O361199	O361910	O361911	O361912	O361913
O361914	O361915	O361919	O361920	O361921	O361922	O361923	O361924
O361925	O361929	O361930	O361931	O361932	O361933	O361934	O361935
O361939	O361990	O361991	O361992	O361993	O361994	O361995	O361999
O368210	O368211	O368212	O368213	O368214	O368215	O368219	O368220
O368221	O368222	O368223	O368224	O368225	O368229	O368230	O368231
O368232	O368233	O368234	O368235	O368239	O368290	O368291	O368292
O368293	O368294	O368295	O368299	O4690	O4691	O4692	O4693

FIUT (procedure code 36460) is reimbursed as a global fee and, therefore, includes all other services provided by the same physician, including umbilical blood sampling or cordocentesis (procedure code 59012).

Appeals for cordocentesis performed for a diagnosis other than the ones listed in the appropriate table in the policy will be reviewed on a case by case basis.

In addition to the physician performing the FIUT (procedure code 36460), another physician may assist with echography control.

Therapeutic amniocentesis (procedure code 59001) is restricted to the following diagnosis codes:

Diagnosis Codes							
O401XX0	O401XX1	O401XX2	O401XX3	O401XX4	O401XX5	O401XX9	O402XX0
O402XX1	O402XX2	O402XX3	O402XX4	O402XX5	O402XX9	O403XX0	O403XX1
O403XX2	O403XX3	O403XX4	O403XX5	O403XX9	O409XX0	O409XX1	O409XX2
O409XX3	O409XX4	O409XX5	O409XX9				

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Transabdominal amnioinfusion (procedure code 59070), fetal fluid drainage (e.g., vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance (procedure code 59074), and fetal shunt placement, including ultrasound guidance (procedure code 59076) are restricted to one of the following diagnosis codes:

Diagnosis Codes							
O360110	O360111	O360112	O360113	O360114	O360115	O360119	O360120
O360121	O360122	O360123	O360124	O360125	O360129	O360130	O360131
O360132	O360133	O360134	O360135	O360139	O360190	O360191	O360192
O360193	O360194	O360195	O360199	O360910	O360911	O360912	O360913
O360914	O360915	O360919	O360920	O360921	O360922	O360923	O360924
O360925	O360929	O360930	O360931	O360932	O360933	O360934	O360935
O360939	O360990	O360991	O360992	O360993	O360994	O360995	O360999
O361110	O361111	O361112	O361113	O361114	O361115	O361119	O361120
O361121	O361122	O361123	O361124	O361125	O361129	O361130	O361131
O361132	O361133	O361134	O361135	O361139	O361190	O361191	O361192
O361193	O361194	O361195	O361199	O361910	O361911	O361912	O361913
O361914	O361915	O361919	O361920	O361921	O361922	O361923	O361924
O361925	O361929	O361930	O361931	O361932	O361933	O361934	O361935
O361939	O361990	O361991	O361992	O361993	O361994	O361995	O361999

4.1.2 Vaginal and Cesarean Deliveries

The following procedure codes submitted with the appropriate modifier may be a benefit for vaginal or Cesarean deliveries:

Procedure Codes									
59409	59410	59514	59515	59612	59614	59620	59622	S8415*	
*** Procedure code S8415 is for home delivery supplies**									

One of the following modifiers must be billed with the procedure codes indicated above for vaginal and cesarean deliveries:

Modifiers	
U1	Prior to 39 Weeks and Medically Necessary
U2	39 Weeks or Later
U3	Prior to 39 Weeks and Not Medically Necessary

Claims will deny if submitted for a delivery prior to 39 weeks of gestation and not medically necessary, or for a delivery service with no modifier.

Claims will deny or recoupment will occur for associated claims for deliveries that are performed prior to 39 weeks and are determined to be not medically necessary including:

- Claims for the provider performing the vaginal or Cesarean delivery
- Inpatient and outpatient hospital claims inclusive of the delivery, planned Cesarean section, induction with vaginal delivery or failed induction with subsequent Cesarean section
- Birthing center claims inclusive of induction with vaginal delivery

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- Claims for medical or surgical admission, including ICU, due to the complications of the delivery for the mother

Home deliveries must be billed with procedure code 59409 or 59410; including postpartum care.

Licensed midwives will not be reimbursed for home deliveries.

4.1.2.1 Home Deliveries

Home deliveries and the home supplies for the delivery (S8415) require submitting a written prior authorization request during the client's third trimester of pregnancy. Home deliveries will not be prior authorized to a licensed midwife.

Documentation must include:

- A statement signed by a licensed physician who examined the client during the third trimester and determined at the time of examination the client is not at high risk for complications and is suitable for a home delivery
- A plan for access to emergency transport for mother and neonate, if needed

4.1.3 Elective Deliveries Prior to 39 Weeks

Texas Medicaid restricts any Cesarean section, labor induction, or any delivery following labor induction to one of the following criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery

Note: *Records are subject to retrospective review. Payments made for Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria (as determined by review of medical documentation), are subject to recoupment. Recoupment may apply to all services related to the delivery, including additional physician fees, birthing center, and inpatient and outpatient hospital fees.*

4.1.4 Other Vaginal and Cesarean Delivery Procedures

The following vaginal and Cesarean delivery procedures do not require vaginal and Cesarean delivery modifiers:

Procedure Codes	
59414	59525

Refer to: Subsection 4.1.8, "Obstetric Ultrasound" in this handbook for information about ultrasound limitations.

4.1.5 Surgical Treatment of Early Intrauterine Failed Pregnancy

A provider must conduct an evaluation to make a definitive diagnosis of early intrauterine failed pregnancy; this may include a comprehensive medical history and examination, serum human chorionic gonadotropin (hCG) testing, other lab tests, and ultrasound examination.

The following procedure codes may be submitted for surgical management of early intrauterine failed pregnancy. The provider must choose the most appropriate code:

Procedure Codes		
59812	59820	59821

Performing providers must maintain appropriate documentation in the medical record of the client's early intrauterine failed pregnancy and the surgical treatment provided for the individual circumstances.

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Surgical treatment of early intrauterine failed pregnancy (procedure codes 59812, 59820, and 59821) must include one of the following diagnosis codes as the reference or primary diagnosis on the claim. The provider must choose the most appropriate code:

Diagnosis Codes					
O021	O0339	O034	O071	O0730	O0739

4.1.6 Abortion

The following procedure codes may be submitted for abortion services:

Procedure Codes								
59830	59840	59841	59850	59851	59852	59855	59856	59857

Abortion services are benefits of Texas Medicaid if submitted with the following modifier:

Modifier	Description
G7	Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening

In accordance with federal directives, abortions may be reimbursed when performed to save the life of the mother or for pregnancies resulting from rape or incest.

In accordance with federal law, providers are required to use specific language regarding the reason the mother's condition is life-threatening. An abortion for a life-threatening condition must be due to a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion was performed.

Reimbursement of an abortion is based on the physician's certification that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest.

One of the following statements, signed by the physician is mandatory for any abortion performed. Substitute wording will not be accepted. One of these statements must accompany any claim for abortion in order for reimbursement to be made:

- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client's full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place her in danger of death unless an abortion is performed."

  Signature

- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities."

  Signature

- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities."

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Signature

A stamped or typed physician signature on the original certification statement is not acceptable. The physician signature must be an original signature. A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time. The physician must maintain the original certification statement in the client's file.

Abortion services must be billed with modifier G7.

Performing physicians, facilities, anesthesiologists, and certified respiratory nurse anesthetist (CRNA) providers must submit modifier G7 with the appropriate procedure code when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid. Modifier G7 must be submitted with the procedure code that identifies abortion services.

Important: *To bill a Texas Medicaid client for a service that TMHP denies as not medically necessary, the billing provider must ensure that the client or client's guardian has signed an acknowledgment statement. The statement must be obtained by a provider who has contact with the client.*

4.1.6.1 Services Related to Abortion Procedures

An anesthesia service that is provided for an abortion procedure may be reimbursed if the abortion procedure meets medical necessity criteria and complies with the Texas Medicaid guidelines in the section above.

All other services that are related to abortion services are also subject to medical necessity review. All services that are related to a non-covered abortion procedure will be denied or recouped.

4.1.7 Other Maternity Care and Delivery Services

The following procedure codes may be submitted for other maternity care and delivery services:

Procedure Codes									
59100	59160	59200	59300	59320	59325	59350	59412	59870	59871
59897	59898	59899							

4.1.8 Obstetric Ultrasound

The following procedure codes may be submitted for obstetric ultrasound services:

Procedure Codes									
76801	76802	76805	76810	76811	76812	76813	76814	76815	76816
76817									

Texas Medicaid requires providers to follow the documentation requirements as set forth in the Diagnostic Ultrasound section of the Current Procedural Terminology (CPT) manual for the diagnostic studies of the fetus, including when ultrasound is used to guide a procedure.

Documentation requirements set forth in the CPT manual include, but are not limited to:

- Permanently recorded images with measurements, when measurements are clinically indicated
- Final written report included in the client's medical record (includes written interpretation)
- Report must include description of elements that comprised a "complete" or "limited" exam and the reasons an element could not be visualized
- Permanently recorded images are also required for ultrasound guidance procedures of the site to be localized. In addition, description of the localization process, either separately or within the report of the procedure when the guidance is utilized.

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Permanently recorded images must be available on request by the Texas Health and Human Services Commission (HHSC).

Prior authorization is required for greater than three obstetrical ultrasounds per pregnancy. Requests for additional obstetric ultrasounds may be considered when submitted with documentation of medical necessity on the Obstetric Ultrasound Prior Authorization Request Form.

Refer to: Obstetric Ultrasound Prior Authorization Request Form on the TMHP website at www.tmhp.com.

Authorization is not required for obstetric ultrasounds performed in the emergency department, outpatient observation, or inpatient hospital setting.

Texas Medicaid follows the American Congress of Obstetricians and Gynecologists (ACOG) indications for sonography.

First trimester ultrasounds may be medically necessary for, but not limited to, the following conditions:

- Confirm the presence of an intrauterine pregnancy
- Evaluation of a suspected ectopic pregnancy
- Evaluation of vaginal bleeding
- Evaluation of pelvic pain
- Estimation of gestational age
- Diagnosis or evaluation of multiple gestations
- Confirmation of cardiac activity
- Adjunct to chorionic villus sampling or localization and removal of an intrauterine device
- Assessment of certain fetal anomalies, such as anencephaly, in clients at high risk
- Evaluation of maternal pelvic or adnexal masses or uterine abnormalities
- Screening for fetal aneuploidy
- Evaluation of suspected hydatidiform mole

Second- and third-trimester ultrasounds may be medically necessary for the following conditions:

- Estimation of fetal age
- Evaluation of fetal growth
- Evaluation of vaginal bleeding
- Evaluation of cervical insufficiency
- Evaluation of abdominal and pelvic pain
- Determination of fetal presentation
- Adjunct to amniocentesis or other procedure
- Evaluation of suspected multiple gestation
- Evaluation of a significant discrepancy between uterine size and clinical dates
- Evaluation of pelvic mass
- Evaluation of suspected hydatidiform mole
- Adjunct to cervical cerclage placement
- Evaluation of a suspected ectopic pregnancy

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- Evaluation of suspected fetal death
- Evaluation of suspected uterine abnormality
- Evaluation for fetal well-being
- Evaluation of suspected amniotic fluid abnormalities
- Evaluation of suspected placental abruption
- Adjunct to external cephalic version
- Evaluation for premature rupture of membranes or premature labor
- Evaluation for abnormal biochemical markers
- Follow-up evaluation of a fetal anomaly
- Follow-up evaluation of placental location for suspected placenta previa
- Evaluation for clients with a history of previous congenital anomaly
- Evaluation of fetal condition in late registrants for prenatal care
- Assessment of findings that may increase the risk of aneuploidy
- Screening for fetal anomalies

A request for retroactive authorization must be submitted no later than 14 calendar days, beginning the day after the study is completed.

Requests for prior authorization or retroactive authorization may be submitted by mail or an approved electronic method.

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, dated, and maintained in the client's medical record by the provider requesting the test. The form must include information related to medical necessity of the test including all of the following:

- Procedure requested (CPT code) and quantity requested
- The trimester(s) during which the requested ultrasounds will be performed
- The date range during which the procedure(s) will be performed
- Client's estimated date of confinement (EDC) at the time the request is submitted
- Diagnosis

Additional documentation to support medical necessity may include any of the following:

- Treatment history
- Treatment plan
- Medications
- Previous imaging results

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, and dated by the ordering provider (physician, nurse practitioner/clinical nurse specialist, certified nurse midwife [CNM], or physician assistant) when requesting prior authorization for obstetric ultrasounds, regardless of the method of request for authorization.

Residents may order obstetric ultrasounds; however, the attending physician must sign the authorization form and provide the group or supervising provider's NPI

Providers may be requested to provide additional documentation.

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Obstetric ultrasounds provided in the emergency department or outpatient observation must be submitted with Modifier U6 when submitted on the professional claim form in order to be considered for reimbursement.

Obstetric ultrasounds provided in the emergency department or hospital observation must be submitted with the appropriate corresponding emergency services or hospital observation revenue code in order to be considered for reimbursement.

Note: *Any obstetric ultrasound performed in the emergency department or hospital observation will not count toward the limit of three per pregnancy.*

Any obstetric ultrasound claims submitted with or without prior authorization for the initial three will count toward the limit of three per pregnancy.

For transvaginal obstetric ultrasound performed in addition to one of the transabdominal examinations, documentation is required to substantiate the need to perform both tests on the same day.

Reimbursement for obstetric ultrasounds may be considered on appeal when submitted with documentation of any one of the following:

- Ultrasound was performed for a different pregnancy
- The provider was unable to obtain the previous ultrasound records from a different provider
- The provider was new to treating the client and was not aware the client had received three obstetric ultrasounds

Only one appeal will be considered per client for the same provider. Providers must obtain prior authorization for additional obstetric ultrasounds performed after the appealed service.

Add-on procedure codes (76802, 76810, 76812, and 76814) when billed with the primary procedure code for obstetric ultrasounds do not count toward the limit of three per pregnancy.

Claims for add-on codes for multiple fetuses should be billed with Modifier 76 if greater than one additional fetus. Claims for multiple fetuses greater than two will be considered on appeal with documentation indicating number of fetuses.

Three dimensional (3-D) rendering of obstetric ultrasound (procedure code 76376 or 76377) is not a benefit of Texas Medicaid.

Procedure code 76810 must be billed in conjunction with primary procedure code 76805, by the same provider.

Procedure code 76812 must be billed in conjunction with primary procedure code 76811, by the same provider.

Procedure code 76814 must be billed in conjunction with primary procedure code 76813, by the same provider.

4.1.9 Diagnostic Ultrasound and Ultrasonic Guidance

The following procedure codes may be submitted for diagnostic ultrasound and ultrasonic guidance services:

Procedure Codes			
76818	76819	76941	76946

Ultrasonic guidance (procedure code 76941) is restricted to the diagnoses listed in the following table:

Diagnosis Codes							
O353XX0	O353XX1	O353XX2	O353XX3	O353XX4	O353XX5	O353XX9	O358XX0

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Diagnosis Codes							
O360110	O360111	O360112	O360113	O360114	O360115	O360119	O360120
O360121	O360122	O360123	O360124	O360125	O360129	O360130	O360131
O360132	O360133	O360134	O360135	O360139	O360190	O360191	O360192
O360193	O360194	O360195	O360199	O360910	O360911	O360912	O360913
O360914	O360915	O360919	O360920	O360921	O360922	O360923	O360924
O360925	O360929	O360930	O360931	O360932	O360933	O360934	O360935
O360939	O360990	O360991	O360992	O360993	O360994	O360995	O360999
O361110	O361111	O361112	O361113	O361114	O361115	O361119	O361120
O361121	O361122	O361123	O361124	O361125	O361129	O361130	O361131
O361132	O361133	O361134	O361135	O361139	O361190	O361191	O361192
O361193	O361194	O361195	O361199	O361910	O361911	O361912	O361913
O361914	O361915	O361919	O361920	O361921	O361922	O361923	O361924
O361925	O361929	O361930	O361931	O361932	O361933	O361934	O361935
O361939	O361990	O361991	O361992	O361993	O361994	O361995	O361999
O368210	O368211	O368212	O368213	O368214	O368215	O368219	O368220
O368221	O368222	O368223	O368224	O368225	O368229	O368230	O368231
O368232	O368233	O368234	O368235	O368239	O368290	O368291	O368292
O368293	O368294	O368295	O368299	O4690	O4691	O4692	O4693

Ultrasonic guidance for intrauterine fetal transfusion (procedure code 76941) will be reimbursed separately when billed by a different physician.

Fetal biophysical profile (procedure code 76818 or 76819), when billed with 76805, 76810, 76811, 76812, 76813, 76814, 76815, or 76816, will be reimbursed separately.

4.1.10 Doppler Studies

The following procedure codes may be submitted for doppler study services:

Procedure Codes	
76820	76821

As supported by ACOG, umbilical artery doppler (procedure code 76820) is limited to suspected intrauterine growth restriction (IUGR), post-term gestation, diabetes mellitus, systemic lupus erythematosus, or antiphospholipid antibody syndrome.

Middle cerebral artery doppler (procedure code 76821) is indicated, but not limited to fetuses who are alloimmunized.

4.1.11 Echocardiography

The following procedure codes may be submitted for echocardiography services:

Procedure Codes			
76825	76826	76827	76828

Fetal echocardiography (procedure codes 76825, 76826, 76827, and 76828) may be reimbursed for the following factors/syndromes:

- Fetal Risk Factors

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- Extracardiac anomalies
  - Chromosomal
  - Anatomic
- Fetal cardiac dysrhythmia
  - Irregular rhythm
  - Tachycardia
  - Bradycardia
- Nonimmune hydrops fetalis
- Suspected cardiac anomaly on ultrasound
- Abnormal fetal situs

- Maternal Risk Factors
  - Congenital heart disease
  - Cardiac teratogen exposure
    - Lithium
    - Alcohol
    - Phenytoin
    - Trimethadione
    - Isoretinoin
  - Maternal Metabolic Disorders
    - Diabetes mellitus
    - Phenylketonuria
- Familial Risk Factors for congenital heart disease
  - Previous sibling
  - Paternal
- Syndromes
  - Marfan's
  - Noonan's
  - Tuberous sclerosis

4.1.12 Fetal Surgery

The following procedure codes may be submitted for fetal surgery:

Procedure Codes						
59072	S2401	S2402	S2403	S2405	S2409	S2411

Fetal surgery procedures require prior authorization.

Prior authorization requests must be submitted on a Special Medical Prior Authorization (SMPA) Request Form to the SMPA department.

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Refer to: Special Medical Prior Authorization (SMPA) Request Form on the TMHP website at www.tmhp.com.

Procedure codes S2401, S2402, S2403, S2405 and S2409 may be authorized for Texas Medicaid only when the hospital is a member of the North American Fetal Therapy Network (NAFTNet).

The pediatric surgeon for procedure codes S2401, S2402, S2403, S2405, or S2409 must submit documentation which includes:

- A clear description of the fetal malformation(s). The malformation(s) must interfere with the in utero organ development and fetal survival and have potential fatal consequences before or after birth
- Evidence that in utero correction of the fetal congenital malformation(s) results in a clinical outcome that is better than that which would be seen in expectant management

Note: *Services and procedures that are investigational or experimental are not a benefit of Texas Medicaid.*

Umbilical cord occlusion (procedure code 59072) may be considered when all the following is documented:

- Diagnosis of monoamniotic-monochorionic twins is present
- Spontaneous fetal death of one of the twins with the presence of hydrops
- The ratio of the acardia twin weight to the pump twin weight is greater than 50 percent
- The abdominal circumference of the twin with reversed arterial perfusion fetus is greater than or equal to the abdominal circumference of the pump twin

Note: *Elective abortions are not benefits of Texas Medicaid*

Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome (procedure code S2411) may be considered when all the following are documented:

- Fetal gestational age of less than 26 weeks
- Evidence of polyhydramnios in the recipient fetus
- Donor fetus is oligohydramniotic
- Evidence of abnormal blood flow documented by Doppler studies in one or both fetuses

4.1.13 Antenatal and Postnatal Care Visits

The following procedure codes may be submitted for antenatal and postnatal care visits:

Procedure Codes									
59430	99202	99203	99204	99205	99211	99212	99213	99214	99215
99341	99342	99344	99345	99347	99348	99349	99350		

Texas Medicaid reimburses prenatal care, deliveries, and postpartum care as individual procedures.

Prenatal and postpartum care visits billed in an inpatient hospital (place of service 3), will be denied as part of another procedure when billed within the three days before delivery or the six weeks after delivery. The inpatient intrapartum and postpartum care are included in the fee for the delivery or Cesarean section and should not be billed separately.

Physicians (obstetricians, family practice physicians, and maternal-fetal medicine specialists), CNMs, and maternity service clinics (MSCs) are limited to 20 prenatal care visits per pregnancy and one postpartum care visit after discharge from the hospital.

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Licensed midwives (LMs) are limited to 20 outpatient antepartum care visits per pregnancy to be performed in a birthing center; postpartum visits are not separately reimbursed. Routine pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk obstetrical visits are not limited to 20 visits per pregnancy. The provider can appeal with documentation supporting a complication of pregnancy. Documentation reflecting the need for increased visits must be maintained in the physician's files and is subject to retrospective review.

Providers must bill the most appropriate new or established patient prenatal or postnatal visit procedure code. New patient codes may be used when the client has not received any professional services from the same physician, or another physician of the same specialty who belongs to the same group, within the past three years (36 months).

New patient and established patient evaluation and management services for antenatal and postnatal visits (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) may be provided via a telemedicine service delivered using synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit.

New and established patient evaluation and management services delivered using synchronous audio-visual technology must be billed using modifier 95.

Refer to: *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) and the *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) restrictions for services delivered using synchronous audiovisual technology.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: Subsection 9.2.60.1.1, "New and Established Patient Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about established patient E/M services.

When billing for prenatal services, use modifier TH with the appropriate E/M procedure code to the highest level of specificity.

Note: *Failure to use the TH modifier may result in recoupment of payment rendered.*

LMs are not reimbursed for postpartum visits.

One postpartum care procedure code may be reimbursed per pregnancy. The claim for the postpartum visit may be submitted with either procedure code 59430 or with a delivery procedure code (59410, 59515, 59614, or 59622) that includes postpartum care. The reimbursement amount for the submitted procedure code covers all postpartum care per pregnancy regardless of the number of postpartum visits provided.

Postpartum depression screening is a benefit at the infant's Texas Health Steps medical checkup or follow-up visit, as a separately reimbursed service in the 12 months following the infant's birth.

Refer to: Section 4.3.12.1.4, "Postpartum Depression Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information regarding postpartum depression screening for mothers during the infant's Texas Health Steps medical checkup or follow-up visit.

Any other E/M office visit will not be reimbursed when billed on the same date of service, by the same provider, as any antenatal or postpartum office visit. Modifier 25 may be used to identify a significant separately identifiable E/M service by the same physician on the same date of service as the procedure

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or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Note: *All unlisted surgical procedure codes have a 42 global period assigned by Texas Medicaid.*

4.1.13.1 Maternity Service Clinic (MSC)

MSCs are limited provider clinics, unrelated to a hospital, that only provide maternity services. An MSC will be reimbursed for antepartum and/or postpartum care visits only. Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for antepartum care and not separately reimbursed. Services other than antepartum and postpartum care visits will be denied.

4.1.14 Birthing Centers—Professional Services

The following procedures may be performed by professionals in the birthing center setting:

Procedure Codes				
59409	59410***	99221	99222	99223
***Licensed Midwives may not use code 59410.				

The following table includes procedure codes that may be benefits for licensed midwife (LM) services rendered in the birthing center setting:

Procedure Codes						
59409	99202	99211	99212	99221	99222	99223

Note: *Licensed Midwives may not use code 59410.*

Antenatal services provided by LMs may be a benefit when billed with modifier TH. If the client is discharged prior to delivery, procedure codes 99221, 99222, or 99223 may be billed by the professional for labor services only. Clinical documentation that clearly demonstrates level of medical decision making (i.e., moderate or complex) must be included in the client's medical record. All medical documentation is subject to retrospective review. Those services not supported by the documentation in the client's medical record are subject to recoupment.

Refer to: Subsection 9.2.47, "Newborn Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information related to the care of the newborn.

4.1.15 Birthing Centers—Facility Services

The following procedures may be performed by birthing center facilities:

Procedure Codes	
59409	S4005

Deliveries at a facility licensed as a birthing center by the Department of State Health Services (DSHS) must be billed with procedure code 59409.

If the client is discharged prior to delivery, procedure code S4005 may be billed by the facility for labor services only.

4.1.16 Smoking and Tobacco Use Cessation Counseling

Counseling for cessation of the habit of using tobacco products by pregnant women is a benefit of Texas Medicaid.

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The following procedure codes listed may be billed for smoking and tobacco use cessation counseling using an applicable diagnosis code:

Procedure Codes	
99406	99407

One of the following diagnosis codes must be submitted for tobacco use cessation with the appropriate procedure code:

Diagnosis Codes					
O99330	O99331	O99332	O99333	O99334	O99335

Refer to: Subsection 9.2.60.4.3, "Smoking and Tobacco Use Cessation Counseling" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information related to smoking and tobacco use cessation counseling and additional covered diagnoses.

Procedure codes 99406 and 99407 are limited to once per day, same or different procedure code, any provider.

Smoking and tobacco use cessation counseling delivered by group modality are limited to a maximum of 8 individuals and must be billed with modifier HQ.

Procedure codes 99406 and 99407 may be billed in any combination, individual or group, by the same or different provider, and are limited to eight services per rolling year. Additional services require documentation of medical necessity to exceed the established limit.

4.1.17 Zika Virus Testing

Refer to: Subsection 2.2.11.1, "Zika Virus Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for information about Zika virus testing.

5 Noninvasive Prenatal Screening (NIPS)

Noninvasive prenatal screening (NIPS) is a benefit of Texas Medicaid when medically necessary for the advanced screening of fetal chromosomal abnormalities in pregnant women who meet specific screening criteria. Genetic screening results, when informative, may influence clinical management decisions.

NIPS may be performed as early as ten weeks gestation for specific fetal aneuploidy screening, restricted to Trisomy 13, Trisomy 18, Trisomy 21, and fetal sex chromosome aneuploidy (SCA). To determine NIPS appropriateness, a baseline ultrasound, if not previously performed, is strongly recommended to confirm viability, the number of fetuses, and gestational dating.

If NIPS provides an abnormal screening result, invasive prenatal confirmatory diagnostic testing is strongly encouraged due to the potential risk of a false-positive result from NIPS. Confirmatory diagnostic tests include chorionic villus sampling (CVS) or amniocentesis.

It is recommended that clients who receive an indeterminate result be offered further genetic counseling, comprehensive evaluation with ultrasound, and diagnostic testing due to the increased risk of aneuploidy. Higher body mass index (BMI) may affect NIPS results. Clients weighing more than 250 pounds are at risk of having an inconclusive result from NIPS.

NIPS does not assess the risk for fetal anomalies such as neural tube defects or ventral wall defects. Ultrasound evaluation and maternal serum alpha-fetoprotein screening should be offered for these risk assessments.

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If a fetal structural anomaly (e.g., hydrops, cystic hygroma, cardiac malformations, abdominal wall defects, or skeletal abnormalities) is identified upon ultrasound examination, it is recommended that diagnostic testing be offered rather than NIPS.

NIPS is a benefit for a confirmed intrauterine singleton pregnancy when serum analyte testing with any of the following screening tests were previously elected for the current pregnancy instead of NIPS, the results indicate an increased risk of Trisomy 13, Trisomy 18, or Trisomy 21, and the client wishes to postpone invasive diagnostic testing:

- First trimester screen
- Sequential screen
- Integrated screen
- Quadruple screen

NIPS must be ordered by the medical provider rendering direct care to the client. The provider must order the most appropriate screening based on the client's medical history and the results of previous screenings, if available. The provider must clarify for the client the option to decline, and the provider must document that the option to decline was clearly provided in the client's medical record.

Note: *Some noninvasive prenatal screenings include an extended panel that screens for microdeletions and additional trisomies, such as T16 and T22. However, this use has not been validated, and the "opt-out" box on the requisition form should be checked.*

5.1 Screening for Fetal Sex Chromosome Aneuploidy

In addition to trisomy (e.g., T13, T18, T21), NIPS may also screen for fetal SCA (e.g., 45, X; 47, XXX; 47, XXY; 47, XYY).

Note: *Currently, clinical evidence is unclear for concluding the net health benefits when using cell-free fetal DNA to screen for fetal sex chromosome aneuploidy (SCA). The potential benefit of early detection for management must be balanced against potential harms, stigmatization, and distorted perceptions of the child.*

Sex chromosome aneuploidy of maternal origin should be considered when NIPS results suggest fetal sex chromosome aneuploidy (e.g., 45, X; 47, XXX, 47, XXY; 47, XYY). Other considerations include the risk for incidental findings with NIPS. Appropriate client counseling is encouraged.

5.1.1 Screening Criteria

NIPS is a benefit for clients with a confirmed intrauterine singleton pregnancy dated at least ten weeks gestation.

5.2 Genetic Counseling Requirement

Genetic counseling must be provided by a trained genetic counselor, nurse specialist in genetics, maternal-fetal medicine specialist, or other medical provider (e.g., obstetrician) possessing expertise in genetic counseling. Genetic counseling must provide the depth of content and time for the client to make an informed decision.

The client must be provided with information about the purpose and nature of the screenings. Documentation in the medical record must reflect that the client has been given information on the benefits, risks, and limitations of advanced screening; as well as the nature, inheritance, and implications of genetic disorders. Documentation requirements include all of the following:

- Genetic counseling includes all of the following:
  - The date(s) that formal genetic counseling was provided, with the name and qualifications of the counseling professional

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- The explanation of risks, benefits, and limitations that was discussed with the client
- The client's ability to understand the risks, benefits, and limitations and the client's informed choice to proceed with NIPS as evidenced by the client's signature on a consent form specific to the NIPS to be performed
- The client's other prenatal radiological or lab results, if available, to support medical necessity of NIPS
- The client's NIPS results
- The clear, non-directive explanation provided to the client concerning the findings and implications of the NIPS results
- The client's ability to understand the results and explanation provided

The genetic counseling must be nondirective. The purpose of the provider's information is not to direct the client, but to allow the client to make informed medical and personal decisions.

Clients should be informed that a negative NIPS result does not ensure an unaffected pregnancy.

5.3 Prior Authorization

Prior authorization is not required for NIPS procedure codes 81420 and 81507.

A no-call or inconclusive result is possible and further diagnostic testing is strongly recommended in these cases.

NIPS procedure codes 81420 and 81507 are limited to once per pregnancy. Additional tests will not be reimbursed.

Note: *Providers may appeal denied claims with documentation of a new pregnancy.*

5.3.1 Additional Documentation Requirements

In addition to the documentation of genetic counseling, and the option to decline NIPS provided to the client, the following NIPS documentation must also be maintained in the client's medical record and is subject to retrospective review:

- The appropriateness and benefit of NIPS specific to the client

5.4 NIPS Limitations

Procedure codes 81507 and 81420 are restricted to female clients only who are 10 through 55 years of age. Procedure code 81420 will be denied when billed during the same pregnancy as procedure code 81507, by any provider. Claims that have been paid for procedure code 81420 are subject to recoupment if procedure code 81507 is submitted later for the same pregnancy.

5.5 Non-Covered Services

The following NIPS services are not a benefit of Texas Medicaid:

- NIPS as part of a routine prenatal laboratory assessment
- NIPS if performed without informed patient choice and genetic counseling from a qualified professional
- NIPS for women who do not meet the criteria outlined above
- NIPS for women with multiple gestations (e.g., twins, triplets, etc.)
- NIPS for screening of chromosomal microdeletion syndromes
- NIPS for screening of trisomy other than T13, T18, or T21

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- NIPS for sex determination, paternity determination, or non-medical reasons
- NIPS is not reimbursed with procedure code 81599

6 Gynecological Health Services

6.1 Services, Benefits, Limitations, and Prior Authorization

Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

The following gynecological procedures and services may be benefits of Texas Medicaid:

- Gynecological and family planning examinations
- Contraceptives
- Diagnostic tests
- Surgical procedures
- Gynecological treatments

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in this handbook for information about contraception, sterilizations, and family planning annual examinations.

6.2 Surgical and Laparoscopic Treatment of Ectopic Pregnancy

Surgical and laparoscopic treatment of ectopic pregnancy (procedure codes 59120, 59121, 59130, 59136, 59140, 59150, and 59151) is a benefit of Texas Medicaid.

6.3 Laparoscopic Procedures

Laparoscopic procedures (procedure codes 58545, 58546, 58578, and 58674) are a benefit of Texas Medicaid.

6.4 Endometrial Cryoablation

Endometrial cryoablation (procedure codes 58353 and 58356) is a benefit of Texas Medicaid.

6.5 Uterine Suspension

Uterine suspension (procedure codes 58400 and 58410) is a benefit of Texas Medicaid.

6.6 Vulvectomy

Vulvectomy (procedure code 56620) is a benefit of Texas Medicaid.

6.6.1 Prior Authorization for Vulvectomy

Prior Authorization is required for vulvectomy.

The prior authorization request must include documentation of one of the following conditions:

- Vulvar intraepithelial neoplasia (VIN)
- Labial enlargement that results in abrasion, irritation, or intractable skin infection

Note: *A vulvectomy will not be considered for cosmetic reasons.*

6.7 Salpingostomy

Salpingostomy (procedure codes 58673 and 58770) is a benefit of Texas Medicaid.

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6.7.1 Prior Authorization for Salpingostomy

Prior authorization is required for salpingostomy.

The prior authorization request must include documentation of one or more of the following conditions:

- Ectopic pregnancy
- Hydrosalpinx unrelated to infertility
- Salpingitis unrelated to infertility
- Torsion of the fallopian tube
- Abscess of the fallopian tube
- Peritubal adhesions unrelated to infertility
- Cyst or tumor of the fallopian tube unrelated to infertility
- Hematosalpinx

6.8 Ovarian Wedge Resection

Ovarian wedge resection (procedure code 58920) is a benefit of Texas Medicaid.

6.8.1 Prior Authorization for Ovarian Wedge Resection

Prior Authorization is required for ovarian wedge resection.

The prior authorization request must include documentation of polycystic ovarian syndrome (PCOS).

Note: *Ovarian wedge resection will not be considered to improve chances of conceiving if the PCOS lead to infertility.*

6.9 Assays for the Diagnosis of Vaginitis

Vaginitis assay procedure codes 87478, 87480, 87484, 87510, 87660, 87661, 87797, 87798, and 87800 are benefits of Texas Medicaid.

Providers are reminded to code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 87797.

Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If a positive test result was not treated, documentation must be present indicating why treatment was not rendered.

6.10 Hysteroscopy

Hysteroscopy (procedure codes 58555, 58558, 58559, 58560, 58561, 58562, 58563, and 58579) is a benefit of Texas Medicaid.

6.11 Examination Under Anesthesia

Pelvic examination under anesthesia (procedure code 57410) is considered part of another gynecological surgery performed the same day.

If the examination is performed as an independent procedure or at the time of a nongynecological surgery, the procedure may be reimbursed.

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6.12 Laminaria Insertion

Insertion of a laminaria or dilateria (procedure code 59200) is a benefit of Texas Medicaid.

6.13 Hysterectomy Services

Texas Medicaid reimburses hysterectomies when they are medically necessary. Texas Medicaid does not reimburse hysterectomies performed for the sole purpose of sterilization.

Providers can use any of the following procedure codes to submit claims for hysterectomy procedures:

Procedure Codes									
51925	58150	58152	58180	58200	58210	58240	58260	58262	58263
58267	58270	58275	58280	58285	58290	58291	58292	58294	58541
58542	58543	58544	58548	58550	58552	58553	58554	58570	58571
58572	58573	58575	59525						
Providers can refer to the Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for components and fees that may be reimbursed.									

6.13.1 Hysterectomy Acknowledgment

Hysterectomy services are considered for reimbursement when a signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is faxed to TMHP, the claim is filed with a signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form, or documentation supporting that the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form could not be obtained or was not necessary.

All Texas Medicaid clients (including those in a STAR or STAR+PLUS Program health plan) receiving hysterectomy services must sign a Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form. The acknowledgment must be submitted to TMHP with the claim or to the client's health plan.

The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form must be signed and dated by the client. The statement must indicate that the client was informed both orally and in writing before the surgery that the hysterectomy would leave her permanently incapable of bearing children.

Note: *A client representative's signature will be required for mentally incompetent clients.*

The client's eligibility file is updated upon receipt of the signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form. Claims for services related to the hysterectomy cannot be reimbursed unless the signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is on file; therefore to avoid claim denials, each individual provider involved in the hysterectomy procedure is encouraged to submit a copy of the valid Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form rather than relying on another provider to do so.

The provider is responsible for maintaining the original, signed copy of the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form in the client's medical record when a claim is submitted for consideration of payment. These records are subject to retrospective review.

When a hysterectomy, whether abdominal or vaginal, is performed without a client's acknowledgement form:

- The hysterectomy procedure code is denied.
- The other surgical procedures are evaluated for their clinical relevance.
- Multiple procedures are processed according to the multiple surgery guidelines.

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A Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not required if the performing physician certifies that at least one of the following circumstances existed before the surgery:

- The patient was already sterile before the hysterectomy, and the cause of the sterility is stated (e.g., congenital disorder, sterilized previously, or postmenopausal). Providers must use a post menopause or sterilization diagnosis code on the claim form. If the provider submits a claim and does not attach the acknowledgment, the provider must maintain the signed statement in the client's records, and the physician's signature will not be required on the claim form. These records are subject to retrospective review.
- The patient requires a hysterectomy on an emergency basis because of a life-threatening situation. The physician must state the nature of the emergency and certify that it was determined that prior acknowledgment was not possible. Because the acknowledgment may be signed the day of or an hour before surgery, an emergency situation requires that the patient be unconscious or under sedation and unable to sign the acknowledgment.

Although the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not required if the criteria previously listed are met, the performing physician must certify that one or more of the circumstances existed prior to the surgery. This certification may be submitted before the claim is submitted or attached to the claim and signed by the performing provider.

Refer to: Title 42 of CFR 441.255 and 25 TAC Part 1, Chapter 29, Subchapter F, section 25.501 for more information.

Refer to: Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

For clients with retroactive Medicaid coverage, one of the following must be submitted with the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form:

- A copy of the client's Your Texas Benefits Medicaid card, which covers the date of the hysterectomy.
- A copy of the retroactive approval notice for Medicaid coverage.

Faxing Forms

All Medicaid providers may fax the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form to 1-512-514-4218. The form must include the client's Texas Medicaid number. All consent forms should be faxed with a cover sheet that identifies the provider and includes the telephone number and address. If the fax is incomplete or the consent form is invalid, the form is returned by mail or fax for correction. Completed consent forms that are faxed for adjustments or appeals are validated in the TMHP system. However, claims associated with the consent forms must be appealed through the mail to Appeals/Adjustments at the following address:

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

6.14 Pap Smear (Cytopathology Studies)

Pap smears are benefits of Texas Medicaid for early detection of cancer. Family planning clients are eligible for annual Pap smears. Procurement and handling of the Pap smear are considered part of the E/M of the client and are not reimbursed separately.

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The following procedure codes are reimbursed only to pathologists and CLIA-certified laboratories (whose directors providing technical supervision of cytopathology services are pathologists):

Procedure Codes									
88142	88143	88147	88148	88150	88152	88153	88155	88164	88165
88166	88167	88174	88175						

These procedure codes must be billed with the place of service where the Pap smear is interpreted.

Procedure code 88141 is reimbursed in addition to and when billed with the cytopathology procedure codes in the table above.

Procedure code 88155 will only be reimbursed when billed in conjunction with one of the following procedure codes on the same date of service by the same provider:

Procedure Codes									
88142	88143	88147	88148	88150	88152	88153	88164	88165	88166
88167	88174	88175							

Note: *Pap smear procedures will not be reimbursed separately to either the physician or a laboratory when billed on the same day as a THSteps medical check-up visit.*

6.15 Clitoroplasty and Vaginoplasty

Clitoroplasty and vaginoplasty are performed for clients who possess ovaries and are female by genetic sex, but the external genitalia are not those of a normal female. Surgical correction of abnormalities of the external genitalia is the only indicated treatment for this disorder. Clitoroplasty and vaginoplasty procedure codes 56805 and 57335 may be considered for reimbursement for female clients who are 20 years of age and younger when submitted for reimbursement with one of the following diagnosis codes:

Diagnosis Codes							
E250	E258	E259	E271	E272	E2740	E2749	E3450
E3451	E3452	Q560	Q561	Q562	Q563	Q564	

6.16 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological services.

Gynecological health services are subject to retrospective review and recoupment if documentation does not support the service billed.

6.17 Claims Filing and Reimbursement

Gynecological services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Super-bills, or itemized statements, are not accepted as claim supplements.

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Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in the *Section 6: Claims Filing* (*Vol. 2, Provider Handbooks*).

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

Section 104 of the *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982 requires that Medicare and Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.

6.17.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page or correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

6.18 National Drug Code

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

7 Claims Resources

Resource	Location
2017 Claim Form Instructions	Subsection 6.8, "Family Planning Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

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Resource	Location
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

8 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday – Friday from 7 a.m. to 7 p.m., Central Time.

9 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)
Abortion Certification Statements Form
Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information
2017 Claim Form

10 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Family Planning Claim Form
Nurse Practitioner/Clinical Nurse Specialist (Family Planning)

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HEALTH AND HUMAN SERVICES COMMISSION FAMILY PLANNING PROGRAM SERVICES HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human Services

HEALTH AND HUMAN SERVICES COMMISSION FAMILY PLANNING PROGRAM SERVICES HANDBOOK

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1 Provider Enrollment for HHSC Family Planning Program Contractors

Agencies that submit claims for HHSC Family Planning Program Services must have a contract with HHSC. The HHSC Family Planning Program determines client eligibility and benefits. Refer to the HHSC Family Planning Program Policy Manual for specific eligibility, services, and policy information at www.hhs.texas.gov/handbooks/family-planning-program-policy-manual.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 2.1, "Title XIX Provider Enrollment" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 1.1, "Family Planning Overview" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about family planning funding sources, guidelines for family planning providers, and family planning services for undocumented aliens and legalized aliens.

2 Services, Benefits, Limitations, and Prior Authorization

This section contains information about family planning services funded through the HHSC Family Planning Program funding source, including:

- Health history and physical.
- Counseling and education.
- Laboratory testing.
- Provision of a contraceptive method.
- Pregnancy tests.
- Postpartum depression screenings and treatment.
- Uncomplicated diabetes screenings and treatment.
- Uncomplicated hypertension screenings and treatment.
- Elevated cholesterol screenings and treatment.
- Sexually transmitted infection screenings and treatment.
- Referrals for additional services, as needed.
- Immunizations.
- Breast and cervical cancer screening and diagnostic services.
- Prenatal services.
- Other services subject to available funding.

Providers are encouraged to include the appropriate diagnosis codes on the claim in conjunction with all family planning procedures and services.

Refer to: The *HHSC Family Planning Program Policy Manual*.

The choice of diagnosis code must be based on the type of family planning service performed.

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2.1 Family Planning Annual Exams

An annual family planning exam consists of a comprehensive health history and physical examination, including medical laboratory evaluations as indicated, an assessment of the client's problems and needs, and the implementation of an appropriate contraceptive management plan.

HHSC family planning program providers must bill the most appropriate evaluation and management (E/M) with modifier FP visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, providers must include the appropriate E/M procedure codes and must be billed with modifier FP on the claim in conjunction with all family planning procedures and services.

Refer to: The *HHSC Family Planning Program Policy Manual*

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

Billing Criteria	Frequency
New patient: Appropriate E/M procedure code with modifier FP	One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group
Established patient: Appropriate E/M procedure code with modifier FP	Once per state fiscal year*
*** The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same state fiscal year.**	

For appropriate claims processing, providers are encouraged to use a family planning diagnosis code to bill the annual family planning exam.

Refer to: The *HHSC Family Planning Program Policy Manual*

An annual family planning examination (billed with modifier FP) will not be reimbursed when submitted with the same date of service as an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using Modifier 25 to indicate that the client's condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

2.1.1 FQHC Reimbursement for Family Planning Annual Exams

FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the *HHSC Family Planning Program Policy Manual*.

The annual exam is allowed once per fiscal year, per client, per provider. Other family planning office or outpatient visits may be billed within the same year.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Refer to: The *HHSC Family Planning Program Policy Manual*.

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2.2 Family Planning Office or Outpatient Visits

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

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

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

Refer to: The *HHSC Family Planning Program Policy Manual* for more information about general family planning office or outpatient visits.

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for general family planning office or outpatient visits:

Billing Criteria	Frequency
New patient: Appropriate E/M procedure code	One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group
Established patient: Appropriate E/M procedure code	As needed*
*** The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same state fiscal year.**	

For appropriate claims processing, providers are encouraged to use a family planning diagnosis code to bill the annual family planning exam.

Refer to: www.tmhp.com/resources/rate-and-code-updates/hcpcs-updates

2.2.1 FQHC Reimbursement for Family Planning Office or Outpatient Visits

FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated previously in the tables in the *HHSC Family Planning Program Policy Manual*.

The new patient procedure codes will be limited to one new patient E/M procedure code three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

A general family planning office or outpatient visit (billed without modifier FP) will not be reimbursed when submitted with the same date of service as an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client's condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

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Refer to: The *HHSC Family Planning Program Policy Manual*.

Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about FQHC services.

2.2.1.1 Laboratory Procedures

Refer to: The *HHSC Family Planning Program Policy Manual* for more information about laboratory procedures.

Appropriate documentation must be maintained in the client's record.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The TMHP website Required CLIA Lab Certifications web page at https://www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

2.3 Immunization Administration

Refer to: The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for medications, immunizations, and vaccines.

2.3.1 Human Papilloma Virus (HPV) Vaccine

Refer to: The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for medications, immunizations, and vaccines for HPV.

2.4 Radiology

Refer to: The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for radiology services performed for the purpose of localization of an IUD.

2.5 Contraceptive Devices and Related Procedures

2.5.1 Barrier Contraceptives

Refer to: The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for barrier contraceptives separately from fitting and instruction.

2.5.2 IUD

Refer to: The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for IUDs and the insertion of IUDs.

2.5.2.1 Removal of the IUD

Refer to: The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for the removal of an IUD.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD removal procedure code or the IUD replacement procedure code, the following reimbursement may apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- The removal or the replacement of the IUD will be denied.

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2.5.3 Contraceptive Implants

The contraceptive implant, procedure code J7307, and the implantation of the contraceptive implant, procedure code 11981, and the removal of the contraceptive implant, procedure codes 11982 and 11983, may be reimbursed.

Progesterone-containing subdermal contraceptive implants (Norplant) were previously used for birth control. Although subdermal contraceptive implants are no longer approved by the FDA, the removal of the implanted contraceptive implant may be considered for reimbursement.

Refer to: The *HHSC Family Planning Program Policy Manual* for the appropriate contraceptive implant removal procedure code.

2.6 Drugs and Supplies

Refer to: The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for providing contraceptive methods.

2.6.1 Prescriptions and Dispensing Medication

Providers may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill the HHSC Family Planning Program.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to the HHSC Family Planning Program. Only providers with an appropriate pharmacy license may be reimbursed for dispensing family planning drugs and supplies. Provider types with an appropriate pharmacy license may be reimbursed for dispensing up to a one-year supply of contraceptives in a 12-month period.

Refer to: The *HHSC Family Planning Program Policy Manual* for more information about dispensing contraceptives.

HHSC Family Planning Program clients may have their prescriptions filled at the clinic pharmacy. HHSC Family Planning Providers can refer to the *HHSC Family Planning Policy and Procedure Manual* for additional guidance on dispensing medication.

2.6.2 Oral Medication Reimbursement

Refer to: The *HHSC Family Planning Program Policy Manual* for more information about oral medication.

2.7 Family Planning Education

Refer to: The *HHSC Family Planning Program Policy Manual* for the procedure codes that may be reimbursed for providing Contraceptive Method Instruction.

2.7.1 Medical Nutrition Therapy

For clients requiring intensive nutritional guidance, medical nutritional therapy can be provided as an allowable and billable service. Medical nutritional therapy, however, must be provided by a registered dietician in order to be reimbursed.

Refer to: The *HHSC Family Planning Program Policy Manual* for more information about medical nutritional therapy.

2.7.2 Instruction in Natural Family Planning Methods

Counseling with the intent to instruct a couple or an individual in methods of natural family planning may be reimbursed twice a year.

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Refer to: The *HHSC Family Planning Program Policy Manual* for more information about natural family planning.

2.8 Sterilization and Sterilization-Related Procedures

2.8.1 Sterilization Consent

Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require the following Sterilization Consent forms.

Refer to: www.tmhp.com/sites/default/files/provider-forms/medicaid/F00090_Sterilization_Consent_Form_English.pdf on the TMHP website at www.tmhp.com.

www.tmhp.com/sites/default/files/provider-forms/medicaid/F00090_Sterilization_Consent_Form_Spanish_0.pdf on the TMHP website at www.tmhp.com.

Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.

DISCLOSURE AND CONSENT Medical Care and Surgical Procedures, required per Texas Administrative Code Title 25, Part 7, Chapter 601, Rule §601.4.

2.8.2 Incomplete Sterilizations

Sterilizations are considered to be permanent, once per lifetime procedures. If the claim is denied indicating a sterilization procedure has already been reimbursed for the client, the provider may appeal with documentation that supports the medical necessity for the repeat sterilization.

2.8.3 Tubal Ligation and Hysteroscopic Occlusion

Refer to: The *HHSC Family Planning Program Policy Manual* for more information about tubal ligation and hysteroscopic occlusion.

2.8.4 Vasectomy

Refer to: The *HHSC Family Planning Program Policy Manual* for more information about vasectomies.

Vasectomies are considered to be permanent, once-per-lifetime procedures. If the claim is denied indicating a vasectomy procedure has already been reimbursed for the client, the provider may appeal with documentation that supports the medical necessity for the repeat sterilization.

2.9 Prior Authorization

Prior authorization is not required for sterilization and sterilization-related procedures.

3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological and reproductive health services and family planning services.

Gynecological and reproductive health services and family planning services are subject to retrospective review and recoupment if documentation does not support the service billed.

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4 Claims Filing and Reimbursement

4.1 Claims Information

Providers must use the appropriate claim form to submit HHSC Family Planning Program claims to TMHP. Claims for dates of service that span multiple contract periods must be submitted on separate claims for services performed within each contract period.

Note: *To submit HHSC Family Planning Program claims using TexMedConnect, providers must choose Family Planning Program "Title X-DFPP" on the electronic version of the 2017 claim form.*

4.1.1 Filing Deadlines

The following table summarizes the filing deadlines for HHSC Family Planning Program claims:

Deadline	Appeals
95 days from the date of service on the claim or date of any third party insurance explanation of benefits (EOB)	120 days from the date of the Remittance and Status (R&S) Report on which the claim reached a finalized status
If the filing deadline falls on a weekend or TMHP-recognized holiday, the filing deadline is extended until the next business day.	

Note: *As stated in the HHSC Family Planning Policy and Procedure Manual, all claims and appeals must be submitted and processed within 60 days after the end of the contract period.*

4.1.2 Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client's confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.

4.2 Reimbursement

Reimbursement for family planning procedures is available in the TMHP Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

4.2.1 Funds Gone

HHSC family planning providers are contracted to provide services for a specific time period, either the state fiscal year or a contract period within the fiscal year. The providers receive a specific budget amount for their contract period. When their claims payments have reached their budget allowance, providers must continue to submit claims. The amount of funds that they would have received had the funds been available will be tracked as "funds gone."

Providers may receive additional funds for a contract period at a later time. Claims identified as "funds gone" may be reimbursed at that time.

On the R&S Report, "Claims Paid" is the dollar amount of claims paid during this financial transaction period. "Approved to Pay/Not Funds Gone" is the dollar amount that has been processed and approved to pay, but the payment has not been issued yet. "Funds Gone" is the dollar amount that has been submitted after the provider's budget allowance has been reached. The amount in "Approved to Pay/Not Funds Gone" added to the amount in "Funds Gone" will equal the amount in the "Approved to Pay - New Claims" section.

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4.3 NCCI and MUE Guidelines

The Healthcare Common Procedural Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI Medically Unlikely Edit (MUE) guidance, Texas Medicaid limitations prevail.

4.4 National Drug Code

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

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HEALTHY TEXAS WOMEN PROGRAM HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human
Services

HEALTHY TEXAS WOMEN PROGRAM HANDBOOK

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1 General Information

The information in this handbook is intended for Healthy Texas Women (HTW) program providers. The handbook provides information about Texas Medicaid's HTW benefits, policies, and procedures that are applicable to these service providers.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients, including HTW clients, in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: The *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about providing services to Texas Medicaid and Texas Health Steps (THSteps) clients.

"Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

"Texas Medicaid Administration" in the *Preliminary Information* (*Vol. 1, General Information*).

The Healthy Texas Women website at www.healthytexaswomen.org for information about family planning and the locations of clinics receiving family planning funding from HHSC.

The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about Texas Medicaid fee-for service and Title XIX family planning benefits for gynecological and reproductive health services.

The *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about services provided in a Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

2 Healthy Texas Women (HTW) Program Overview

The goal of HTW is to expand access to women's health and family planning services to reduce unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and wellbeing of women and their families in the eligible population.

HTW is established to achieve the following objectives:

- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions.
- Ensure the efficient and effective use of state funds in support of these objectives and to avoid the direct or indirect use of state funds to promote or support elective abortions.
- Reduce the overall cost of publicly-funded healthcare (including federally-funded healthcare) by providing low-income Texans access to safe, effective services that are consistent with these objectives.
- Enforce Human Resources Code §32.024(c-1).

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Refer to: Subsection 1.1, "Family Planning Overview" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for an overview of family planning funding sources.

The HTW page of the TMHP website at www.tmhp.com for more information about provider certification.

Healthy Texas Women Plus (HTW Plus) is a set of additional physical health, mental health, and substance use disorder benefits that are available to HTW clients during the first 12 months of their eligibility following a pregnancy in addition to all standard HTW benefits. These outpatient services target major health conditions that contribute to maternal mortality and severe morbidity in the extended postpartum period and provide continuity of care for chronic conditions treated during the pregnancy period.

Health-care providers who want to provide HTW Plus services must be enrolled as Texas Medicaid providers and have completed the HTW provider certification process. There are no additional requirements for HTW providers to provide HTW Plus benefits within their scope of education and training, because HTW Plus is not a separate program from HTW.

2.1 Guidelines for HTW Providers

HTW provides family planning services, related preventive health services that are beneficial to reproductive health, and other preventive health services that positively affect maternal health and future pregnancies for women who:

- Are 15 through 44 years of age.

  Note: *Women who are 15 through 17 years of age must have a parent or legal guardian apply on their behalf.*

- Are a United States citizen or eligible immigrant.
- Are a resident of Texas.
- Do not currently receive benefits through another Medicaid program (including Medicaid for Pregnant Women), Children's Health Insurance Program (CHIP), or Medicare Part A or B.
- Have a household income at or below 204.2 percent of the federal poverty level.
- Are not pregnant.
- Do not have other insurance that covers the services that HTW provides.

Exception: *A client who has other private health insurance may be eligible to receive HTW services if a spouse, parent, or other person would cause physical, emotional, or other harm to the client because the client filed a claim on the health insurance.*

HTW medical services are provided by a physician or by another qualified health-care professional operating under physician direction. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by an RN, PA, NP, or CNS. HTW participants may receive services from any provider that participates in HTW.

HTW clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate. They must also be allowed the freedom to accept or reject services without coercion. All HTW-covered methods of contraception must be made available to the client, either directly or by referral to another provider of contraceptive services. Services must be provided without regard to age, marital status, race, ethnicity, parenthood, disability, religion, national origin, or contraceptive preference.

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Client eligibility can be verified by:

- Using TexMedConnect.
- Accessing the Medicaid Client Portal for Providers.
- Checking an electronic or printed copy of Your Texas Benefits Healthy Texas Women card.
- Calling the Automated Inquiry System at 1-800-925-9126.

Refer to: Subsection 4.4.3, "Client Eligibility Verification" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

HTW clients will have the following identifiers on the feedback received from the stated source:

- Medicaid Coverage: W - MA - HTW
- Program Type:
  - 68 - MEDICAL ASSISTANCE - HEALTHY TEXAS WOMEN (HTW)
  - 69 - MEDICAL ASSISTANCE - HEALTHY TEXAS WOMEN PLUS (HTW PLUS)
- Program: 100 - MEDICAID
- Benefit Plan: 100 - Traditional Medicaid

HTW clients will receive 12 months of continuous eligibility unless:

- The client dies.
- The client voluntarily withdraws from HTW.
- The client no longer satisfies the HTW eligibility criteria.
- The client is certified for another Medicaid program, such as Medicaid for Pregnant Women, or CHIP.
- State law no longer allows the woman to be covered.
- HHSC or its designee determines the client provided information affecting her eligibility that was false at the time of application.

If a provider suspects that a HTW client has committed fraud on the application, the provider should report the client to the HHSC Office of Inspector General (OIG) at 1-800-436-6184.

2.1.1 Referrals

If a provider identifies a health problem that is not within their scope of practice, the provider must refer the HTW client to another provider or clinic that can treat her. As mandated by Texas Human Resources Code §32.024(c-1), HTW does not reimburse office visits during which clients are referred for elective abortions.

A provider must refer and provide information about the HHSC Primary Health Care Services Program. Additionally, the toll-free Information and Referral hotline 2-1-1 can assist clients and providers with locating low-cost health services for clients in need.

2.1.2 Referrals for Clients Diagnosed with Breast or Cervical Cancer

Medicaid for Breast and Cervical Cancer (MBCC) provides access to cancer treatment through full Medicaid benefits for qualified women diagnosed with breast or cervical cancer. Health facilities that contract with the Breast and Cervical Cancer Screening (BCCS) program are responsible for helping women with the MBCC application.

To find a BCCS provider, call 2-1-1. For questions about the BCCS program, contact the state office at 512-458-7796, or visit www.healthytexaswomen.org/bccs-program.

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2.1.3 Abortions

Elective and non-elective abortions are not covered by HTW.

Texas Human Resources Code Section 32.024(c-1) and Title 1 Texas Administrative Code, §382.17 prohibit the participation of a provider that performs or promotes elective abortions or affiliates with an entity that performs or promotes elective abortions.

A provider that performs elective abortions (through either surgical or medical methods) or that is affiliated with an entity that performs or promotes elective abortions for any patient is ineligible to serve HTW clients and cannot be reimbursed for any services rendered to a HTW client. This prohibition only applies to providers delivering services to HTW clients.

"Elective abortion" means the intentional termination of a pregnancy by an attending physician who knows that the female is pregnant, using any means that is reasonably likely to cause the death of the fetus. The term does not include the use of any such means: (A) to terminate a pregnancy that resulted from an act of rape or incest; (B) in a case in which a woman suffers from a physical disorder, physical disability, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the woman in danger of death or risk of substantial impairment of a major bodily function unless an abortion is performed; or (C) in a case in which a fetus has a life-threatening physical condition that, in reasonable medical judgment, regardless of the provision of life-saving treatment, is incompatible with life outside the womb.

Certain providers that want to participate in HTW must certify that they do not perform or promote elective abortions and do not affiliate with any entity that does, as directed by HHSC.

Refer to: Subsection 2.2, "HTW Provider Enrollment" in this handbook for more information about certification regarding elective abortions.

2.2 HTW Provider Enrollment

Providers who have completed the Medicaid enrollment process through TMHP, and have certified that they do not perform elective abortions or affiliate with providers that perform elective abortion are eligible to participate. Teaching hospital, independent laboratory, and radiology facility providers are not required to certify.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Certain providers that want to participate in HTW must certify that they do not perform or promote elective abortions and do not affiliate with any entity that does, as directed by HHSC. Providers may complete the Healthy Texas Women Certification and disclose the required information as part of the Medicaid enrollment process, or at any time after completing the Medicaid enrollment process. New providers may use the TMHP website to submit the Healthy Texas Women Certification through the Provider Enrollment and Management System (PEMS). Medicaid-only providers may use the TMHP website to submit the Healthy Texas Women Certification through the PEMS.

The following provider types are not required to certify:

- Teaching hospitals
- Independent laboratories
- Radiology facilities

Information that providers submit through PEMS can be searched by clients who use the Find a Doctor feature on the HTW website at www.healthytexaswomen.org.

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2.3 Services, Benefits, Limitations, and Prior Authorization

2.3.1 Prior Authorization Requirements

Prior authorization is required for the following HTW services:

- Magnetic resonance imaging (procedure codes 77046, 77047, 77048, and 77049)
- Non-prescription drugs (procedure code) when submitted for glucose tablets or gel

Medical Nutrition Counseling Services do not require prior authorization for HTW clients up to the following quantities:

Procedure Code	Limitation
97802	4 units per rolling year
97803	12 units per rolling year
97804	8 units per rolling year
S9470	1 visit per rolling year

Prior authorization is required for the following HTW Plus services:

- Computed tomographic angiography (procedure codes 70498, 71275, 73706, 74174, 74175, 75574, and 75635)
- Magnetic resonance angiography (procedure codes 70547 and 70548)
- Computed tomography (procedure code 75571)
- Blood glucose monitor with integrated voice synthesizer (procedure code E2100)

Blood glucose test/reagent strips (procedure code A4253) do not require prior authorization for HTW Plus clients up to the following quantities:

Procedure Code	Limitation
A4253 (Non-insulin dependent)	1 box per month
A4253 (Insulin dependent)	2 boxes per month

Peer specialist services (procedure code H0038) do not require prior authorization for HTW Plus clients for the first 104 units in a rolling six-month period. Prior authorization is required once a person exceeds 104 units of individual or group peer specialist services in a rolling six-month period.

> ***Note:*** *Prior authorization requirements, forms, and documentation requirements for specific services can be found in the appropriate TMPPM handbooks.*

2.3.2 HTW Services

HTW benefits include:

- Annual family planning exam and cervical cancer screening, which may include screening for diabetes, sexually transmitted infections (STIs), high blood pressure, cholesterol, tuberculosis, and other health issues.
- Counseling on specific methods and use of contraception (as part of evaluation and management services), including natural family planning and female sterilization.
- Follow-up visits related to sterilization, including procedures to confirm sterilization.
- Women's health and family-planning services including:
  - Pregnancy tests during a family planning exam.

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- STI screenings during a family planning exam.
- Treatment of certain STIs.
- Contraceptive methods.
- Treatment related to diabetes, high blood pressure, and cholesterol.
- Breast cancer screening and cervical cancer screening and treatment of cervical dysplasia.
- Additional preventive health services and screenings.

- Lab services related to a service listed above.
- Self-measured blood pressure monitoring (SMBPM) when used as a diagnostic tool to assist a physician in diagnosing hypertension in individuals whose blood pressure is either elevated, or inconclusive when evaluated in the office alone.
- Health and Behavioral Assessment and Intervention (HBAI) services.

All procedure codes listed in the tables below are subject to the HTWP (Healthy Texas Women Procedure) grouping and are benefits for HTW and HTW Plus clients.

The following family planning services are benefits of HTW:

Contraceptives Procedure Codes									
11976	11981	11982	11983	57170	58300	58301	A4261	A4266	A4267
A4268	A4269	A9150	H1010	J1050	J1410	J3490	J7294	J7295	J7296
J7297	J7298	J7300	J7301	J7304	J7307	S4993			

Drugs and supplies that are dispensed directly to the client must be billed to HTW. Only provider types with an appropriate pharmacy license may be reimbursed for dispensing family planning drugs and supplies. Provider types with an appropriate pharmacy license may be reimbursed for dispensing up to a one-year supply of contraceptives in a 12-month period using procedure codes J7294, J7295, J7304, or S4993.

Pharmacies participating in the Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule for up to a six-month supply.

Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Refer to: Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

2.3.2.1 Long-Acting Reversible Contraception Products (LARC)

Certain LARC products are available as a pharmacy benefit of HTW and are available through a limited number of specialty pharmacies that work with LARC manufacturers. Providers can refer to the Texas Medicaid/CHIP Vendor Drug Program website at provider.txvdpportal.com/SPContent/DocumentLibrary/Manuals for additional information, including a list of covered products and participating specialty pharmacies.

The following sterilization services are benefits of HTW:

Procedure Codes									
00851	58340	58600	58611	58615	58670	58671	74740		

Sterilizations are considered to be permanent, once-per-lifetime procedures. Denied claims may be appealed with documentation that supports the medical necessity for a repeat sterilization.

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The sterilization services that are available to HTW clients include surgical or nonsurgical sterilization, follow-up office visits related to confirming the sterilization, and any necessary short-term contraception.

HTW covers sterilization as a form of birth control. To be eligible for a sterilization procedure through HTW, the client must be 21 years of age or older and must complete and sign a Sterilization Consent Form within at least 30 days of the date of the surgery but no more than 180 days. In the case of an emergency, there must be at least 72 hours between the date on which the consent form is signed and the date of the surgery. Operative reports that detail the need for emergency surgery are required. Providers are required to submit a copy of the Sterilization Consent Form to HTW to be considered for claims reimbursement.

Per federal regulation 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: *The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not sterilization consent.*

Refer to: Sterilization Consent Form (English) on the TMHP website at www.tmhp.com.

Refer to: Sterilization Consent Form (Spanish) on the TMHP website at www.tmhp.com.

Refer to: Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.

The following immunization and vaccination procedure codes are benefits of HTW:

Procedure Codes									
90460	90471	90472	90480	90623	90624	90632	90633	90636	90651
90656	90660	90661	90670	90673	90677	90684	90686	90688	90707
90710	90714	90715	90716	90732	90733	90734	90736	90743	90744
90746	91320	91322							

The following behavioral health services are benefits of HTW:

Procedure Codes									
90791	90792	96156	96158	96159	96167	96168	99000	99078	99406
99407									

The following medical nutritional counseling services are benefits of HTW:

Procedure Codes									
97802	97803	97804	S9470						

The following procedure codes for supplies and services are benefits of HTW:

Procedure Codes									
93000	94760	96372							

The following laboratory and pathology services are benefits of HTW:

Procedure Codes									
80048^	80050	80051^	80053^	80061^	80069^	80074	80076	81000	81001
*** CLIA-waived test** **^ QW modifier**									

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Procedure Codes									
81002*	81003^	81005	81015	81025*	81513	81514^	81515^	82166	82270*
82465^	82681	82947^	82948	82950^	82951^	83020	83021	83036^	84443^
84450^	84460^	84478	84479	84702	84703^	85007	85013*	85014^	85018^
85025^	85027	85610^	85660^	85730	86318^	86580	86592	86631	86677
86689	86695	86696	86701^	86702	86703	86704	86706	86762	86780^
86803^	86885	86900	86901	87070	87086	87088	87102	87110	87205
87210	87220	87252	87270	87340	87389^	87480	87490	87491^	87510
87512	87529	87530	87535	87563	87590	87591^	87624	87625	87626
87660	87661	87797	87800	87801^	87810	87850	88150	88164	88175
88305	88307	G0433^							
*** CLIA-waived test** **^ QW modifier**									

For HTW laboratory services, if the provider who obtains the specimen does not perform the laboratory procedure, the provider who obtains the specimen may be reimbursed one lab handling fee per day, per client.

The fee for the handling or conveyance of the specimen for transfer from the provider's office to a laboratory may be reimbursed using procedure code 99000.

More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.

Handling fees are not paid for Pap smears or cultures. When billing for Pap smear interpretations, the claim must indicate that the screening and interpretation were actually performed in the office by using the modifier SU (procedure performed in physician's office).

If more than one of procedure codes 87480, 87510, 87660, 87661, or 87800 are submitted by the same provider for the same client with the same date of service, all of the procedure codes are denied. Only one procedure code (87480, 87510, 87660, 87661, or 87800) may be submitted for reimbursement, and providers must submit the most appropriate procedure code for the test provided.

Providers are reminded to code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 87797.

Procedure code G0433 will deny if billed on the same day by the same provider as procedure code 86703.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)*.

Appropriate documentation must be kept in the client's record.

Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

HTW follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The TMHP website Required CLIA Lab Certifications web page at https://www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

The following evaluation and management procedure codes are benefits of HTW:

Procedure Codes									
99202	99203	99204	99205	99211	99212	99213	99214	99215	99242

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Procedure Codes									
99243	99244	99384	99385	99386	99394	99395	99396	99417	99473
99474	G0466	G0467	G0468	G0469	G0470	Q3014	T1015		

For new patients, a new patient visit for the annual exam may be reimbursed once every three years following the last evaluation and management (E/M) visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Federally Qualified Health Centers (FQHCs) may be reimbursed for three family planning encounters per HTW client, per year.

Procedure codes J7296, J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment.

When seeking reimbursement for an intrauterine device (IUD) or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the contraceptive device along with the procedure code for the encounter. The contraceptive device is not subject to FQHC limitations. Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

Refer to: Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)* for more information about FQHC services.

Outpatient visits for non-family planning-related encounters provided by FQHCs for HTW and/or HTW Plus covered physical and behavioral health services may be reimbursed when medically necessary.

An E/M procedure code will not be reimbursed when it is billed with the same date of service as the removal of an IUD (procedure code 58301) unless the E/M visit is a significant, separately identifiable service from the removal of the IUD. If the E/M visit occurs on the same date of service as the removal of the IUD, modifier 25 may be used to indicate that the E/M visit was a significant, separately identifiable service from the procedure.

Self-measured blood pressure monitoring (SMBPM) patient education and device calibration (procedure code 99473) is limited to one service per year, any provider.

SMBPM patient education and device calibration (procedure code 99473) may be considered for more than once per year when documentation of medical necessity is submitted with the claim.

SMBPM patient education and device calibration (procedure code 99473) must be billed within 12 rolling months of collection of data and communication of treatment plan (procedure code 99474).

SMBPM collection of data and communication of treatment plan (procedure code 99474) is limited to four services per year, any provider.

2.3.2.2 * Family Planning History Check

HTW clients must receive family planning services annually, but no later than the third visit as an established client. These services must include family planning counseling and education, including natural family planning and abstinence. In order to receive reimbursement, all existing HTW clients must have received family planning services and/or counseling within the past rolling year.

The following HTW clients do not require a family planning history check:

- New clients
- Women who are sterilized
- Women who have a long-acting reversible contraception (LARC)

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The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

Billing Criteria	Frequency
New patient: Most appropriate E/M procedure code	One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group

Refer to: The Family Planning section of the HHSC website for information about the HHSC Family Planning Program.

The following imaging services are benefits of HTW:

Procedure Codes									
71045	71046	73060	74018	74019	76098	76700	76705	76770	76830
76856	76857	76881	76882						

The following breast cancer screening services are benefits of HTW:

Procedure Codes									
76641	76642	76942	77046	77047	77048	77049	77053	77063	77065
77066	77067	G0279							

The following diagnostic procedure codes are benefits of HTW:

Procedure Codes									
00400	19000	19081	19082	19083	19084	19100	19101	19120	19125
19126	19281	19282	19283	19284	19285	19286			

The following cervical cancer screening services are benefits of HTW:

Procedure Codes									
88141	88142	88143	88155	88160	88161	88165	88167	88172	88173
88174									

The following gynecological procedures are benefits of HTW:

Procedure Codes									
00940	56405	56420	56501	56515	56605	56606	56820	57023	57061
57100	57421	57452	57454	57455	57456	57460	57461	57500	57505
57511	57520	57522	58100	58110	58562				

The following procedure codes are Clinician-Administered Drug (CAD) benefits for HTW:

[Revised] Procedure Codes									
J0131	J0134	J0136	J0137	J0138	J0278	J0281	J0290	J0291	J0295
J0360	J0528	J0558	J0561	J0616	J0665	J0666	J0668	J0670	J0687
J0688	J0689	J0690	J0696	J0699	J0713	J0714	J0736	J0737	J1271
J1460	J1580	J1800	J1805	J1806	J1808	J1812	J1814	J1815	J1836

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[Revised] Procedure Codes									
J1920	J1921	J1938	J1939	J2010	J2249	J2250	J2251	J2252	J2305
J2371	J2372	J2373	J2401	J2540	J2597	J2598	J2599	J2601	J2675
J2700	J2795	J3000	J3260	J7177	J7178	J7354	J7682	S5550	S5551
S5553									

2.3.3 Other Family Planning Office or Outpatient Visits

HTW does not cover office visits during which clients are referred for elective abortions.

A provider is allowed to bill clients for services that are not a benefit of HTW.

Refer to: Subsection 1.7.12.1, "Client Acknowledgment Statement" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for the requirements for billing clients.

2.3.4 Treatment for Sexually Transmitted Infections (STIs)

HTW covers treatment for the following conditions:

- Gardnerella
- Trichomoniasis
- Candida
- Chlamydia
- Gonorrhea
- Herpes
- Syphilis

2.3.5 Immunizations and Vaccinations

HTW covers the following immunizations and vaccinations:

- HPV
- Hep A
- Hep B
- Chicken pox
- MMR
- Tdap
- Flu

2.3.6 Telemedicine and Telehealth Services

Certain telemedicine and telehealth services may be provided for HTW clients if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interactions, such as an in-person visit, as well as the use of synchronous audio-visual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology.

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2.3.6.1 Synchonous Audiovisual Technology

2.3.6.1.1 Telemedicine

The following HTW services are authorized for telemedicine delivery using synchronous audiovisual technology:

HTW Telemedicine Evaluation and Management Services									
99202	99203	99204	99205	99211	99212	99213	99214	99215	99242
99243	99244	99417	Q3014						

HTW Telemedicine Behavioral Health Services									
90791	90792	96156	96158	96159	96167	96168			

HTW Telemedicine Medical Nutritional Counseling Services			
97802	97803	97804	S9470

2.3.6.1.2 Telehealth

The following HTW services are authorized for telehealth delivery using synchronous audiovisual technology:

HTW Telehealth Behavioral Health Services									
90791	90792	96156	96158	96159	96167	96168			

HTW Telehealth Medical Nutritional Counseling Services									
97802	97803	97804	S9470						

Medical Nutrition Counseling Services (procedure codes 97802, 97803, 97804, and S9470) are authorized only during certain public health emergencies. New patient and established client services provided by synchronous audiovisual technology must be billed using modifier 95. Procedure codes that indicate remote (telemedicine medical and telehealth services) delivery in the description do not need to be billed with the 95 modifier.

2.3.6.2 Synchronous Telephone (Audio-Only) Technology

The following HTW services are authorized for telemedicine and telehealth delivery using synchronous telephone (audio-only) technology:

Procedure Codes									
99211	99212	99213	99214	99215					

Established patient services for non-behavioral health conditions provided by synchronous telephone (audio-only) technology must be billed using modifier 93.

Note: *Established client service (procedure code 99211) is only during certain public health emergencies.*

HTW Behavioral Health Services									
90791	90792	96156	96158	96159	96167	96168			

Established patient services for behavioral health or substance use conditions provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

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2.3.6.3 FQHC and RHC Telemedicine and Telehealth Services

FQHCs and RHCs that provide telemedicine and telehealth services using synchronous audiovisual and synchronous telephone (audio-only) technology may be reimbursed for the following HTW services:

HTW Distant Site Telemedicine and Telehealth Services									
G0466	G0467	G0468	G0469	G0470	T1015				

FQHCs and RHCs may be reimbursed for telemedicine and telehealth in the following manner:

- The distant site provider fee is reimbursable as a prospective payment system (PPS), alternative prospective payment system (APPS), or AIR (All Inclusive Rate) PPS.
- The facility fee (procedure code Q3014) is an add-on procedure code that should not be included in any cost reporting that is used to calculate a FQHC PPS, APPS, or the RHC AIR (All Inclusive Rate) PPS per visit encounter rate.

Services delivered using synchronous audiovisual technologies must be billed using modifier 95. Procedure codes that indicate remote (telemedicine medical and telehealth services) delivery in the description do not need to be billed with the 95 modifier.

Refer to the appropriate handbooks in this manual for more information about telemedicine and telehealth benefits and restrictions.

2.3.7 * HTW Plus Services, Benefits, and Limitations

HTW Plus Services are enhanced postpartum services available to eligible HTW clients in addition to all HTW services. The targeted health conditions and the services covered to treat them are as follows:

- Behavioral health conditions
  - Individual, family, and group psychotherapy services
  - Peer specialist services
- Cardiovascular and coronary conditions
  - Cardiovascular evaluation imaging and laboratory studies
  - Blood pressure monitoring equipment
  - Anticoagulant, antiplatelet, and antihypertensive medications
- Substance use disorders
  - Screening, brief intervention, and referral for treatment
  - Outpatient substance use counseling
  - Smoking and tobacco use cessation counseling
  - Medication-assisted treatment
  - Peer specialist services
- Diabetes
  - Laboratory studies
  - Additional injectable insulin options
  - Blood glucose testing supplies
  - Voice-integrated glucometers for women with diabetes who are visually impaired
  - Glucose monitoring supplies

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- Asthma
    - Medications and supplies

All procedure codes listed in the tables below are subject to the HTWH (Healthy Texas Women Plus) procedure grouping and are benefits for HTW Plus clients only.

The following behavioral health services are benefits of HTW Plus:

Procedure Codes									
90832	90833	90834	90836	90837	90838	90847	90853	90870	96130
96131	96136	96137	H0038						

The following cardiovascular and coronary services are benefits of HTW Plus:

Procedure Codes									
37187	37211	37212	70498	70547	70548	71275	73706	74174	74175
75571	75574	75635	75716	75736	93005	93010	93015	93016	93017
93018	93041	93042	93224	93225	93226	93227	93241	93242	93243
93244	93245	93246	93247	93248	93306	93307	93308	93312	93319
93320	93321	93325	93350	93351	93660	93893	93923	93970	93971
94619	A4663	A4670							

The following substance use disorder services are benefits of HTW Plus:

Procedure Codes									
99408	H0001	H0004	H0005	H0020	H0049				

The following diabetes services are benefits of HTW Plus:

Procedure Codes									
83037	A4253	A4258	A4259	E2100					

The following asthma services are benefits of HTW Plus:

Procedure Codes									
94150	94617	A4614	A4627	E0570	S8101				

The following laboratory services are benefits of HTW Plus:

Procedure Codes									
81240	81241	81291	82530	82533	82550	82553	82945	82946	82955
82960	82985	83050	83525	83527	83605	83615	83625	84144	84146
84206	85004	85041	85044	85045	85048	85049	85130	85210	85220
85250	85302	85303	85305	85306	85362	85370	85378	85379	85380
85384	85385	85390	85396	85520	85525	86147	86337	86340	86341
86905	86906								

The following gynecological services are benefits of HTW Plus:

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Procedure Codes									
19020									

The following procedure codes are Clinician-Administered Drug (CAD) benefits for HTW Plus:

[Revised] Procedure Codes									
J0570	J0577	J0578	J0702	J1010	J1100	J1437	J1439	J1643	J1644
J1645	J1650	J1652	J1720	J1750	J1756	J2312	J2313	J2315	J2916
J2919	J3301	J3304	J3535	J7531	J7611	J7612	J7613	J7614	J7620
J7644	J8541	Q0138	Q9991	Q9992					

Refer to: The relevant handbooks for detailed coverage information of HTW Plus benefits.

2.3.7.1 HTW Plus Telemedicine and Telehealth Services

Certain telemedicine and telehealth services may be provided for HTW Plus clients if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interactions, such as an in-person visit, as well as the use of synchronous audio-visual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

2.3.7.1.1 Synchronous Audiovisual Technology

The following HTW Plus services are authorized for delivery using synchronous audiovisual technologies:

Behavioral Health Services									
90832	90833	90834	90836	90837	90838	90847	90853	96130	96131
96136	96137	H0038							

HTW Plus Substance Use Disorder Services									
99408	H0001	H0004	H0005	H0049					

Services delivered using synchronous audiovisual technologies must be billed using the 95 modifier.

2.3.7.1.2 Synchronous Telephone (Audio-Only) Technology

The following HTW Plus services are authorized for delivery using synchronous telephone (audio-only) technology:

HTW Plus Behavioral Health Services									
90832	90833	90834	90836	90837	90838	90847	90853	H0038	

HTW Plus Substance Use Disorder Services									
99408	H0001	H0004	H0005	H0049					

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Procedure code H0001 is authorized for delivery by synchronous telephone (audio-only) technology only during certain public health emergencies or natural disasters; to the extent allowed by federal law (assessments for withdrawal management services are excluded); and the 'existing clinical relationship' requirement is waived.

Behavioral health services using synchronous telephone (audio-only) technologies must be billed using the FQ modifier.

Note: *Procedure codes 90833, 90836, and 90838 are add-on codes and must be billed with a primary procedure code in order to be reimbursed.*

Refer to: The *Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks)* for information on restrictions for behavioral health services delivered by synchronous audiovisual and synchronous telephone (audio-only) technologies.

2.3.8 Modifiers

The following are modifiers to be used for HTW and HTW Plus services:

Modifier	Description
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System Service provided as part of the Family Planning Program
FQ	The service was furnished using audio-only communication technology
QW	CLIA waived test
SU	Procedure performed in physician's office (to denote use of facility and equipment)
U8	U8 denotes a contraceptive device purchased through the 340B Drug Pricing Program

2.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered.

HTW services are subject to retrospective review and recoupment if documentation does not support the service billed.

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for information on restrictions for services delivered by synchronous audiovisual and synchronous telephone (audio-only) technologies.

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Additional documentation requirements apply for certain behavioral health services delivered by synchronous audiovisual technology and synchronous telephone (audio-only) technology.

2.5 HTW Claims Filing and Reimbursement

2.5.1 Claims Information

HTW and HTW Plus benefits are subject to the same restrictions and limitations applied to Texas Medicaid's coverage for the same procedure codes. Please refer to the relevant subsections in this handbook for detailed coverage information of HTW and HTW Plus benefits.

Providers must use the appropriate claim form to submit HTW claims to TMHP.

Refer to: Subsection 2.4, "Claims Filing and Reimbursement" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about filing family planning claims.

2.5.1.1 HTW and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential.

Because seeking information from third party insurance may jeopardize the client's confidentiality, third party billing for HTW is not allowed.

2.5.2 Reimbursement

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

2.5.3 National Drug Code

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

2.5.4 NCCI and MUE Guidelines

The Health Care Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

3 Claims Resources

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
2017 Claim Form Instructions	Subsection 6.8, "Family Planning Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

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4 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday-Friday from 7 a.m. to 7 p.m., Central Time.

5 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)
2017 Claim Form
Healthy Texas Women Certification

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HOME HEALTH NURSING AND PRIVATE DUTY NURSING SERVICES HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human Services

HOME HEALTH NURSING AND PRIVATE DUTY NURSING SERVICES HANDBOOK

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1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. The information in this handbook is intended for home health nursing services. Nursing services include home health skilled nursing visits, home health aide services, and private duty nursing services. The Handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these therapies.

For information about managed care services, refer to the Medicaid Managed Care Handbook. Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the Medicaid Managed Care Handbook (*Vol. 2, Provider Handbooks*).

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

1.1 Client Eligibility for Home Health Nursing and Aide Services

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is eligible to receive. To verify client Medicaid eligibility and retroactive eligibility, the home health agency, durable medical equipment (DME), or medical supplier must verify eligibility by accessing the Medicaid Client Portal for Providers. Additionally, eligibility can be verified by calling the Automated Inquiry System (AIS) at 1-800-925-9126 or the Texas Medicaid & Healthcare Partnership (TMHP) Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.

Home health clients do not need to be homebound to qualify for services.

The Medicaid client must be eligible on the date of service (DOS) and must meet all of the following requirements to qualify for home health services:

- Have a medical need for home health professional services, DME, or medical supplies that is documented in the client's plan of care (POC) and considered a benefit under home health services
- Receive services that meet the client's existing medical needs and can be safely provided in the client's home
- Receive prior authorization from TMHP for most home health professional services, DME, or medical supplies

Refer to: Subsection A.12.3, "Automated Inquiry System (AIS)" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

Note: *Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this home health services benefit may receive those services through the Comprehensive Care Program (CCP).*

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1.1.1 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

For services provided to fee-for-service Medicaid clients during the client's retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client's add date and before a claim for those services is submitted to TMHP. For services provided on or after the client's add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access the Medicaid Client Portal for Providers, TexMedConnect, or AIS to verify eligibility frequently while providing services to the client. If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: "Section 4: Client Eligibility" (*Vol. 1, General Information*).

1.1.2 Client Evaluation

When a home health agency receives a referral to provide home health nursing and therapy services for a client who is eligible for Texas Medicaid, the agency-employed registered nurse (RN) must evaluate the client in the home before calling TMHP for prior authorization. A home evaluation by the agency-employed RN is required for SN, home health aide (HHA), occupational therapist (OT), physical therapist (PT), DME, or medical supplies requested on a home health services POC. It is expected that appropriate referrals will be made between home health agencies and DME suppliers for care. It is recommended that DME suppliers keep open communication with the client's physician to ensure the client's medical record is current.

This evaluation must include assessment of the following:

- Medical necessity for home health services, DME, or medical supplies requested.
- Client safety.
- Appropriateness of care in the home setting.
- Capable caregiver available if clients are unable to perform their own care or monitor their own medical condition.

Following the RN's assessment or evaluation of the client in the home setting for home health services needs, the agency-employed RN who completed the home evaluation must contact TMHP for prior authorization within three business days of the start of care (SOC).

1.2 Client Eligibility for PDN Services

PDN is considered medically necessary when a client has a disability, physical, or mental illness, or chronic condition and requires continuous, skillful observations, judgments, and interventions to correct or ameliorate his or her health status.

To be eligible for PDN services, a client must meet all the following criteria:

- Be birth through 20 years of age and eligible for Medicaid and THSteps
- Meet medical necessity criteria for PDN
- Have a primary physician who must:
  - Provide a prescription for PDN.

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- Establish a POC.
- Provide documentation to support the medical necessity of PDN services.
- Provide continuing medical care and supervision of the client, including, but not limited to, examination or treatment within 30 calendar days prior to the start of PDN services, or examination or treatment that complies with the THSteps periodicity schedule, or is within six months of the PDN extension SOC date, whichever is more frequent (for extensions of PDN services). This requirement may be waived based on review of the client's specific circumstances.

  Note: *The physician visit may be waived when a diagnosis has already been established by the physician, and the client is under the continuing care and medical supervision of the physician. A waiver is valid for no more than 365 days, and the client must be seen by his or her physician at least once every 365 days. The waiver must be based on the physician's written statement that an additional evaluation visit is not medically necessary. This documentation must be maintained by the physician and the provider in the client's medical record.*

- Provide specific written, dated orders for the client who is receiving continuing or ongoing PDN services.
- Require care beyond the level of services provided under Texas Medicaid (Title XIX) home health services.

Clients who are birth through 17 years of age must reside with a responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

PDN is based on the need for skilled care in the client's home; however, these services may follow the client and may be provided in accordance with 42 CFR §440.80. The POS must be able to support the client's health and safety needs. It must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and backup utilities, communication, fire, and safety systems must be available at all times.

The amount and duration of PDN must always be commensurate with the client's medical needs. Requests for services must reflect changes in the client's condition that affect the amount and duration of PDN.

2 Enrollment

Refer to: Subsection 1.7.16, "Private Duty Nursing (PDN) Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for enrollment information.

3 Home Health Skilled Nursing and Home Health Aide Services

3.1 Services, Benefits, Limitations, and Prior Authorization

Home health skilled nursing (SN) and HHA visits are a benefit of Texas Medicaid Title XIX home health services when a client requires home nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. For clients who are 20 years of age or younger, SN and HHA visits are a benefit of Texas Medicaid Title XIX home health services when a client requires nursing services for an acute condition, a chronic condition, or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. SN visits are

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intended to provide SN care to promote independence and support the client living at home. HHA visits are intended to provide personal care services under the supervision of an RN, PT, or OT employed by the home health agency to promote independence and support the client living at home.

The following codes are a benefit of Texas Medicaid:

Procedure Codes		
G0156	G0299	G0300

Title XIX home health services must be provided by a licensed and certified home health agency enrolled in Texas Medicaid.

When the client's needs are beyond the benefit of Title XIX home health services, additional benefits may be accessed through the following:

- Services for clients who are 20 years of age or younger may include, but are not limited to, private duty nursing (PDN) or personal care services (PCS).
- Services for clients who are 21 years of age or older may include, but are not limited to, long-term care assistance.

Refer to: Section 4, "Private Duty Nursing (PDN) Services - CCP" in this handbook for information about PDN services.

Subsection 2.12, "Personal Care Services (PCS) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about PCS services.

3.1.1 Medical Necessity

SN and HHA visits are considered medically necessary for a client who:

- Requires skillful observations and judgement to improve health status, skilled assessment, or skilled treatments or procedures.
- Requires individualized, intermittent, acute skilled care.
- Requires skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in:
  - Deterioration of a chronic condition
  - Loss of function
  - Imminent risk to health status due to medical fragility, or risk of death
- Requires general supervision of nursing care provided by an HHA over whom the RN is administratively or professionally responsible.

Note: *When documentation does not support medical necessity for home health SN or HHA visits, providers may be directed to possible alternative services based on the client's age and needs.*

3.2 Skilled Nursing and Home Health Aide Services

All SN and HHA services must be prior authorized.

The following definitions apply to Title XIX Home Health SN and HHA visits:

- Acute is defined as a condition or exacerbation that is anticipated to improve and reach resolution within 60 days.
- Part-time is defined as SN or HHA visits provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

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- Intermittent is defined as SN or HHA visits provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day.

SN visits are nursing services ordered by a physician or an allowed practitioner, included in the Texas Medicaid home health services Plan of Care (POC), and provided by an RN or a licensed vocational nurse (LVN) currently licensed by the Board of Nurse Examiners of the State of Texas (BNE). SN visits may be considered when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically has an end-point. SN visits may be provided on consecutive days.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or a clinical nurse specialist (CNS).*

HHA visits are services ordered by the physician or allowed practitioner, included in the nursing Texas Medicaid home health services POC, and are services the HHA is permitted to perform under State law. HHA visits may be considered when a client requires services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically has an end-point. HHA visits will not be considered unless the client also requires SN or therapy services. HHA visits may be provided on consecutive days.

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about home health PT, OT, and ST services.

3.2.1 Skilled Nursing Visits

SN visits are limited to SN procedures performed by an RN or LVN licensed to perform these services under the Texas Nursing Practice Act and include the following:

- Direct SN care, and parent, guardian, or caregiver training and education
- SN observation, assessment, and evaluation by an RN, provided a physician or an allowed practitioner specifically requests that a nurse visit the client for this purpose, and the physician or allowed practitioner's order reflects the medical necessity for the visit
- Supervision of delegated services provided by an HHA or others over whom the RN is administratively or professionally responsible

SN care consists of those services that must, under State law, be performed by an RN or LVN, and meet the criteria for SN services specified in the Code of Federal Regulations (42 CFR §§ 409.32, 409.33, and 409.44):

- In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.
- The fact that the SN service can be, or is, taught to the client or to the client's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse.
- If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a SN service.
- If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as a SN service.
- Some services are classified as SN services on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client's illness or injury, would be a benefit on that basis. However, in some cases, the client's

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condition may cause a service that would ordinarily be considered unskilled to be considered an SN service. This would occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.

- A service, which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client's family, or other caregivers. Where the client needs the SN care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.
- The SN services must be reasonable and necessary to the diagnosis and treatment of the client's illness or injury within the context of the client's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client's particular medical needs, and within accepted standards of medical and nursing practice. A client's overall medical condition is a valid factor in deciding whether skilled services are needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is either skilled or not skilled.
- The determination of whether the services are reasonable and necessary should be made in consideration of the physician or allowed practitioner's determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.
- The SN care must be provided on a part-time or intermittent basis.

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician or an allowed practitioner, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teachings of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician or an allowed practitioner.
- Development of the nursing care plan.

Vocational nursing, as defined in the Texas Nursing Practice Act, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.

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- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.
- Assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs.
- Engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

3.2.2 Home Health Aide Visits

HHA visits are intended to provide hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered.

Any HHA services offered by a home health agency must be provided by a qualified HHA under the supervision of a qualified licensed individual (e.g., RN, PT, or OT) employed by the home health agency.

The duties of an HHA during a visit include, but are not limited to:

- Obtaining and recording the client's vital signs (temperature, pulse, respirations, blood pressure)
- Observation, reporting and documentation of the client's status, and the care or service furnished
- Personal care (hygiene and grooming) including, but not limited to:
  - Sponge, tub, or shower bath
  - Shampoo, sink, tub or bed bath
  - Nail and skin care
  - Oral hygiene
- Toileting and elimination care
- Ambulation
- Exercise
- Range of motion
- Safe transfer
- Positioning
- Assisting with nutrition and fluid intake
- Household services essential to the client's health care at home
- Assistance with medications that are ordinarily self-administered
- Reporting changes in the client's condition and needs
- Completing appropriate documentation

3.2.2.1 Supervision of Home Health Aides

Supervision, as defined by the Texas Nursing Practice Act, is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity.

An RN or therapist (PT or OT) must provide the HHA written instructions for all the tasks delegated to the HHA. A therapist may prepare the written instructions if the client is receiving only HHA visits, which do not include delegated SN tasks, in addition to the therapy services.

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The requirements for HHA supervision are as follows:

- When only HHA visits are provided, an RN must make a supervisory visit to the client's residence at least once every 60 days. The supervisory visit must occur when the HHA is providing care to the client.
- When SN, PT, or OT visits are provided in addition to an HHA visit, an RN must make a supervisory visit to the client's residence at least every two weeks. The supervisory visit must occur when the HHA is providing care to the client.
- When only PT or OT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

3.3 Home Health Skilled Nursing and Home Health Aide Services Providers

Providers must be a licensed and certified home health agency enrolled in Texas Medicaid and must comply with all applicable federal, state, and local laws and regulations, and Texas Medicaid's policies and procedures.

All providers must maintain written policies and procedures for:

- Obtaining consent for medical treatment for clients in the absence of the primary caregiver that meets the standards of the Texas Family Code, Chapter 32.
- Obtaining physician or allowed practitioner's signatures for all telephone orders within 14 calendar days of receipt of the order.

Providers must only accept clients on the basis of a reasonable expectation that the client's needs can be adequately met in the place of service. The essential elements of safe and effective home health SN and HHA services include a trained parent, guardian, or caregiver, a primary physician or an allowed practitioner, competent providers, and an environment that supports the client's health and safety needs.

- The place of service must be able to support the health and safety needs of the client and must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client.
- Necessary primary and back-up utility, communication, and fire safety systems must be available.

A parent or guardian, primary caregiver, or alternate care giver may not provide SN or HHA services even if he or she is an enrolled provider or employed by an enrolled provider.

3.4 Authorization Requirements

Home Health SN and HHA visits require prior authorization.

Prior authorization of SN or HHA visits requires that a client's primary physician or an allowed practitioner:

- Provides an order for SN or HHA visits or recertification, identifying that the prescribed SN or HHA visits are medically necessary as defined in the Statement of Benefits
- The physician or allowed practitioner's documentation in the client's medical record must support the prescribed SN or HHA visits are medically necessary as defined in the Statement of Benefits
- The physician or allowed practitioner's documentation in the client's medical record must support that the client's medical condition is sufficiently stable to permit safe delivery of SN or HHA visits as described in the home health services POC

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- Establishes a medical POC, which is maintained in the client's medical record
- Provides continuing care and medical supervision
- Provides specific written, dated orders for clients receiving SN or HHA visits
- Reviews and approves the home health services POC at least every 60 days, or more frequently as the physician or allowed practitioner determines necessary, including but not limited to when the client's condition changes

SN visits requested primarily to provide the following will not be prior authorized:

- Respite care
- Child care
- Activities of daily living for the client
- Housekeeping services
- Routine post-operative disease, treatment, or medication teaching after a physician or an allowed practitioner visit
- Routine disease, treatment, or medication teaching after a physician or an allowed practitioner visit
- Individualized, comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act

Note: *Clients who are 20 years of age or younger may be eligible for private duty nursing services and personal care services through Texas Medicaid Private Duty Nursing Services and Personal Care Services Policies.*

HHA visits requested for the following will not be prior authorized when:

- Primarily requested to perform housekeeping services
- Provided to a client residing in a hospital, SN facility, or intermediate care facility

Note: *Clients who are 20 years of age or younger may be eligible for private duty nursing services and personal care services through Private Duty Nursing (PDN) Services - THSteps-CCP or Personal Care Services (PCS) - THSteps-CCP).*

Certain facilities are required by licensure to meet all the medical needs of the client. SN or HHA visits will not be authorized for clients receiving care in any of the following facilities:

- Hospitals
- SN facilities
- Intermediate care facilities for the individuals with intellectual disability (ICF-IID)
- Special care facilities, including but not limited to, sub-acute units or facilities for the treatment of acquired immune deficiency syndrome (AIDS)
- Prescribed pediatric extended care centers, unless the SN and/or HHA services are provided before or after PPECC services, when rendered on the same day.

When a client, client's responsible adult, client's physician or an allowed practitioner notifies the SN and/or HHA service provider that the client also receives services from a PPECC, the SN and/or HHA service provider must coordinate services with the PPECC provider to prevent duplication of services.

Note: *It is anticipated that the provision of SN and/or HHA services, in addition to PPECC would be uncommon.*

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3.4.1 Initial Assessment and Reassessments

When a provider has received a referral and has physician or allowed practitioner's orders for SN or HHA services, the provider must have an RN perform an initial client assessment in the client's home.

A client can be referred to a home health agency for SN or HHA services by:

- The client
- The client's physician or allowed practitioner
- The client's family

The client assessment or reassessment should include, but is not limited to, the following:

- A nursing assessment of medical necessity for the requested visits, which includes:
  - Complexity and intensity of the client's care
  - Stability and predictability of the client's condition
  - Frequency of the client's need for SN care
  - Identified medical needs and goals
  - Description of wounds, if present
  - Cardiac status
- Whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client.
- Comprehension level of parent, guardian, caregiver, or client.
- Receptivity to training and ability level of the parent, guardian, caregiver, or client.

The initial assessment and any reassessments performed by an RN are required when changes in the client's condition occur during the course of the authorization period. If there is no change in the client's condition, the reassessment must document medical necessity, as defined in the Statement of Benefits, to support continued and ongoing SN or HHA visits beyond the initial 60 day authorization period.

A reassessment is required when the SN and/or HHA provider is notified by the client, client's responsible adult, the client's physician or allowed practitioner that PPECC services have been initiated.

3.4.2 Home Health Services Plan of Care Requirements

The initial assessment or reassessments are used to establish and revise the home health services POC and must support the client's medical necessity for SN services, HHA services, PT services, and OT services.

> ***Note:*** *Providers must use the Texas Medicaid home health services POC located on the TMHP Prior Authorization Texas Medicaid Forms web page; the Centers of Medicare and Medicaid (CMS) Form 485 will not be accepted.*

The POC must be initiated and written in a clear and legible format by the RN and include the following:

- The client's Medicaid number, the physician or allowed practitioner's license number, and the provider's Medicaid number
- Date the client was last seen by the physician or allowed practitioner
- The start of care (SOC) date for home health services
- All pertinent diagnoses
- The client's mental status

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- The prognosis
- The types of service requested, including the number of visits and amount, duration, and frequency
- The equipment or supplies required
- Rehabilitation potential
- Prior and current functional limitations
- Activities permitted
- Nutritional requirements
- Medications, including the dose, route and frequency
- Treatments, including amount and frequency
- Wound care orders and measurements
- Safety measures to protect against injury
- Available caregiver
- List all community or state agency services the client receives in the home including, but not limited to, primary home care (PHC), community based alternative (CBA), medically dependent children's program (MDCP)
- Instructions for timely discharge or referral
- Documentation of coordination with PPECC, when a client receives ongoing skilled nursing in a PPECC setting. When a client receives PPECC, the SN and/or HHA provider must provide a medical rationale to support the need for SN and/or HHA services, when PPECC services are provided on the same day.

The POC must be accompanied by the physician or allowed practitioner's signed and dated orders, or must be signed and dated by the physician or allowed practitioner. The POC must include the SOC date (when the services will begin) and must be signed and dated by the assessing RN.

When a provider has received signed physician or allowed practitioner's orders for SN or HHA visits, the POC does not require a physician or an allowed practitioner's signature before the provider contacts the claims administrator for prior authorization of services. The POC must be signed and dated by a physician or an allowed practitioner familiar with the client prior to submitting a claim for services, and no later than 30 days from the SOC date.

The type and frequency of visits, supplies, or DME must appear in the POC before the physician or allowed practitioner signs the POC and may not be added after the physician or allowed practitioner has signed the POC. If any change in the POC occurs during a prior authorization period (additional visits, supplies, or DME), the provider must update the POC, have the physician or allowed practitioner sign the updated POC, and contact the claims administrator for prior authorization.

Note: *Verbal physician or allowed practitioner orders may only be given to people authorized to receive them under state and federal law. They must be reduced to writing, signed and dated by the RN or qualified therapist responsible for furnishing or supervising the ordered service. The physician or allowed practitioner must sign the written copy of the verbal order within two weeks, or per agency policy if less than two weeks. A copy of the written verbal order must be maintained in the client's medical record prior to and after being signed by the physician or allowed practitioner.*

Note: *All documentation, including all written and verbal orders, and all physician- or allowed practitioner-signed POCs, must be maintained by the physician or allowed practitioner, and the home health agency must keep the original, signed copy of the POC in the client's medical record.*

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The client must be seen by a physician or allowed practitioner within 30 days of the initial SOC, and at least once every six months thereafter unless the client's condition changes.

A revised POC is required for every request for any change in SN or HHA visits. The revised POC must include all continuing and new orders. The revised POC must be updated to document any changes in the client's condition or diagnosis.

A new POC is required with every request for recertification. The new POC must include all continuing and new orders. The new POC must document all changes in the client's condition or diagnosis and reflect the need for continued SN or HHA services in relation to the original need for care. The physician or allowed practitioner must certify he or she has provided continuing care and medical supervision including, but not limited to, examination or treatment of the client within six months or when the client's condition has changed.

3.4.2.1 Written Plan of Care (POC)

A home health services POC is required for SN, HHA, OT, or PT services. The POC is not required as an attachment with the claim, but a signed and dated POC must be maintained by the provider and primary physician in the client's medical record. The client's primary physician must recommend, sign, and date a POC. The POC must be initiated by the RN in a clear and legible format.

Refer to: Subsection 4.6, "Frequency and Duration Criteria for PT, OT, and ST Services" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about PT, OT, and ST services.

Services billed in excess of those authorized for the prior authorization week or month are subject to recoupment.

For the home health services POC to be valid, the primary physician must sign and date it, and indicate when the services will begin. The home health agency must update and maintain the POC at least every 60 days or as necessitated by a change in the client's condition.

3.4.2.2 DME and Medical Supplies Submitted with a Plan of Care (POC)

The cost of incidental medical supplies used during an SN or HHA visit are included in the rate for G0299 and G0300. Medical supplies left at the home for the client to use must be billed with the National Provider Identifier (NPI) enrolled as a DME supplier after prior authorization has been granted by the TMHP Home Health Services Prior Authorization Department.

Refer to: Subsection 2.2, "Services, Benefits, Limitations and Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for information about DME and medical supplies prior authorization.

When the home health services POC is used to submit a prior authorization for DME or medical supplies that will be used in conjunction with the professional services provided by the agency, such as SN, HHA, OT, or PT, the home health agency's DME NPI must be submitted on the POC, and all of the requested DME and medical supplies must be listed in the "Supplies" section of the POC.

The POC does not require a physician's signature before prior authorization of professional services, DME, or medical supplies is requested but does require the assessing RNs dated signature. The POC must be signed and dated by a primary physician familiar with the client prior to submitting a claim for services and no later than 30 days from the SOC date.

If the home health agency uses the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form, the agency must complete Section A. A primary physician familiar with the client must complete, sign, and date Section B prior to submission to TMHP for prior authorization of the requested DME or medical supplies.

The following information is required to consider these medical supplies for prior authorization:

- Item description

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- Procedure code
- Quantity of each medical supply requested
- Manufacturer's suggested retail price (MSRP) for items that do not have a maximum fee assigned

Refer to: Subsection 2.2, "Services, Benefits, Limitations and Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for information about DME and medical supplies prior authorization.

3.4.3 Prior Authorization of SN and HHA Services

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

Home Health SN and HHA services require prior authorization. Providers must obtain authorization within three business days of the SOC date for an initial authorization. For recertifications, providers must obtain authorization within seven business days of the new SOC date. During the authorization process, providers are required to deliver the requested services from the SOC date, which is the date agreed to by the physician or allowed practitioner, the RN, the Home Health Agency, and the client, parent, guardian, or caregiver. The SOC must be documented on the POC.

A provider requesting prior authorization for SN or HHA Services must submit the following documentation:

- A completed client assessment
- A completed Texas Medicaid home health services POC that must:
  - Be signed and dated by the assessing RN
  - Signed and dated by the physician or allowed practitioner or submitted with the signed and dated physician or allowed practitioner's orders.

Note: *To complete the prior authorization process by paper, the SN or HHA provider must fax or mail the completed documentation to the Home Health prior authorization unit and retain a copy of the signed and dated documentation in the client's medical record at the provider's place of business.*

Note: *To complete the prior authorization process electronically, the SN or HHA provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated documentation in the client's medical record at the provider's place of business.*

Note: *All documentation, including all written and verbal orders, and all physician- or allowed practitioner-signed POCs, must be maintained by the ordering physician or allowed practitioner, and the home health agency must keep the original, signed copy of the POC in the client's medical record.*

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN or HHA visits that will safely meet the client's needs. The amount and duration of SN or HHA visits requested will be evaluated by the claims administrator.

The home health agency must ensure the requested services are supported by the client assessment, POC, and the physician or allowed practitioner's orders.

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The length of the authorization is determined on an individual basis and is based on the goals and timelines identified by the physician or allowed practitioner, home health agency, RN, and client, parent, guardian, or caregiver. SN and HHA visits will be prior authorized for no more than 60 days at a time. As a client's problems are resolved and goals are met, a client's condition is expected to become more stable, and the client's needs for SN and HHA services may decrease.

3.4.3.1 Routine Laboratory Specimens

SN visits to obtain routine laboratory specimens may be considered when the only alternative to obtain the specimen is to transport the client by ambulance.

3.4.3.2 Home Phototherapy

SN visits to address hyperbilirubinemia will not be considered for prior authorization if the client has an open authorization for home phototherapy. Home phototherapy is reimbursed as a daily global fee and includes coverage of SN visits for client, parent, or caregiver teaching and monitoring, and customary and routine laboratory work.

3.4.3.3 Prothrombin Time/Internationalized Normalized Ration (TP/INR) Home Testing Device

SN visits will not be authorized for the set-up or teaching of the Prothrombin Time/Internationalized Normalized Ration (TP/INR) home testing device.

3.4.3.4 Total Parenteral Nutrition (TPN)

SN visits to address total parenteral nutrition (TPN) must:

- Be provided by an RN appropriately trained in the administration of TPN.
- Include education of the client or caregiver regarding the in-home administration of TPN before administration initially begins.
- Include the use and maintenance of required supplies and equipment.
- Occur at least once every month to monitor the client's status and to provide ongoing education to the client or caregivers regarding the administration of TPN.

For clients receiving PDN who also require TPN administration education, intermittent SN visits may be considered for separate prior authorization when:

- The PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.
- There is documentation to support the medical need for an additional skilled nurse to perform TPN.

The SN services may be prior authorized only for the client or caregiver training in TPN administration.

3.4.3.5 Instruction in the Self-administration of Prescribed Injections

For clients receiving SN visits, instruction to the client or caregiver in the self- administration of prescribed injections (IM, SQ, or IV), including but not limited to Factor 8 and IVIg are considered part of the existing authorized skilled nursing home visits. Additional nursing visits for teaching and (initial) supervision to the client or caregiver will not be allowed.

Instruction and initial supervision must be provided by an RN appropriately trained in the administration of the drug or product being administered, and the client and caregiver must be involved in the decision to self-administer the medication.

The client or caregiver administering the injectable medication (IM, SQ, or IV), including but not limited to Factor 8 product or IVIg, must:

- Be medically stable.

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- Have a history of compliance with other medications.
- Have a simple drug regimen.
- Have the ability to read and understand directions on the medication label.
- Demonstrate knowledge of the administration technique, maintenance of the required supplies and equipment, and storage requirements.

SN visits will not be approved for the sole purpose of instructing the client on the use of the subcutaneous injection port device. Any necessary instruction must be performed as part of the office visit with the prescribing physician or allowed practitioner.

3.4.3.6 Prior Authorization Status and Limitations

The claims administrator will notify the provider of the authorization or other action taken on the request for services.

Up to a maximum combined total of three SN and HHA visits may be prior authorized per day. One visit may last up to a maximum of 2.5 hours. SN or HHA visits may be provided on consecutive days.

> ***Note:*** *When documentation does not support medical necessity for home health SN or HHA visits, providers may be directed to possible alternative services based on the client's age and needs.*

A nurse or HHA may be authorized to provide services to more than one client over the span of the day as long as:

- Each client's care is based on an individualized POC; and
- Each client's needs and POC do not overlap with another client's needs and POC.

Settings in which a nurse or HHA provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving home health services, foster homes, and independent living arrangements.

A prior authorization for SN or HHA visits is no longer valid when:

- The client is no longer eligible for Medicaid;
- The client no longer meets the medical necessity criteria for SN or HHA services;
- The place of service cannot provide for the health and safety of the client;
- The client, parent, guardian, or caregiver refuses to comply with the attending physician or allowed practitioner's plan of treatment and compliance is necessary to assure the health and safety of the client; or
- The client changes providers and the change of notification is submitted to the claims administrator in writing with a prior authorization request from the new provider.

3.4.3.7 Canceling a Prior Authorization

The client has the right to choose their home health agency provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

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3.4.4 Medicare and Medicaid Prior Authorization

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

For eligible Medicare and Medicaid clients, Medicare is the primary insurance and providers must contact Medicare first for prior authorization and reimbursement. Home health service prior authorizations may be given for HHA services, certain medical supplies, or DME suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) does not qualify for home health services under Medicare because SN care, OT, or PT are not a part of the client's care.
- When the medical supplies and DME are not a benefit of Medicare Part B and are a home health services benefit.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third party resources or other insurance.

Note: *If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization.*

To ensure that Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of home health services for clients:

- Contact TMHP for prior authorization of Medicaid services (based on medical necessity and home health services benefits) within 30 days of the date on the MRAN. Fax a copy of the original MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.
- An MRAN is not required when a client is eligible for Medicare or Medicaid and needs HHA visits only. However, a skilled supervisory nursing visit must be made on the same day as the initial HHA visit and at least every 60 days (on the same day an HHA visit is made) thereafter as long as no skilled need exists. An SN supervisory visit is reimbursable, but an SN visit made for the primary purpose of assessing a client's nursing care is not. The SOC date will be the date of the first requested Medicare home health services visit as listed on the original MRAN.

  Note: *Claims for State of Texas Access Reform (STAR)+PLUS MQMB clients (those with Medicare and Medicaid) should always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.*

For Medicaid qualified Medicare beneficiary (MQMB) clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states "not medically necessary."

Medicaid will only consider prior authorization requests if the Medicare denial states "not a benefit" of Medicare.

When the client is 65 years of age or older or appears otherwise eligible for Medicare (e.g., a person who is blind or disabled), but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a "pending status" for Medicare determination is 90 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Subsection 3.2.1, "Skilled Nursing Visits" in this handbook.

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Home health providers should follow these guidelines:

- Clients who are 64 years of age and younger without Medicare Part A or B:
- If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of Texas Medicaid.
- Clients who are 65 years of age and older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
- In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.
- If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days of the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

3.5 Home Health SN and HHA Procedure Billing and Limitations

Home Health SN or HHA visits provided by home health agencies enrolled in Texas Medicaid must be billed using procedure codes G0299 (SN), G0300 (SN), and G0156 (HHA) and will be reimbursed per visit of up to 2.5 hours; not to exceed a combined total of three visits per day (7.5 hours total).

The reimbursement methodology for professional services delivered by home health agencies is a statewide visit rate calculated in accordance with 1 TAC §355.8021.

When services are provided to more than one client in the same setting, only the units directly provided to each client at distinct, separate time periods will be reimbursed. Provider documentation must support the services were delivered at distinct, separate time periods. Total home health services billed for all clients cannot exceed the individual provider's total number of hours spent at the place of service.

One as needed (PRN) SN visit may be reimbursed every 30 days outside of the prior authorized visits when SN visits have been authorized for the particular client.

For reimbursement purposes, Home Health SN or HHA services are always billed as place of service 2 (home) regardless of the setting in which the services are actually provided. SN or HHA services provided in the day care or school setting will not be reimbursed.

For all clients, SN visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes
- Independent living arrangements

For all clients, HHA visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes

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- Independent living arrangements

An immediate relative, parent or guardian, primary caregiver, or alternate care giver may not be reimbursed for HHA services even if he or she is an enrolled provider or employed by an enrolled provider.

SN and/or HHA services may be billed on the same day as PPECC services, but they may not be billed simultaneously with PPECC services. SN and/or HHA services may be billed before or after PPECC services.

Note: *SN and/or HHA services are subject to retrospective review and possible recoupment when the medical record does not document the provision of SN and/or HHA services are medically necessary based on the client's situation and needs. The service provider's record must explain all discrepancies between the service hours approved and the service hours provided. For example: the parents released the provider from all responsibility for the service hours or the agency was not able to staff the service hours. The release of provider responsibility does not indicate the client does not have a medical need for the services during those time periods.*

3.5.1 Skilled Nursing Visit for TPN Education

The nurse providing the intermittent SN visit for TPN services will only be reimbursed for time spent delivering client or family instruction and for direct client TPN services. The services delivered must be documented in the client's record.

PDN and SN should not be routinely performed on the same date during the same time period.

PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client's medical record the skilled services individually provided, including but not limited to:

- The start and stop time of each nursing provider's specialized task(s)
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Both the intermittent SN visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

A skilled nursing visit for TPN education is not allowable in a PPECC setting.

3.5.2 Medication Administration Limitations

Nursing visits for the purpose of administering medications are not a benefit if one of the following conditions exists:

- The medication is not considered medically necessary to the treatment of the individual's illness or is not approved by the Food and Drug Administration (FDA) or is being used for indications not approved by the FDA.
- The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, or neighbor have been taught or can be taught to administer subcutaneous (SQ/SC), intramuscular (IM), and intravenous (IV) injections and has demonstrated competency.
- The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

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4 Private Duty Nursing (PDN) Services - CCP

4.1 Services, Benefits, Limitations, and Prior Authorization

PDN services are a benefit of the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) for Medicaid clients who are 20 years of age or younger. PDN services are nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, for clients who meet the medical necessity criteria, and who require individualized, continuous, skilled care beyond the level of SN visits normally authorized under Texas Medicaid Home Health SN and Home Health Aide (HHA) Services. PDN services may be provided by a registered nurse (RN) or a licensed vocational nurse (LVN).

Note: *Texas defines a licensed practical nurse (LPN) as a licensed vocational nurse (LVN).*

Procedure code T1000 is a benefit of Texas Medicaid when PDN services are provided by a home health agency or an independently enrolled RN/LVN.

Providers must submit the appropriate modifier(s) from the table below for reimbursement purposes. Independently enrolled RNs or LVNs must include modifier U3 along with TD or TE for reimbursement purposes. Specialized care (procedure code T1000 with UA modifier) requires prior authorization.

Texas Medicaid allows additional reimbursement for specialized care associated with clients who are dependent on invasive ventilator life support or clients with a functioning tracheostomy. A client who is ventilator dependent means that the client requires an invasive ventilator to help them breathe and they cannot breathe on their own without assistance. Invasive mechanical ventilation is defined as the delivery of positive pressure to the lungs via an endotracheal or tracheostomy tube.

To receive additional reimbursement for specialized care, the PDN provider must include procedure code T1000 with modifier UA on the prior authorization request for PDN services.

Specialized care must meet all prior authorization requirements listed in the UA Modifier Requirements section to be approved.

Modifiers	
TD	Registered nurse (RN)
TE	Licensed vocational nurse (LVN)
U3	Independently enrolled provider
UA	Specialized services for clients with an invasive ventilator or functional tracheostomy

Example: *Procedure code T1000 would be submitted with modifiers TD, U3, and UA for reimbursement purposes for PDN in increments of up to 15 minutes when provided by an independently enrolled RN to a client who requires specialized services for invasive ventilator management.*

Because of the nature of the service being provided, some billing situations are unique to PDN. These billing requirements are as follows:

- All hours worked on one day must be billed together, on one detail.
- Nurse A works 7 a.m. to 11 a.m. and then returns and works 7 p.m. to 11 p.m. Services must be billed for eight hours (32 units of 15 minutes each) on one detail for that date of service.
- Nurse B works 7 p.m. to 7 a.m. Services must be billed on two separate details since the shift begins and ends on two different calendar days. The first detail should include 7 p.m. to 11:59 p.m. (20 units of 15 minutes each) and the second detail should include 12 a.m. to 7 a.m. (28 units of 15 minutes each).

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- An individually-enrolled nurse will not be reimbursed for more than 16 hours of PDN services in one day.

PDN may be delivered in a provider to client ratio other than one-on-one. An RN or LVN may provide PDN services to more than one client over the span of the day as long as each client's care is based on an individualized POC, and each client's needs and POC do not overlap with another client's needs and POC. Only the time spent on direct PDN for each client is reimbursed. Total PDN billed for all clients cannot exceed an individual provider's total number of hours at the POS.

A single nurse may be reimbursed for services to more than one client in a single setting when the following conditions are met:

- The hours for PDN for each client have been authorized through the TMHP Prior Authorization Department.
- Only the actual "hands-on" time spent with each client is billed for that client.
- The hours billed for each client do not exceed the total hours approved for that client and do not exceed the actual number of hours for which services were provided.

Example: *If the prior authorized PDN hours for Client A is four hours, Client B is six hours, and the actual time spent with both clients is eight hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client's prior authorized hours or total hours worked. It would be acceptable to bill four hours for Client A and four hours for Client B, or three hours for Client A and five hours for Client B. It would not be acceptable to bill five hours for Client A and three hours for Client B. It would be acceptable to bill ten hours if the nurse actually spent ten hours onsite providing prior authorized PDN services split as four hours for Client A and six hours for Client B. A total of ten hours cannot be billed if the nurse worked only eight hours.*

For reimbursement purposes, PDN services must always be submitted with place of service "home" regardless of the setting in which services are actually provided. PDN services may be provided in the following settings, but are not limited to the:

- Client's home.
- Nurse provider's home.
- Client's school.
- Client's daycare facility.

A parent or guardian of a minor client, or the client's spouse may not be reimbursed for PDN services even if he or she is an enrolled provider or an owner of a home health agency.

PDN services are subject to retrospective review and possible recoupment when the medical record does not document the provision of PDN services are medically necessary based on the client's situation and needs. The PDN services provider's record must explain all discrepancies between the service hours approved and the service hours provided. For example: the parents released the provider from all responsibility for the service hours or the agency was not able to staff the service hours. The release of provider responsibility does not indicate the client does not have a medical need for the services during those time periods.

4.1.1 Medical Necessity

Texas Medicaid defines medically necessary EPSDT services as health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability, physical or mental illness, or chronic conditions.

Medicaid clients who are 20 years of age or younger, and who are eligible for THSteps, are entitled to all medically necessary PDN services to promote independence and support the client living at home.

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PDN services are considered medically necessary when a client has a disability, physical or mental illness, or chronic condition, and he or she requires continuous, skillful observations, judgments, and interventions to correct or ameliorate his or her health status.

The following elements should always be addressed in documentation submitted with a request for PDN services:

- Dependent on technology to sustain life.
- Requires ongoing and frequent skilled interventions to maintain or improve health status; and delayed skilled intervention is expected to result in:
  - Deterioration of a chronic condition;
  - Loss of function;
  - Imminent risk to health status due to medical fragility; or
  - Risk of death.

4.1.2 PDN Services

All PDN services must be prior authorized.

PDN services provide nursing care and parent, guardian, or responsible adult training and education intended to:

- Optimize client health status and outcomes; and
- Promote family-centered, community-based care as a component of an array of service options by:
  - Preventing prolonged or frequent hospitalizations or institutionalization.
  - Providing cost-effective and quality care in the most appropriate, least restrictive environment.

PDN services are nursing services ordered by a physician, included in the nursing plan of care (POC), and provided by an RN or LVN.

> ***Note:*** *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number blocks are required.*

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means that the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

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Vocational nursing, as defined in the Texas Nursing Practice Act, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.
- Assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs.
- Engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

Professional and vocational nursing care consists of those services that must, under state law, be performed by an RN or LVN, and are further defined as nursing services in the Code of Federal Regulations (42 CFR §§ 409.32, 409.33, and 409.44).

- In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the beneficiary, and the accepted standards of medical and nursing practice.
- The fact that the nursing care can be, or is, taught to the client or to the client's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse.
- If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a nursing service.
- If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the services cannot be regarded as nursing care.
- Some services are classified as a nursing care on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if medically necessary for the treatment of the client's illness or injury, would be covered on that basis. However, in some cases, the client's condition may cause a service that would ordinarily be considered unskilled to be considered nursing care. This would occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.
- A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client's family, or other responsible adults.

Because Texas Medicaid is obligated to provide all medically necessary PDN services, a parent or guardian is not obligated to provide PDN services even if the parent or guardian has received the appropriate training. Medically necessary PDN services will not be denied to clients based on the parent or guardian's ability to provide the necessary PDN services.

PDN services that are intended to provide mainly respite care; child care; or do not directly relate to the client's medical needs or disability are not a benefit of Texas Medicaid.

The delivery of PDN services may inherently result in the relief of the parent, guardian, or responsible adult, child care, or some nonmedical, nonskilled activities in the course of providing nursing care.

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4.1.3 PDN Providers

PDN services must be provided by a licensed home health services agency or a licensed and certified home health services agency enrolled in Texas Medicaid or by an RN or LVN enrolled independently with Texas Medicaid. PDN providers must comply with all applicable federal, state, and local laws and regulations and Texas Medicaid policies and procedures.

All providers must maintain written policies and procedures for:

- Obtaining consent for medical treatment for clients in the absence of the parent or guardian that meet the standards of the Texas Family Code, Chapter 32.
- Obtaining physician signatures for all telephone orders within 14 calendar days of receipt of the order.

PDN providers must only accept clients on the basis of a reasonable expectation that the client's needs can be adequately met in the place of service. The essential elements of safe and effective PDN services include a responsible adult when the client is a minor child, a contingency plan, a primary physician, competent providers, and an environment that supports the client's health and safety needs.

The place of service must be able to support the health and safety needs of the client and must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and back-up utilities, communications and fire safety systems must be available.

Clients who are 17 years of age or younger must reside with an identified responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

An identified responsible adult is an individual 18 years of age or older who has agreed to accept the responsibility for a client's provision of food, shelter, clothing, education, nurturing, and supervision. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, individuals court-appointed as managing conservators, and other family members by birth or marriage.

An identified contingency plan is a structured process, designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained, to provide the nursing care. The identified responsible adult must be able to initiate the contingency plan.

The responsible adult's signature must be on the form acknowledging:

- Information about PDN has been discussed and received.
- PDN may change or end based on a client's need for nursing care.
- PDN is not authorized for the primary purpose of providing respite, childcare, ADLs, or housekeeping.
- All requirements have been met before seeking prior authorization for PDN.
- The responsible adult has participated in the development of the POC and the nursing care plan for the client.
- Emergency plans have been made and are part of the client's care plan.
- The client or responsible adult agrees to follow the physician's POC.

Note: *A responsible adult of a minor client or a client's spouse may not be reimbursed for PDN even if the responsible adult is an enrolled provider or employed by an enrolled provider.*

PDN services may be delivered in a provider or client ratio other than 1:1.

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4.1.4 Authorization Requirements

PDN services require prior authorization.

Specialized care under the UA modifier requires prior authorization.

All requests for PDN services must be based on the current medical needs of the client.

PDN services will not be prior authorized when:

- The client does not meet medical necessity criteria as defined in the Statement of Benefits.
- The client does not have a primary physician;
- The client is not 20 years of age or younger;
- When the client's needs are not beyond the scope of services available through Medicaid Title XIX Home Health SN or HHA Services because the needs can be met on a part-time or intermittent basis.

Requests for PDN must be based on the current medical needs of the client.

The following criteria are considered for PDN prior authorization:

- The documentation submitted with the request is complete.
- The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
- The explanation of the client's medical needs is sufficient to support a determination that the requested services correct or ameliorate the client's disability, physical or mental illness, or chronic condition.
- The client's nursing needs cannot be met on an intermittent or part-time basis through Texas Medicaid (Title XIX) home health services skilled nursing services.
- There is no TPR financially responsible for the services.

Only those services that meet the medical necessity criteria for PDN are reimbursed. Before the TMHP Prior Authorization Department or MCO determines the requested nursing services do not meet the criteria, the Medical Director contacts the treating physician to determine whether additional information or clarification can be provided that would allow for the prior authorization of the requested PDN. If the Medical Director is not successful in contacting the treating physician or cannot obtain additional information or clarification, the Medical Director makes a decision based on the available information.

Providers must obtain prior authorization within three business days of the SOC for services that have not been prior authorized. During the prior authorization process, providers are required to deliver the requested services from the SOC date. The SOC date is the date agreed to by the physician, the PDN provider, and the client or responsible adult and is indicated on the submitted POC as the SOC date.

> ***Note:*** *The TMHP Prior Authorization Department does not prior authorize an SOC date earlier than seven calendar days before contact with TMHP.*

Requests for nursing services must be submitted on the required Medicaid authorization forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the client's current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the client's disability, physical or mental illness, or condition.

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4.1.4.1 Authorization Forms

The CCP Prior Authorization Request Form must be completed, signed, and dated by the physician. When PDN services are ordered, by signing the form the physician attests and certifies the client's medical condition is sufficiently stable to permit safe delivery of PDN as described in the plan of care. All requested dates of service must be included.

The POC must be recommended, signed, and dated by the client's primary physician. A POC must meet the standards outlined in the 42 CFR §484.18 related to the written POC. The primary physician must review and revise the POC, in consultation with the provider and the responsible adult, for each prior authorization, or more frequently as the physician deems necessary or the client's situation changes.

The Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form addresses PDN eligibility criteria, nursing care plan summary, health history summary, 24-hour schedule, and the rationale for the hours of PDN requested.

The following is a description of the nursing care plan summary:

- The nursing care summary is not a complete nursing care plan.
- Information must be client-focused and detailed.
- The problem list must reflect the reasons that nursing services are needed. The problem list is not the nursing care plan. Providers must identify two-to-four current priority problems from their nursing care plan. The problem does not need to be stated as a nursing diagnosis. The problems listed must focus on the primary reasons that a licensed nurse is required to care for the client. Other attached documents are not accepted in lieu of this section.
- The Goals must relate directly to the problems listed and be client-specific and measurable. Goals may be short- or long-term; however, for many clients who receive PDN, the goals generally are long-term.
- The Outcomes are the effects of the provider's nursing interventions and must be measurable. Generally, these are more short-term than goals. For initial requests, list expected outcomes. Extension requests should note the results of nursing interventions.
- The Progress must be viewed as a "yardstick" or continuum on which progress toward goals is marked. Initial requests must state expected progress for the authorization period. Extension requests must list the progress noted during the previous authorization period. It is recognized that all progress may not be positive.
- The addendum must summarize the client's health problems relating to the medical necessity for PDN.
- The addendum must clearly communicate a picture of the client's overall condition and nursing care needs.
- The summary of recent health history is imperative in determining whether the client's condition is stable or if new nursing care needs have been identified. This section gives the PDN provider an opportunity to describe the client's recent health problems, including acute episodes of illness, hospitalizations, injuries, and so on. The summary should create a complete picture of the client's condition and nursing care needs. The summary may cover the previous 90 days, even though the authorization period is 60 days; however, the objective of the summary is to capture the client's recent health problems and current health priorities. This section should not be merely a list of events. This section is the place to indicate the frequency of nursing interventions if they are different from the physician's order on the POC, such as, the order may be for a procedure to be PRN (Pro Re Nata "As Needed"), but it is actually being performed every two hours.
- The addendum must include the rationale for increasing, decreasing, or maintaining the level of PDN and must relate to the client's health problems and goals.

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- The addendum must include the provider's plan to decrease hours or discharge from service (if appropriate).

All direct-care services must be identified in the client's 24-hour daily schedule. It is understood that the schedule may change, as the client's needs change. The TMHP Prior Authorization Department does not have to be notified of changes in the schedule except as they occur when a PDN recertification is requested.

4.1.4.2 Primary Physician Requirements

The client must have a primary physician who provides continuing care and medical supervision, including, but not limited to, examination or treatment within 30 calendar days prior to the start of PDN services.

The physician visit may be waived when a diagnosis has already been established by the physician, and the client is under the continuing care and medical supervision of the physician. A waiver is valid for no more than 365 days, and the client must be seen by his or her physician at least once every 365 days. The waiver must be based on the physician's written statement that an additional evaluation visit is not medically necessary. This documentation must be maintained by the physician and the provider in the client's medical record.

> ***Note:*** *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

The primary physician must:

- Provide a prescription for PDN services
- Recommend, sign, and date a plan of care (POC)
- Sign a statement of need that PDN services are medically necessary
- Maintain documentation that the client's medical condition will allow safe delivery of PDN services as described in the POC

The physician recommended POC must include the following:

- The client's Medicaid number, the physician's license number, and the provider's National Provider Identifier
- Date the client was last seen by the physician
- The start of care (SOC) date for PDN services
- All pertinent diagnoses
- The client's mental status
- The prognosis
- The types of service requested, including the amount, duration, and frequency
- The equipment or supplies required
- Settings or mode(s) for required equipment (e.g., ventilator, oxygen)
- Rehabilitation potential
- Prior and current functional limitations
- Activities permitted
- Nutritional requirements
- Medications, including the dose, route, and frequency

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- Treatments, including amount and frequency
- Wound care orders and measurements
- Safety measures to protect against injury
- Responsible adult when the client is a minor child
- Contingency plan
- List all community or state agency services the client receives in the home (including, but not limited to, PCS, Community First Choice (CFC), MDCP
- Instructions for timely discharge or referral
- Client specific goals, including if receiving PPECC, the goal of ensuring coordination of ongoing skilled nursing services with the PPECC provider.
- If the client also receives PPECC services, documentation that the client or client's responsible adult has been involved in the POC development, and description of how ongoing skilled nursing services will be coordinated between PDN and PPECC providers.

Refer to: 42 CFR §484.18 for additional information about POC requirements.

Physician Recertification of PDN services:

- The primary physician's medical care must comply with the THSteps periodicity schedule.
- The primary physician must provide specific, written, dated orders for clients who are receiving continuing or ongoing PDN services.

4.1.4.3 UA Modifier Requirements

The UA modifier allows additional reimbursement for specialized care associated with clients who are dependent on invasive ventilator life support or clients with a functioning tracheostomy and who meet the clinical indications listed below.

For the use of the UA modifier, a client who is ventilator dependent means that the client requires an invasive ventilator to help them breathe and they cannot breathe on their own without assistance.

Prior authorization requests for specialized care under the UA modifier must be submitted with requests for PDN services. Requests for specialized care under the UA modifier must include the modifier with the HCPCS code, a brief description of the requested services, and documentation of medical necessity on the CCP Prior Authorization Request Form.

Note: *PDN services must be considered for prior authorization even if the services for specialized care (UA modifier) are denied.*

Note: *Documentation of medical necessity is also required on the Home Health Plan of Care and the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers forms.*

PDN providers requesting prior authorization for specialized care under the UA modifier must submit all the documentation requirements for PDN services. In addition, providers must submit the clinical indications, as supported by a physician's order and documented in the POC justifying the use of the UA modifier.

Clinical indications for specialized care include the following:

- Clients who require a home ventilator with invasive interface (e.g., tracheostomy) associated with one of the following:
  - Neuromuscular disease
  - Thoracic restrictive disease

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- Chronic respiratory failure consequent to chronic obstructive pulmonary disease
- Congenital central hypoventilation syndrome
- Chronic lung disease of infancy (e.g., bronchopulmonary dysplasia)
- Obesity hypoventilation syndrome
- Restrictive disorder of chest wall
- Other conditions requiring invasive ventilation supported with documentation of medical necessity by a physician

- Clients with a functioning tracheostomy requiring both suctioning and other specified types of nursing care (e.g., dressing changes, skin care, humidification, or changing tracheostomy tubes and ties). Documentation in the treatment plan must include specific interventions and care.

Note: *Texas Medicaid will not approve a request for specialized care (UA modifier) if the client has a tracheostomy but does not meet the above requirements.*

Texas Medicaid will not approve clients with the following clinical indications for specialized care:

- Clients who use a non-invasive ventilator
- Clients who use a ventilator for the sole purpose of functioning as a respiratory assistance device (RAD), including continuous positive airway pressure (CPAP), auto-titrating positive airway pressure (APAP), bilevel positive airway pressure (BPAP, BiPAP), or adaptive servo-ventilation (ASV)

4.1.4.4 PDN Provider Requirements

When a provider receives a referral for PDN services, the provider must have an RN perform a nursing assessment of the client within the client's home environment. This assessment must be performed before seeking prior authorization for PDN services, with any request for PDN services recertification, or any request to modify PDN service hours. The assessment includes, but is not limited to, the determination of:

- Medical necessity for PDN services
- Safety of providing care in the proposed setting;
- Appropriateness of care in the place of service
- Receptivity to training and ability level of the parent, guardian, or responsible adult
- The existing level of care and any additional health-care services to include, but not limited to, School Health and Related Services (SHARS), MDCP, PT, OT, ST, PCS, CFC, or case management services. Services provided under these programs will not prevent a client from obtaining medically necessary services. Certain school services are provided to meet education needs, not medical needs.

When an RN completes a client assessment and identifies a medical necessity for ADLs or health-related functions to be provided by a nurse, the scope of PDN services may include these ADLs or health-related functions.

Note: *The TMHP Prior Authorization Department does not review or authorize PDN based on partial or incomplete documentation.*

4.1.4.5 Prior Authorization of PDN Services

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

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Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

PDN services require prior authorization. Providers must obtain authorization within three business days of the SOC for services that have not been prior authorized. During the authorization process, providers are required to deliver the requested services from the SOC date. The SOC date is the date agreed upon by the physician, the PDN provider, and the client, parent, or guardian and is indicated on the submitted POC as the SOC date.

Note: *Not including PDN services provided during the authorization process, coverage periods may not coincide with calendar weeks or months. A prior authorized week coverage period begins from the day of the week the prior authorization period begins on and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday. The number of nursing hours authorized for a week must be contained in that prior authorization week. Hours billed in excess of those authorized for the PAN week are subject to recoupment.*

A PDN provider requesting prior authorization for PDN services must submit all of the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the primary physician within 30 calendar days prior to the SOC date.
- A completed POC form, signed and dated by the primary physician within 30 calendar days prior to the SOC date.
- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the primary physician, RN completing the assessment, and client, parent, guardian, or responsible adult within 30 calendar days prior to the SOC date. The Nursing Addendum form must include:
  - An updated problem list
  - An updated rationale or summary page
  - A contingency plan
  - A 24-hour daily care flowsheet
  - A signed Acknowledgement

All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation including, but not limited to, nurse's notes, medication administration records, seizure logs, and ventilator logs to support medical necessity as defined in this handbook.

The request can be submitted as follows:

- To complete the prior authorization process by paper, the PDN provider must fax or mail the completed PDN Request Documentation to the TMHP Prior Authorization Department and retain a copy of the signed and dated documentation in the client's medical record at the provider's place of business.
- To complete the prior authorization process electronically, the PDN provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated documentation in the client's medical record at the provider's place of business.

Requests for authorizations of PDN services should always be commensurate with the client's medical needs. Requests for services should reflect changes in the client's condition that affect the amount and duration of PDN.

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For clients who are receiving PDN services who also require phototherapy, parent or guardian education, instructional use of the phototherapy equipment, and obtaining laboratory specimens collection are included in the PDN care provided.

Authorizations for more than 16 hours per day will not be issued to a single, independently enrolled nurse.

The length of the authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and client, parent, or guardian. PDN services will not be authorized for more than 180 calendar days at a time.

The TMHP Prior Authorization Department or MCO is required to notify the client, parent, or guardian, physician, and provider of the approval, denial, or other action taken in response to the authorization request by fax or mail.

Home Health Agencies must provide written notice to clients of their intent to voluntarily terminate PDN services at least five calendar days prior to terminating services, except in situations of a potential threat to the provider's personal safety.

Independently enrolled RNs or LVNs must provide written notice to clients of his or her intent to voluntarily terminate services at least 30 calendar days prior to terminating services, except in situations where there is a potential threat to the nurse's personal safety.

For clients who are receiving PDN services who also require TPN administration education, intermittent SN visits may be separately authorized when the SN services are for client or client caregiver training in TPN administration, and the PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.

Refer to: Subsection 3.3, "Home Health Skilled Nursing and Home Health Aide Services Providers" in this handbook for detailed information about SN benefits.

If the client has no skilled nursing need other than provision of education for self administration of prescribed injections (IM, SQ, or IV), then the client does not qualify for private duty nursing services. Nursing hours for the sole purpose of education to the client and caregiver may be considered through intermittent home health skilled nursing visits.

4.1.4.6 Initial Authorization

An initial PDN prior authorization request requires all of the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the primary physician within 30 calendar days prior to the SOC date.
- A completed POC form, signed and dated by the primary physician within 30 calendar days prior to the SOC date.
- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the primary physician, RN completing the assessment, and client, parent, guardian, or responsible adult within 30 calendar days prior to the SOC date. The completed Nursing Addendum form must include all the following:
  - An updated problem list
  - An updated rationale or summary page
  - A contingency plan
  - A 24-hour daily care flowsheet

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- A signed Acknowledgement

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation including, but not limited to, nurse's notes, medication administration records, seizure logs, and ventilator logs to support medical necessity as defined in this handbook.

Initial requests must be submitted within three business days of the SOC date.

Initial requests may be prior authorized for a maximum of 90 days.

Completed initial requests must be received and dated by the TMHP Prior Authorization Department within three business days of the SOC. The request must be received by the TMHP Prior Authorization Department no later than 5 p.m., Central Time, on the third day to be considered received within three business days. If a request is received more than three business days after the SOC, or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

4.1.4.7 Revisions

The provider may request a revision at any time during the authorization period if medically necessary. The provider must notify the TMHP Prior Authorization Department at any time during an authorization period if the client's condition changes and the authorized services are not commensurate with the client's medical needs.

Requests for revisions must be submitted within three business days of the revised SOC date.

Revisions during a current authorization period must fall within that authorization period. If the revision is requested outside of an authorization period, the provider must request a new authorization and submit the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the primary physician within 30 calendar days prior to the SOC date.
- A completed POC form, signed and dated by the primary physician within 30 calendar days prior to the SOC date.
- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the primary physician, RN completing the assessment, and parent, guardian, client, or responsible adult within 30 calendar days prior to the SOC date.

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

Note: *All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation including, but not limited to nurse's notes, medication administration records, seizure logs, and ventilator logs to support medical necessity.*

Revised services may be prior authorized for up to a maximum of 180 calendar days.

A request for a client that does not satisfy the criteria listed above for a 180 calendar day authorization may be authorized for a period up to 90 calendar days.

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The provider is responsible for ensuring that the physician reviews and signs the POC within 30 calendar days of the start date of the revised authorization period, or more often if required by the client's condition or agency licensure. The provider must maintain the physician-signed POC in the client's record. PDN providers should not submit a revised POC unless they are requesting a revision.

Completed requests for revision of PDN hours during the current authorization period must be received by TMHP Prior Authorization Department within three business days of the revised SOC. The request must be received by TMHP Prior Authorization Department no later than 5 p.m., Central Time, on the seventh day to be considered received within three business days. If a request is received more than three business days after the revised SOC or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Revisions to a current certification must fall within the certification period. If the revision extends beyond the current certification period, new authorization documentation must be submitted to TMHP Prior Authorization Department.

4.1.4.8 Required Coordination between PDN and Prescribed Pediatric Extended Care Centers (PPECCs)

When a client or client's physician notifies the PDN provider that the client also receives services from a Medicaid enrolled PPECC provider, the PDN provider must coordinate services with the PPECC provider. Both PDN and PPECC services are considered ongoing skilled nursing. A client has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing where PPECC services are available. Skilled Nursing services are authorized for a set number of hours based on the client's medical necessity at the time of the prior authorization request. Skilled nursing hours are not expected to increase when the client utilizes a combination of both PDN and PPECC services, unless there is a documented change in medical condition, or the authorized hours are not commensurate to the client's medical needs and additional hours are medically necessary.

PDN and PPECC providers must collaborate in developing their respective 24-hour flow charts found in the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form each time a client's authorization for ongoing skilled nursing is initiated, recertified, and revised.

Both providers must maintain documentation that the client or the client's responsible adult has participated in the development of the POC (e.g., the completed PPECC POC and Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers, with client or client responsible adult signatures on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers).

Both providers must discuss with the client or the client's responsible adult how care will be coordinated between the two providers.

When a new service is initiated for ongoing skilled nursing services, and the client wants to receive both PDN and PPECC services, the TMHP Prior Authorization Department will compare the Nursing Addendum's 24-hour daily care flow sheets and medical necessity documentation (e.g., authorization requests). Upon subsequent approval of PDN or PPECC services, the provider who submitted the initial prior authorization request that established the number of authorized skilled nursing hours will have their authorized hours reduced to prevent duplication (e.g., if the client currently has PDN, and then adds PPECC services, the PDN hours will be reduced).

When hours are reduced, the PDN or PPECC provider affected by the reduction will be notified by the TMHP Prior Authorization Department when the reduction is effective, and the revised amount of authorized hours. Providers that are affected by the reduction are only required to submit a revision request and documentation of medical necessity if there is a change in the client's medical condition or the client's medical needs are not commensurate with authorized hours and additional ongoing skilled nursing hours are medically necessary. No action is required from the provider affected by the reduction if additional hours are not medically necessary.

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4.1.4.9 Client Receives both PDN and PPECC and Shifts Services from One to the Other

A client receiving both PDN and PPECC services may choose to shift approved hours from one ongoing skilled nursing provider to another.

The receiving provider (PDN or PPECC provider who will gain hours in the shift) must submit all required documentation for a revision.

The sending provider (PDN or PPECC provider who will lose hours in the shift) will receive a notice from the TMHP Prior Authorization Department with revised (decreased) hours and the effective date of the reduction. The sending provider does not need to take any action unless there is a change in the client's medical needs, and additional ongoing skilled nursing hours are medically necessary. If there is a medical need for additional ongoing skilled nursing hours, the sending provider may submit a revision request.

The total combined hours between PDN and PPECC services are not expected to increase without client medical necessity for additional hours (e.g., change in client condition or authorized hours are not commensurate with the client's medical needs).

4.1.4.10 Recertifications

Recertifications may be prior authorized for up to a maximum of 180 calendar days.

The following criteria must be met before a client receives a recertification:

- The client must have received PDN services for at least 90 calendar days
- No significant changes in the client's condition for at least 90 calendar days
- No significant changes in the client's condition are anticipated
- The client's parent or guardian, physician, and provider agree the recertification is appropriate

A recertification request must be submitted at least 7 calendar days before, but no more than 30 days before, a current authorization period will expire. The PDN provider must submit the following documentation with the recertification request:

- A completed CCP Private Duty Nursing six-month authorization signed and dated by the primary physician, nurse provider, and client, parent, or guardian
- A completed CCP Prior Authorization Request form signed and dated by the primary physician within 30 calendar days prior to the SOC date
- A completed POC form, signed and dated by the primary physician within 30 calendar days prior to the SOC date
- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the primary physician, RN completing the assessment, and parent, guardian, client, or responsible adult within 30 calendar days prior to the SOC date

  Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

  Note: *All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation including, but not limited to nurse's notes, medication administration records, seizure logs, and ventilator logs to support medical necessity.*

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The provider is responsible for ensuring that the physician reviews and signs the POC within 30 calendar days of the expiration of the authorization period, and this documentation must be maintained in the client's record. PDN providers should not submit a revised POC unless requesting a revision.

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

The provider may request a revision of a recertification at any time during the recertification period if medically necessary. The provider must notify the claims administrator at any time during a recertification period if the client's condition changes and the authorized services are not commensurate with the client's medical needs.

All authorization timelines apply to recertifications.

Completed extension requests must be received and dated by TMHP Prior Authorization Department at least seven calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by TMHP Prior Authorization Department no later than 5 p.m., Central Time, on the seventh day, to be considered received within seven calendar days. If a request is received less than seven calendar days before the current authorization expiration date, or after 5 p.m., Central Time, on the seventh day, authorization is given for dates of service beginning no sooner than seven calendar days after the receipt of the completed request by TMHP Prior Authorization Department.

The nursing care provider must notify TMHP Prior Authorization Department at any time during the authorization period if the client's condition and need for SN care significantly changes.

4.1.4.11 Special Circumstances

PDN services provided in a school or day care facility, at the request of the family, may be authorized provided the client requires the requested amount of PDN services if in the home.

PDN services may be provided in a hospital, SN facility or intermediate care facility for the individuals with intellectual disabilities, or special care facility with documentation from the facility showing it is unable to meet the SN needs of the client, and the services are medically necessary. These facilities are required by licensure to meet all the medical needs of the client.

4.1.4.12 PDN Services Provided in Group Settings

PDN services may be authorized in a provider or client ratio other than 1:1.

An RN or LVN may be authorized to provide PDN services to more than one client over the span of the day as long as:

- Each client's care is based on an individualized POC
- Each client's needs and POC do not overlap with another client's needs and POC

Settings in which a PDN provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving PDN, foster homes, or independent living arrangements.

4.1.4.13 Termination of Authorization

Authorization for PDN services will be terminated when:

- The client is no longer eligible for Medicaid
- The client no longer meets the medical necessity criteria for PDN services
- The place of service does not support the health and safety of the client

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- The client, parent, or guardian refuses to comply with the service plan and compliance is necessary to assure the health and safety of the client

4.1.4.14 Appeal of Authorization Decisions

Providers may appeal denials or modifications of requested PDN services with documentation to support the medical necessity of the requested PDN services. Appeals must be submitted to the TMHP Prior Authorization Department with complete documentation and any additional information within two weeks of the date on the decision letter. If changes are made to the authorization based on this documentation, TMHP Prior Authorization Department will go back no more than three business days for initial, or revision requests and no more than seven calendar days for recertification requests when additional documentation is submitted.

The client, parent, or guardian will be notified of any denial or modification of requested services and will be given information about how to appeal the TMHP Prior Authorization Department decision.

All documentation must be submitted together, and requests are not reviewed until all documentation is received. If complete documentation is received at TMHP Prior Authorization Department by 3 p.m., Central Time, a response is returned to the provider within one business day. Complete documentation for initial, revision, recertification, and extension requests for PDN authorizations include all of the following:

- CCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.
- Home Health Plan of Care (POC) on the TMHP website at www.tmhp.com.
- Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers on the TMHP website at www.tmhp.com.

4.1.4.15 Start of Care (SOC)

The SOC is the date that care is to begin, as agreed on by the family, the client's physician, and the provider, and as listed on the POC and the CCP Prior Authorization Request Form. Providers are responsible for determining whether they can accept the client for services.

Once the provider accepts a client for service and accepts responsibility for providing PDN, the provider is required to deliver those services beginning with the SOC date. Providers are responsible for a safe transition of services when the authorization decision is a denial or a reduction of services. Providers are required to notify the physician and the client's family on receipt of an authorization, a denial, or a change in PDN.

Providers must submit complete documentation no later than three business days from an SOC date to obtain initial coverage for the SOC date.

> ***Note:*** *Texas Medicaid (Title XIX) home health services does not authorize an SOC date earlier than three business days before contact with TMHP.*

For PDN recertification, TMHP Prior Authorization Department must receive complete documentation no later than three business days before the SOC date. It is recommended that recertification requests be submitted up to 30 days before the current authorization ends.

During the prior authorization process for initial and recertification requests, providers are required to deliver the requested services from the SOC date.

4.1.4.16 Client and Provider Notification

When PDN is approved as requested, the provider receives written notification. The provider is responsible for notifying the client or family and the physician of the authorized services.

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The TMHP Prior Authorization Department or MCO notifies the client and provider in writing when the following instances occur:

- PDN is denied.
- PDN hours authorized are less than the hours requested on the POC.
- PDN hours are modified (e.g., hours are requested by the week but are authorized by the day).
- The TMHP Prior Authorization Department or MCO receives incomplete information from the provider.
- Dates of service authorized are different from those requested.
- The provider is responsible for notification and coordination with the physician and family.

4.1.5 Limitations with Other Services

4.1.5.1 PDN Services with PCS, SHARS, or PPECC

When clients are receiving both PDN services and PCS from an individual person over the same span of time, all services will be reimbursed according to the maximum allowable fee schedule.

Texas Medicaid will not reimburse providers for PDN services that duplicate services provided by school districts under the SHARS program. If a provider bills Texas Medicaid for PDN services provided to a client at school, then the school district may be asked to provide documentation that it is not also providing PDN services to the same client at the same time and seeking reimbursement for the service under the SHARS program.

PDN services may be billed on the same day as PPECC services, but may not be billed simultaneously with PPECC services. PDN may be billed when it occurs before or after PPECC services.

4.1.5.2 PDN Provided During a Skilled Nursing Visit for TPN Administration Education

For clients who are receiving PDN services who also require TPN administration education, intermittent SN visits may be separately reimbursed when the SN services are for the client or caregiver training in TPN administration.

Refer to: Subsection 3.3, "Home Health Skilled Nursing and Home Health Aide Services Providers" in this handbook for detailed information about SN benefits.

PDN and SN should not be routinely performed on the same date during the same time period.

PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client's medical record the skilled services individually provided, including but not limited to:

- The start and stop time of each nursing provider's specialized task(s)
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Both the intermittent SN visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

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Intermittent SN visits for clients who receive PDN and who require TPN administration education may be considered for separate prior authorization if:

- The PDN provider is not an RN who has been appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.
- There is documentation that supports the medical need for an additional skilled nurse to perform TPN.

The SN services may be prior authorized only for the client and caregiver who will be trained in TPN administration.

Clients whose only SN need is the provision of education for self-administration of prescribed subcutaneous (SQ), intramuscular (IM), or intravenous (IV) injections will not qualify for PDN services.

Nursing hours for the sole purpose of providing education to the client and caregiver may be considered through intermittent home health SN visits.

5 Documentation Requirements

All documentation, including that which supports medical necessity, and the comprehensive treatment plan related to the therapy services that were prior authorized and provided, must be maintained in the client's medical record and made available upon request.

Documentation elements that are routinely assessed for compliance in retrospective review of client records include, but are not limited to, the required documentation noted previously, as well as the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- Client assessment time is documented at the beginning of each shift.
- All nurses' arrival and departure times are documented with signature and time in the narrative section of the nurses' notes.
- Entries in the nursing flowsheet or narrative notes must be dated and timed every 1 to 2 hours and must include the following:
- The client's condition.
- The name of the medication, dose, route, time given, client response, and other pertinent information is recorded when medication is administered.
- The name of treatment, time given, route or method used, client response, and other pertinent information is provided when treatments are administered.
- The amount, type, times given, route or method used, client response, and other pertinent information is provided when feedings are administered.
- The POC and documentation of services correlate with and reflect medical necessity for the services provided on any given day.
- A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.
- Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

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- Documentation of teaching the client or the client's responsible adult includes the length of time, the subject of the teaching, the understanding of the subject matter by the person receiving the teaching, and other pertinent information.
- Supervisory visits include specifics of the visit.
- If a client is receiving SN services through another program or service in addition to PDN, such as MDCP, each provider's shift notes designate specifically which type of service they are providing during that shift.

6 Claims Filing and Reimbursement

6.1 Claims Filing

Providers may purchase CMS-1500 or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions.

6.1.1 Home Health Skilled Nursing and Home Health Aide Providers

Providers must use only type of bill (TOB) 321 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and will result in a claim denial. Home health services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form.

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding Healthcare Common Procedure Coding System (HCPCS) code or narrative description. The prior authorization number must appear on the CMS-1500 paper claim form in Block 23 and in Block 63 of the UB-04 CMS-1450 paper claim form. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.

6.1.2 PDN Providers

Independently enrolled RNs or LVNs providing PDN services must submit claims on the CMS-1500 claim form. PDN Providers who are home health agencies must submit claims on the UB-04 CMS-1450 claim form.

PDN providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Home health agencies must submit claims on the UB-04 CMS-1450 paper claim form. Independently enrolled nurses must submit claims on the CMS-1500 paper claim form.

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6.1.3 Method for Counting Minutes for Timed Procedure Codes

All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

Time intervals for 1 through 12 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes
9 units	128 minutes through 142 minutes
10 units	143 minutes through 157 minutes
11 units	158 minutes through 172 minutes
12 units	173 minutes through 187 minutes

6.2 Reimbursement

The reimbursement methodology for professional services delivered by home health agencies is a statewide visit rate calculated in accordance with 1 TAC §355.8021.

Home health agencies are reimbursed for DME and medical supplies in accordance with 1 TAC §355.8023.

PDN services are reimbursed in accordance with 1 TAC §355.8441.

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

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INPATIENT AND OUTPATIENT HOSPITAL SERVICES HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human Services

INPATIENT AND OUTPATIENT HOSPITAL SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for Texas Medicaid hospital (medical and surgical acute care facility) providers and covers services that take place only in an inpatient or outpatient hospital setting. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to acute care hospitals, including military hospitals.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: The *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about services offered in settings such as rural health clinics (RHCs), Federally Qualified Health Centers (FQHCs), dialysis centers, and other similar facilities.

1.1 National Drug Codes (NDC)

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

1.2 Medicaid Managed Care Services

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

2 Enrollment

To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with the Health and Human Services Commission (HHSC), and have completed the Texas Medicaid & Healthcare Partnership (TMHP) enrollment process.

2.1 Hospital Eligibility Through Change of Ownership

Under procedures set forth by the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS), a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

- The provider must obtain recertification as a Title XVIII (Medicare) hospital.
- The hospital under new ownership must submit a new signed and dated HHSC Medicaid Provider Agreement between the hospital and HHSC.

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Providers can download the HHSC Medicaid Provider Agreement from the TMHP website at www.tmhp.com.

Refer to: Subsection 1.4, "Provider Reenrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.1.1 Hospital-based Ambulatory Surgical Center (HASC) Enrollment

All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an HASC provider number at the time of enrollment.

2.2 Hospital-based Rural Health Clinic Enrollment

To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. An RHC can also apply for enrollment as a family planning agency.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA are not reimbursed for laboratory services.

Refer to: Subsection 9.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for RHC benefit and limitation information.

Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures, including information on Changes of Ownership.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

3 Inpatient Hospital (Medical/Surgical Acute Care Inpatient Facility)

This section contains benefit, limitation, authorization, and claims filing information for inpatient hospital facility accommodation and ancillary services.

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more comprehensive information about claims filing and appeals.

"Section 7: Appeals" (*Vol. 1, General Information*) for more comprehensive information about claims filing and appeals.

Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.

3.1 General Information

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Texas Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of patients. Services must be medically necessary and are subject to Texas Medicaid's utilization review requirements. Claims submitted to TMHP must comply with the applicable Texas Medicaid policies and procedures.

3.1.1 Reimbursement Limitations

For clients who are 21 years of age and older, Texas Medicaid reimbursement for acute care inpatient hospital services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments that exceed $200,000 are recouped.

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This $200,000 limitation does not apply to the following:

- Services related to certain organ transplants.
- Services rendered to Texas Health Steps (THSteps) clients when provided through the Comprehensive Care Program (CCP).

For clients who are 20 years of age and younger, dollar limitations do not apply.

3.1.2 Spell of Illness

Reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively.

After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

Exceptions to the spell of illness are as follows:

- A prior-approved solid organ transplant. The 30-day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.
- THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.

Texas Medicaid will conduct a quarterly utilization review of inpatient claims to determine whether the claims were paid outside of the spell-of-illness limitation.

The first of these utilization reviews were for claims with dates of service from April 27, 2010, through January 6, 2012.

3.1.3 Take-Home Drugs, Self-Administered Drug, or Personal Comfort Items

Take-home drugs and comfort items that are provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

Take-home drugs and supplies may be a benefit through the Vendor Drug Program (VDP) when supplied by prescription.

Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements. Self-administered drugs provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

The client cannot be billed for take home drugs, comfort supplies or self-administered drugs that are provided by the hospital during an inpatient hospital stay.

3.1.4 Services Included in the Inpatient Stay

The following services are included in the inpatient stay and are not separately reimbursed:

- *Whole blood and packed red blood cells.* Inpatient services include whole blood and packed red blood cells that are reasonable and necessary for treatment of illness or injury. Whole blood and packed red blood cells that are available without cost are not reimbursed by Texas Medicaid.

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- *Laboratory, radiology, and pathology services.* Inpatient services include all medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology services.

  Note: *Ultrasound interpretations in the inpatient hospital setting will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.*

  Note: *All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.*

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about CLIA.

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

3.1.5 Outpatient Observation Services

Outpatient observation services are not a substitute for a medically appropriate inpatient admission. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay.

Refer to: Subsection 4.2.4, "Outpatient Observation Room Services" in this handbook for more information.

3.2 Services, Benefits, Limitations, and Prior Authorization - Acute Care

Inpatient hospital services include the following:

- Bed and board
- Whole blood and packed red blood cells
- All medically necessary services ordered by a physician to include laboratory, radiology, and pathology
- All medically necessary supplies ordered by a physician
- Medically necessary emergency and non-emergency ambulance transports during the inpatient stay
- Maternity care
- Newborn care
- Inpatient surgery and rehabilitation
- Organ and tissue transplant services
- Colorectal cancer screening services

3.2.1 Bed and Board

Inpatient bed and board include semiprivate accommodations or accommodations in an intensive care or coronary care unit. The accommodations include:

- Meals
- Special diets

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- General nursing services

Private accommodations including meals, special diets, and general nursing services may be reimbursed up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations may be reimbursed in full if required for medical reasons as certified by the physician. The hospital must document the medical necessity for a private room (i.e., the existence of a critical or contagious illness, a condition that could result in disturbance to other patients). The medical necessity for the private accommodations must be included in Block 80 of the UB-04 CMS-1450 paper claim form or added as an attachment to the claim submission.

3.2.2 Hysterectomy Services

Hysterectomy services are considered for reimbursement when the claim is filed with a signed Hysterectomy Acknowledgment Form or submitted documentation indicates that the Hysterectomy Acknowledgment Form could not be obtained.

Claims for services related to the hysterectomy cannot be reimbursed unless the signed Hysterectomy Acknowledgement Form is on file; consequently, to avoid claim denials, each individual provider is encouraged to submit a copy of the valid Hysterectomy Acknowledgement Form and not rely on another provider to do so.

Refer to: Subsection 6.13.1, "Hysterectomy Acknowledgment" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information.

Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

3.2.3 Maternity Care

Inpatient maternity care includes usual and customary care for all female clients.

3.2.3.1 Emergency Coverage

For women with a family income at or below 198 percent of the Federal Poverty Level (FPL), hospital facility charges are paid through Emergency Medicaid. A client must be determined eligible for Emergency Medicaid by HHSC for a claim to be paid to a Medicaid provider. Claims are sent to Texas Medicaid & Healthcare Partnership (TMHP) for processing.

3.2.3.2 Mother and Newborn Hospital Stay

Circumstances that require the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a cesarean section must be documented in the clients' medical records.

Continuation of hospitalization is a benefit for the infant when the mother is required to remain hospitalized for medical reasons. The reason for the continuation of hospitalization must be documented in the client's medical record.

3.2.3.3 Children's Health Insurance Program (CHIP) Perinatal Coverage

For clients who are eligible for CHIP perinatal services as determined by HHSC, CHIP perinatal services include newborn services and inpatient hospital charges related to the delivery of the newborn. Preterm or false labor that does not result in a birth are not CHIP perinatal services.

Inpatient services limited to labor with delivery for women with income at or below 202 percent of FPL will be covered under CHIP perinatal. Newborn services will also be covered under CHIP perinatal.

For CHIP perinatal newborns with a family income at or below 198 percent of the federal poverty level, TMHP will process newborn transfer hospital claims even if the claim from the initial hospital stay has not been received. The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay.

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Transfer claims must be filed to TMHP using the admission type 1, 2, 3, or 5 in block 14; source of admission code 4 or 6 in block 15; and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.

Refer to: Subsection 6.19.1, "CHIP Perinatal Newborn Transfer Hospital Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

3.2.4 Newborn Care

Newborn care includes routine newborn care, routine screenings, and specialized nursery care for newborns with specific problems.

Hospital providers must provide all state-mandated newborn screenings and vaccinations.

Refer to: Subsection 4.3.12.2.3, "Hearing Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

3.2.4.1 Newborn Eligibility

A child is deemed eligible for Texas Medicaid through 12 months of age if the mother is receiving Medicaid at the time of the child's birth, and the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant. Therefore, it is not acceptable for a hospital to require a deposit for newborn care from a Medicaid client. The child's eligibility ends if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household.

Hospitals must complete Hospital Report (Newborn Child or Children) (Form 7484) on the TMHP website at www.tmhp.com to provide information about each child born to a mother who is eligible for Medicaid. If the newborn's name is known, the name must be on the form.

Important: *If the newborn's name is not known, the name may be left blank. The use of "Baby Boy" or "Baby Girl" delays the assignment of a number.*

The form must be completed by the hospital no later than five days after the child's birth and sent to HHSC at the address identified on the form. The form should not be completed for stillbirths. Hospitals should duplicate the form as needed, because they are not supplied by HHSC or TMHP.

Hospitals that submit the birth certificate information using the Department of State Health Services (DSHS), Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth software and the HHSC Form 7484, receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies that provide outpatient prescription benefits for medically-needy newborns.

For additional information about obtaining a newborn Medicaid identification number, providers may call 1-888-963-7111, Ext. 7368 or 1-512-458-7368.

After receiving a completed form, HHSC verifies the mother's eligibility. Within 10 days of receiving the completed form, HHSC sends notices to the hospital, mother, caseworker, and attending physician, if identified. The notice includes the child's Medicaid client number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification (Form H3087).

Claims submitted for services provided to a newborn child who is eligible for Medicaid must be filed using the newborn child's Medicaid client number.

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Newborns who are from families with an income at or below 198 percent of the FPL and who receive CHIP perinatal benefits are assigned a client number for Texas Medicaid. This number is only assigned for reimbursement of the newborn's hospital facility charges (on a UB-04 CMS-1450 paper claim form) for the initial hospital stay after delivery. Claims for the newborn's hospital facility charges should be sent to TMHP.

3.2.5 Organ and Tissue Transplant Services

3.2.5.1 Transplant Facilities

A facility that renders organ transplants must be a designated children's hospital or a facility in continuous compliance with the criteria set forth by the following:

- Organ Procurement and Transportation Network (OPTN)
- United Network for Organ Sharing (UNOS)
- National Marrow Donor Program (NMDP)

Facilities whose status of "good standing" has been suspended for any reason by the national credentialing bodies will not be reimbursed by Texas Medicaid for transplant services until the status of "good standing" is restored.

If a Medicaid client receives a transplant in an in-state or out-of-state facility that is not approved by Texas Medicaid, the client must be discharged from the facility to be considered to receive other medical and hospital benefits under Texas Medicaid. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable.

Texas Medicaid will not pay for routine post-transplant services for transplant patients in facilities that are not approved by Texas Medicaid.

3.2.5.1.1 Out-of-state Transplant Facilities

Out-of-state facilities may be reimbursed for transplants rendered to Texas Medicaid clients under certain conditions. In order for Texas Medicaid to reimburse for an out-of-state transplant, the out-of-state facility and professional providers must enroll as Texas Medicaid providers. The out-of state transplant facilities must submit proof of transplant facility UNOS or NMDP certification as required by the Texas HHSC.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Physicians who are licensed by the state of Texas may request prior authorization for transplant services to be performed at out-of-state facilities when all of the following criteria are met:

- The required organ transplant is not available in Texas
- The facility is nationally recognized as a Center of Excellence
- The services are medically necessary, reasonable, and federally allowable
- The client is enrolled in Texas Medicaid

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The pretransplant evaluation must be performed by a Texas facility. If it is medically necessary that the pretransplant evaluation be performed at the out-of-state facility as well, the prior authorization request for the out-of-state pretransplant evaluation must be submitted with a copy of the evaluation that was performed by the Texas facility. The documentation must support the need for an out-of-state pretransplant evaluation.

Important: *Texas Medicaid does not cover transplant services provided out-of-state that are available in Texas.*

3.2.5.2 Transplant Benefits and Limitations

If a transplant has been authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during Title XIX spell of illness may be a benefit, beginning with the actual first day of the transplant. This benefit is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Refer to: Subsection 3.1.2, "Spell of Illness" in this handbook for additional information about the 30-day spell of illness period.

Reimbursement for transplant is limited to an initial transplant as a lifetime benefit and one subsequent re-transplant because of rejection. Expenses incurred by a living donor will not be reimbursed.

All transplants require prior authorization. If a solid organ transplant is not prior authorized, services that are directly related to the transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the transplant surgery will be paid separately.

If the organ is rejected, the re-transplant requires its own prior authorization. If the re-transplant is not prior authorized, services that are directly related to the re-transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the re-transplant surgery will be paid separately.

Note: *The re-transplant is not included in the prior authorization for the initial transplant. The subsequent re-transplant must be prior authorized separately.*

Refer to: Subsection 9.2.51, "Organ/Tissue Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.2.5.3 Prior Authorization for Organ and Transplant Services

All solid organ transplant services provided by facilities and professionals must be prior authorized. If a solid organ transplant is not prior authorized, services directly related to the transplant within the three day pre-operative and six-week postoperative period also will be denied, regardless of who provides the service, (e.g., laboratory services, status-post visits, and radiology services). Services unrelated to the transplant surgery will be paid separately.

A transplant request signed by a physician associated with transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution's transplant protocol.

Refer to: Subsection 9.2.51, "Organ/Tissue Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

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3.2.5.4 Transplants for Medicare-Eligible Clients

Transplants are also a benefit under the Medicare program; therefore, for clients eligible for Medicare and Medicaid, Texas Medicaid will pay only the deductible or coinsurance portion as applicable according to current payment guidelines. Prior authorization must be obtained for Medicaid-only clients; authorization will not be given for Medicare/Medicaid-eligible clients. Texas Medicaid will not pay for a transplant service denied by Medicare for a Medicare-eligible client.

3.2.5.5 Experimental or Investigational Services

Benefits are not available for any experimental or investigational services (including xenotransplantation and artificial/bioartificial liver transplants), supplies, or procedures.

3.2.5.6 Reimbursement for Transplant Services

The hospital diagnosis related group (DRG) payment for the transplant includes procurement of the organ and services associated with the organ procurement. Section 1138 of the Social Security Act defines the conditions of participation for institutions in the organ procurement program. Organ procurement costs are not reimbursed to a hospital that fails to meet the conditions of participation. The specific guidelines may be found in the appropriate areas of the Code of Federal Regulations (CFR) Title 42, Parts 405, 413, 441, 482, and 485. Documentation of organ procurement must be maintained in the hospital's medical record.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

3.2.5.7 Nonsolid Organ Transplants

Under current Texas Medicaid policy, procedures are considered to be medically necessary and reasonable based on safety and efficacy, as demonstrated by scientific evidence and controlled by clinical studies.

Nonsolid organ transplants that are benefits of Texas Medicaid include:

- Allogeneic and autologous stem cell transplantation
- Allogeneic and autologous bone marrow transplantation
- Autologous islet cell transplantation

All nonsolid organ transplants require prior authorization and must be performed in a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP).

Experimental or investigational services, supplies, or procedures are not a benefit of Texas Medicaid.

3.2.5.7.1 Inpatient Hospitalization

For a nonsolid organ transplant that has been prior authorized for clients who are 21 years of age and older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness is covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes but is included under one DRG payment.

Autologous harvesting of stem cells (single or multiple sessions) are reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient facility setting. Harvesting of stem cells performed in a hospital inpatient setting is included in the DRG and is not reimbursed separately.

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Refer to: Subsection 9.2.51.9, "Nonsolid Organ Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.3 Services, Benefits, Limitations, and Prior Authorization - Inpatient Rehabilitation Services

Inpatient rehabilitation services are a benefit of Texas Medicaid when provided as part of a general acute care inpatient admission, or with prior authorization for clients who are 20 years of age and younger in a freestanding rehabilitation facility.

Inpatient rehabilitation services in an acute care setting are included in the hospital DRG payment. All rehabilitation services are subject to Medicaid benefit limitations including the spell of illness. Exceptions to those limitations may be offered under CCP.

Refer to: Subsection 1.7.18, "Physical, Occupational, and Speech Therapy Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.18, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

3.4 Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services

3.4.1 Enrollment

Acute care hospitals and publicly-operated psychiatric facilities, i.e. state hospitals, must:

- Be certified by Medicare.
- Have a valid provider agreement with the Texas Health and Human Services Commission (HHSC).
- Complete the TMHP enrollment process.

Refer to: Subsection 6.1, "Enrollment" in this handbook for more information about acute care hospital enrollment.

Privately-operated psychiatric facilities must:

- Be licensed by HHSC.
- Providers must be accredited by a CMS-approved accrediting organization for psychiatric hospitals.

To be eligible to participate in the Comprehensive Care Program (CCP) to render services to Texas Health Steps clients, privately- and publicly-operated psychiatric facilities (henceforth, referred to as 'psychiatric facilities') must:

- Be accredited by a CMS-approved accrediting organization for psychiatric hospitals.
- Have a valid provider agreement with HHSC.
- Complete the TMHP enrollment process.

Note: *Acute care hospitals cannot enroll as CCP facilities.*

Refer to: Section 2, "Medicaid Children's Services Comprehensive Care Program (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

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Psychiatric facilities must enroll in Texas Medicaid as Institutions for Mental Disease (IMD).

Note: *According to TAC Rule §419.373(6) and based on 42 Code of Federal Regulations (CFR) §435.1009, an IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental illness, including medical attention, nursing care, and related services.*

Note: *Acute care hospitals are not considered IMDs, even if the hospital has a psychiatric ward.*

Acute care hospitals must comply with Centers for Medicare & Medicaid Services (CMS) Conditions of Participation for general hospitals.

Psychiatric facilities certified by Medicare must meet accreditation requirements from a CMS-approved accrediting organization for psychiatric hospitals and comply with CMS Conditions of Participation for both general hospitals and psychiatric hospitals.

3.4.2 General Information

Admissions to acute care hospitals for inpatient psychiatric services are a benefit of Texas Medicaid for persons of all ages in fee-for-service (FFS) Medicaid or managed care.

Admissions to psychiatric facilities, i.e. IMDs, for inpatient psychiatric services are a benefit of Texas Medicaid for:

- Persons 20 years of age and younger and 65 years of age and older in FFS Medicaid.
- Persons 21 through 64 years of age enrolled in managed care as an in lieu of service if the MCO and the person receiving services agree to an IMD as the setting for inpatient psychiatric services. The benefit is for a maximum of 15 calendar days per month, not per stay.

Note: *In lieu of services are services substituted for Medicaid State Plan services or settings, as allowed by 42 CFR §438.3(e).*

Admissions to acute care hospitals and psychiatric facilities must be medically necessary. Court orders for inpatient psychiatric services constitute the determination of medical necessity and are not subject to utilization management reviews to include prior authorizations, concurrent reviews or retrospective reviews that have the effect of denying, reducing or controverting the court-ordered service. Court-ordered services include:

- Mental health commitments.
- Condition of probation.

Refer to: Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about court-ordered services.

Upon admission, or once a person who is 20 years of age or younger becomes Medicaid eligible while in the facility, a certification of need for services, as required by Title 42, Code of Federal Regulations (CFR), Section 441.152, must be completed and placed in the person's medical record within 14 days of the admission.

All Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, known as Texas Health Steps in Texas, are available to persons 20 years of age and younger in a Medicaid covered inpatient psychiatric facility, as required by Section 12005 of the 21st Century Cures Act.

3.4.2.1 Documentation Requirements

The certification of need for services (42 CFR §441.152) for persons 20 years of age and younger must specifically address:

- Why community-based services cannot meet the treatment needs of the person.

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- Why inpatient psychiatric services under the care of a psychiatrist are required to treat the acute episode of the person.
- How inpatient psychiatric services can reasonably be expected to improve the condition, or prevent further regression of the person's condition in a proximate period.

Documentation of medical necessity for persons of all ages for inpatient psychiatric services in an acute care hospital or psychiatric facility, to include the certification of need for services (42 CFR §441.152) for persons 20 years of age and younger, must be:

- Documented in the person's medical record.
- Maintained by each facility, as applicable to state and federal guidelines.
- Readily available for review whenever requested by HHSC or designee.

3.4.2.2 Noncovered Services

Inpatient psychiatric services are not a benefit of Texas Medicaid for the following:

- Persons with a single diagnosis of a substance use disorder, as classified in the current edition of the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Persons with a single diagnosis of Intellectual or Developmental Disability, as classified in the current edition of the APA's DSM.
- Persons with a neurocognitive disorder (due to a general medical condition, not a mental disorder), e.g., delirium, dementia, traumatic brain injury, etc.
- Persons who are considered incarcerated, which is defined as when a criminal justice facility, such as a city or county jail or state prison, has custody of the person.

Refer to: Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about court-ordered services.

3.4.2.3 CLIA Certification for Laboratory Services

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate-holders.

Refer to: The TMHP website Required CLIA Lab Certifications web page at https://www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

3.4.2.4 Initial Inpatient Psychiatric Services

The person must have as the principal reason for admission a psychiatric diagnosis, as listed in the current version of the APA DSM, and documented reasons by a psychiatrist for why an inpatient level of care is required or that outpatient treatment has been attempted and failed.

The person must meet one of the following criteria:

- A present danger to self, e.g., recent suicide attempt, active suicidal ideations with intent to act, recent self-mutilative behaviors that cause or intend to cause significant medical harm, command auditory or visual hallucinations or delusions that are likely to lead to serious self-harm, and other indirect or direct acts that are hazardous to the life of the person.

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- A present danger to others (behavior must be attributed to the DSM diagnosis and can be adequately treated in an inpatient setting), e.g., recent life threating actions, homicidal threats with a deadly plan and available means to act on, or carry out, the plan, recent serious assaultive behaviors or active threats of same with a likelihood of acting, or command auditory or visual hallucinations or delusions that are likely to lead to harm to others.
- The person is at risk of substantial physical or mental deterioration because of the mental illness, e.g., acute or chronic psychosis or thought disorganization or severe disorientation to person, place or time.
- The person exhibits behaviors because of the mental illness that prevent, or interfere with, safe or effective treatment in a less restrictive setting.
- The person exhibits psychiatric symptoms, is involved in the legal system, and is ordered by a court to undergo a comprehensive assessment in an inpatient psychiatric setting to clarify the diagnosis and treatment needs.

The proposed treatment must require 24-hour-a-day medical observation, supervision and intervention and include:

- Active supervision, in accordance with facility guidelines, state and federal requirements and accreditation standards, by a psychiatrist with the appropriate credentials, as determined by the Texas Medical Board.
    - For children and adolescents, a psychiatrist must also have documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents.
- Formulation and implementation of a person-centered recovery plan (also known as a plan of care or treatment plan).
- Formulation and implementation of an initial discharge plan, to include documented contact with a community-based mental health provider.
- Provision of services are reasonably expected to improve the person's condition or prevent further regression, so that a lesser level of care may be implemented.

The treatment of the person's psychiatric condition must be provided in the least restrictive appropriate setting available and ambulatory care resources available in the community do not meet the needs of the person.

3.4.2.5 Extended Inpatient Psychiatric Services

Extended inpatient psychiatric services, i.e. extended stays, are considered for persons who require an inpatient level of care beyond the initial five-day admission period, as evidenced by continuing to meet at least one of the medical criteria listed in the initial inpatient psychiatric services section above. Treatment must include:

- Active supervision, in accordance with facility guidelines, state and federal requirements and accreditation standards, by a psychiatrist with the appropriate credentials, as determined by the Texas Medical Board.
    - For children and adolescents, a psychiatrist must also have documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents.
- Formulation and implementation of an initial discharge plan, to include documented contact with a community-based mental health provider.

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Extended stays are considered medically necessary for children and adolescents in the conservatorship of the Texas Department of Family and Protective Services (DFPS) when there are barriers to an immediate return to the child's or adolescent's residence, placement, or next setting for services. The extended stay facilitates an efficient transfer to the new setting without disrupting needed services. If DFPS is in the process of finalizing placement for the child or adolescent, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three 5-day extensions may be authorized.

3.4.3 Prior Authorization and Authorization Requirements

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via 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 person'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 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, persons receiving services and responsible adults of persons receiving services may sign prior 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 to the TMHP Prior Authorization Department and retain a copy of the signed and dated prior authorization form in the person's medical record.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated prior authorization form in the person'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 services requested. The physician must maintain documentation of medical necessity in the person's medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services.

Court-ordered inpatient psychiatric services are not subject to the five-day initial admission limitation or the seven-day extended stay limitation.

Providers must submit the following documentation for authorization of court-ordered inpatient psychiatric services no later than seven calendar days after the date on which services began:

- A copy of the court order signed by the presiding judge or magistrate that includes the statute under which the court is ordering services to determine incarceration status of the person.

Prior authorization is not required for persons in FFS Medicaid admitted to a psychiatric unit in an acute care hospital.

Prior authorization is not required for initial admissions to psychiatric facilities for persons who are birth through 20 years of age or 65 years of age and older in FFS Medicaid for a maximum of five days, based on medical necessity.

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Prior authorization is required for extended stays in psychiatric facilities for persons who are birth through 20 years of age and 65 years of age and older in FFS Medicaid for up to seven days per extension request.

Providers must submit a completed Psychiatric Inpatient Extended Stay Request Form that describes the necessary inpatient psychiatric services and reflects the need for an extended stay in relation to the original need for admission to include any change in the diagnosis of the person. Additional documentation or information supporting the need for an extended stay may be attached to the form.

Requests for an extension of stay must be received on or before the fifth day of an initial admission and/or on or before the last day authorized or denied for subsequent stay requests. If an extended stay is requested and the fifth day of the initial admission or the last date authorized or denied of the previous stay falls on a holiday or a weekend, the request for an extended stay is due by 5:00 p.m. of the next business day. The provider is notified of the decision in writing by the TMHP Prior Authorization Department.

- Extended stay requests for persons who are 11 years or age or younger require review by a psychiatrist.
- Extended stay requests for persons who are 12 through 20 years of age require review by a mental health professional. Any requests for extended stays that do not meet the medical necessity criteria for extended stays shall be referred to a psychiatrist for final determination.

3.4.3.1 Prior Authorization Appeals

All prior authorization requests not submitted or received by the TMHP Prior Authorization Department in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. The TMHP Prior Authorization Department must receive appeals within 15 days of receipt of the TMHP Prior Authorization Department denial notice.

- Appeals of a denial for an extended stay must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.
- Appeals of a denial for late submission of information must be accompanied by documentation which the provider believes supports the compliance with HHSC claims submission guidelines.

Appeals are reviewed first by an experienced psychiatric licensed clinical social worker, licensed professional counselor, or a registered nurse to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider will be notified of all denial determinations in writing by the TMHP Prior Authorization Department.

3.4.4 Reimbursement Guidelines

Revenue code 124 must be used for inpatient psychiatric services for persons birth through 20 years of age and 65 years of age and older in psychiatric facilities for FFS Medicaid.

Procedure codes 99238 (30 minutes or less) and 99239 (more than 30 minutes) must be used for a hospital discharge.

Professional services in an acute care hospital may be reimbursed to the professional who provides the service.

Professional services in psychiatric facilities, i.e. IMDs, for persons 20 years of age and younger and 65 years of age and older may be reimbursed to the professional who provides the service.

- Services that are rendered in psychiatric facilities must be identified in the person-centered recovery plan of the person receiving services. Services that are not included in the person-centered recovery plan are subject to recoupment.

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- Services that are rendered on the date of admission to and the date of discharge from a psychiatric facility may be reimbursed.
- If the person receiving services has not been discharged from a psychiatric facility, the facility is responsible for acute care services that are rendered to the person in an acute care facility. Claims that are submitted for these services will be denied as a duplicate service that has been paid to another provider.

Refer to: Subsection 9.2.60.6.1, "Inpatient or Observation Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) and Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Important: *Claims for professional services rendered during an inpatient stay in a psychiatric facility must include the psychiatric facility's ten-digit National Provider Identifier (NPI). Claims that do not include the psychiatric facility's NPI will be denied.*

Except for court-ordered services, admissions to acute care hospitals and psychiatric facilities are subject to the Texas Medicaid retrospective utilization review requirements.

3.4.4.1 Medicare Coinsurance and Deductible Reimbursement

Psychiatric facilities that are enrolled in Medicare may also receive Medicaid payment for the Medicare coinsurance or deductible according to current Medicaid guidelines.

Exception: *IMD services for clients who are 21 through 64 years of age are not eligible for fee-for-service reimbursement. If delivered through managed care and the managed care organization and client agree to an IMD as the setting for inpatient services, IMD services for clients who are 21 through 64 years of age are eligible for reimbursement for a total of 15 days per calendar month. The 15-day limitation is counted per calendar month, not per stay. As such, a stay of up to 15 days in a single month and a stay of up to 15 days in a following month may both be eligible for reimbursement. Medicaid will not reimburse coinsurance and deductible payments for psychiatric services that are rendered to these clients in an IMD beyond 15 days per calendar month.*

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) additional information about Medicaid guidelines for Medicare coinsurance and deductible payments.

3.4.5 Providing IMD Client Information to TMHP

IMD providers are requested to inform TMHP of the Medicaid clients who are residing in their facilities before submitting inpatient claims for those clients.

IMD providers can use the TMHP secure web page to enter client information and the admission and discharge dates by going to My Account and choosing the Manage IMD Clients Segment link in the Acute Care Online Portal field.

IMD providers can search for Medicaid client records that are associated with their NPIs.

Providers will be asked to submit the client's identification number and admission date. After the client is discharged, providers will be requested to enter the discharge date on the same Manage IMD Clients Segment screen.

Providers will not be able to change previously reported client information except for the To Date of Service information.

Providers that submit inaccurate information can call the Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638 to have that client segment inactivated if the request is made within 24 hours of submission. After the erroneous client segment has been inactivated by TMHP, providers may submit a

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new client segment to replace it. After 24 hours have elapsed, providers must contact HHSC to request a correction to the information. This change must include the appropriate documentation of the client's patient control number (PCN) and the admission and discharge dates.

The change request and appropriate documentation must be submitted in writing to the following address:

Texas Health and Human Services Commission
Mail Code 91X PO Box 204077
Austin, Texas 78720-4077

3.5 Inpatient Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

The HHSC Office of Inspector General (OIG) UR Unit is responsible for retrospective review of inpatient DRG and TEFRA admissions. These reviews are accomplished through onsite visits, electronic access, or mail-in.

3.6 Utilization Review Process

The inpatient UR process for admissions reimbursed under the DRG prospective payment system consists of sampling medical records of paid Medicaid claims. The review process consists of three major components:

- *Admission review.* Determination of the medical necessity of the admission. For purposes of the Texas Medical Review Program (TMRP), TEFRA, and facility-specific per diem methodology reviews, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.
- *Quality review.* Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.
- *DRG validation.* Determination that the critical elements necessary to assign a DRG are present in the medical record and the diagnosis and procedures are sequenced correctly. The critical elements are age, sex, admission date, discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or comorbidities), and principal and secondary procedures.

The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, including the present on admission (POA) indicator, and quality of care. The medical record must reflect that any services reimbursed by Texas Medicaid were ordered by a physician or non-physician provider.

When an admission denial or a denial of extended stay is issued, or when a technical denial becomes final, all money is recouped from the hospital for the admission or days of stay that are denied. When a DRG is reassigned as a result of UR, the payment to the hospital is adjusted.

Refer to: Subsection 3.6.3, "Technical Denials (DRG Prospective Payment)" in this handbook.

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If an inpatient admission is denied, but a physician's order is present documenting the client originally was placed in observation, the UR unit may authorize the resubmission of services rendered during the first 48 hours on an outpatient claim.

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action, such as recoupment or referral to the HHSC OIG Medicaid Program Integrity (MPI) or Sanctions Unit.

3.6.1 Admission Review

All services, supplies, or items submitted as certified on the claim submission must be medically necessary for the client's diagnosis or treatment. Heath and Human Services Commission-Office of Inspector General-Utilization Review (HHSC-OIG-UR) personnel evaluate the medical necessity of an admission by comparing the medical record documentation to Change Healthcare InterQual® evidence-based guidelines. Non-physician reviewers use this criteria to determine medical necessity for initial approval of admission. If the case does not meet the initial approval criteria, the reviewer refers the case to a physician consultant who will determine the medical necessity of the inpatient admission. If the initial approval criteria are met but the medical necessity of the admission is still questionable, the non-physician reviewer refers the case to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, HHSC-OIG-UR will issue a denial.

3.6.1.1 Readmission Review

If a hospital admission or readmission occurs within 30 days of a discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity, quality, and DRG validation including POA indicators.

Transfers from one facility to another and readmissions are also subject to review.

3.6.1.2 Hospital-Based Ambulatory (HASC) Surgical Procedures

Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

3.6.1.3 Quality Review

Each Medicaid case is evaluated for quality of client care, adequacy of discharge planning, and medical stability of the client at discharge. Quality of care review includes the use of discharge screens and generic quality screens. Potential quality of care issues are identified by the physician. HHSC contracts with physician consultants to review medical records for quality of care. Physician consultants, of the specialty related to the care rendered, may make clinical recommendations or determine corrective actions when deemed appropriate. Child and adolescent psychiatrists may make recommendations based on review of inpatient psychiatric services provided to Medicaid clients younger than 21 years of age. Failure to verify completion of any corrective action recommendation within the specified time frame may result in referral of the case to the HHSC OIG MPI or Sanctions Unit.

3.6.1.4 Diagnosis-Related Group Validation

Each medical record is reviewed to validate the elements critical to the DRG assignment. These elements are the client's age, sex, admission date, patient discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or co-morbidities), POA indicators, and principal and secondary procedures. Documentation of these critical DRG elements in the medical record is evaluated for the correlation to the information provided on the claim form.

The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The condition must be treated or evaluated during this admission to the hospital.

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The secondary diagnoses are conditions that affect client care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and monitoring, or have clinically significant implications for future health-care needs.

The coding of diagnoses that have clinically significant implications for future health-care needs applies only to newborns and must be identified by the physician. Normal newborn conditions or routine procedures are not to be considered as complications or co-morbidities for DRG assignment.

Refer to: Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

The POA review will validate the POA indicator assigned to the principal and secondary diagnoses codes reported on claim forms. If it is determined that the principal and/or secondary diagnoses were not present at the time the order for inpatient admission occurs, the Commission will revise the POA indicator for the diagnosis code. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery are considered POA.

If the principal diagnosis, secondary diagnoses (complications or co-morbidities), or procedures are not substantiated in the medical record; sequenced correctly; have an incorrect POA indicator; or have been omitted, codes may be deleted, changed, or added. All diagnosis or procedure coding changes potentially resulting in a DRG change are referred to a physician consultant. When it is determined that the diagnoses and procedures are substantiated and sequenced correctly, the information will be entered into the applicable version of the Grouper software for a DRG determination. The CMS-approved DRG software considers each diagnosis and procedure and the combination of all codes and elements to make a determination of the final DRG assignment. When the DRG is reassigned, the payment to the provider is adjusted.

3.6.2 Recommendations to Enhance Compliance with Texas Medicaid Fee-for-Service Hospital Claims Submission

The following information highlights an area for physician and hospital providers where collaboration in client care delivery exists but can improve. Texas Medicaid, through its hospital UR activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims.

To enhance compliance with Texas Medicaid fee-for-service hospital claims submission and decrease the submission of inappropriate inpatient hospital claims, providers should adhere to the following:

- The hospital may admit clients in observation status if the physician has the reasonable expectation that the client will be discharged within 48 hours. If an inpatient claim was denied per retrospective UR, the hospital may resubmit the claim for the first 48 hours as an outpatient claim if the client was initially admitted in observation status (per physician order) and the stay was more than 48 hours.
- When a client is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This practice is acceptable when the physician makes changes to the admitting order before the hospital submits the claim for payment.
- The correction in admission status, when the above criteria are met avoids errors in claims submission and the potential need for a more lengthy appeal process.
- If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

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3.6.3 Technical Denials (DRG Prospective Payment)

3.6.3.1 On-Site Reviews

The following information describes on-site reviews:

- If the complete medical record is not made available during the on site review, a preliminary technical denial is issued on site. The hospital is allowed 60 calendar days from the date of the exit conference to provide the complete medical record to HHSC. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.
- If a complete medical record is made available on site, but a copy is required for further review, and the copy is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Note: *A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider failing to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: Subsection 1.7.4, "Retention of Records and Access to Records and Premises" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

3.6.3.2 Mail-In Reviews

If the complete medical record is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Hospital inpatient claim payments that have been recouped because of a technical denial may not be resubmitted on an outpatient claim.

Note: *A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider who fails to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: Subsection 1.7.4, "Retention of Records and Access to Records and Premises" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

3.6.4 Acknowledgment of Penalty Notice

Hospitals must have on file a signed acknowledgment from the physician stating that the physician received the following notice:

> "**Notice to Physicians:** Medicaid payment to hospitals is based, in part, on each client's principal and secondary diagnoses and the major procedures performed on the client, as attested to by the client's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws."

The acknowledgment of penalty notice must be specific to Texas Medicaid. Medicare penalty notices are not accepted.

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3.6.5 Sanctions

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG MPI or Sanctions Unit.

3.6.6 Utilization Review Appeals

Hospital providers may appeal adverse decisions by HHSC OIG UR Unit to the HHSC UR Medical Appeals Unit. A UR Medical Appeals decision is the final administrative decision of HHSC. Neither HHSC OIG UR Unit nor TMHP are responsible for Medical UR appeals.

Refer to: Subsection 7.3.3, "Utilization Review Appeals" in "Section 7: Appeals" (*Vol. 1, General Information*).

3.7 Claims Filing and Reimbursement

3.7.1 Medicaid Relationship to Medicare

Texas Medicaid may make deductible or coinsurance payments according to current Medicaid payment guidelines on valid, assigned Part A (hospital) and Part B (medical) Medicare claims.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about coinsurance and deductible payment guidelines.

Texas Medicaid provides reimbursement for 30 inpatient benefit days per spell of illness. When the 30 days coincide with the first 30 days of the Medicare benefit period and the client is eligible for both Medicare and Medicaid, Texas Medicaid pays the:

- Inpatient hospital deductible under Medicare Part A.
- Medicare Part A deductible for the first three pints of whole blood or packed red cells.

When the client only has Medicare Part B coverage, the hospital must follow these guidelines:

- Submit to Medicare the charges for certain inpatient ancillary services on a Medicare Claim Form 1483 for payment under the client's Part B coverage. The ancillary charges include the following:
  - Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests
  - X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
  - Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations
  - Prosthetic devices (other than dental) that replace all or part of an internal body organ or member (including contiguous tissue) or all or part of the function of a permanently inoperative or malfunctioning internal body organ or member including replacement or repairs of such devices (e.g., cardiac pacemakers, breast prostheses, maxillofacial devices, colostomy bags, and prosthetic lenses)
  - Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements and adjustments (if required) because of a change in the client's physical condition
  - Physical therapy (PT) services
  - Speech pathology services
  - Dialysis treatments

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- Submit to TMHP the remaining Part A charges on a UB-04 CMS-1450 paper claim form (or its electronic equivalent) indicating in Block 80 that the client is eligible for Medicare Part B benefits only. The client's Medicare number must appear on the Medicaid claim in Block 80. TMHP must receive these charges within 95 days of the last date of service on the claim.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

3.7.2 Inpatient Claims Information

Medicaid present on admission (POA) reporting is required for all inpatient hospital claims.

All hospital providers are required to submit a POA value for each diagnosis on the claim form, and no hospital is exempt from this POA requirement. Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values.

POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient visit, including emergency department, observation, or outpatient surgery, are considered POA.

The following table shows the POA values:

POA Value	Description	Payment
Y	Diagnosis was present at the time of admission	Payment will be made by Medicare when a hospital-acquired condition (HAC) is present
N	Diagnosis was not present at the time of admission	No payment will be made by Medicare when an HAC is present
U	Documentation was insufficient	No payment will be made by Medicaid when an HAC is present
W	Clinically undetermined	Payment will be made by Medicaid when an HAC is present:
(blank)	Exempt from POA reporting	Exempt from POA reporting
Note: Texas Medicaid follows Medicare guidelines for payments referenced in this table.		

Note: *If a diagnosis code is exempt from POA reporting, providers should leave the POA indicator field blank on the claim.*

TMHP will not recalculate the DRG based on POA indicator values for Medicare crossover claims or MCOs.

Depending on the POA indicator value, the DRG may be recalculated, resulting in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a POA DRG recalculation, the lesser of the number of days will be reimbursed.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*).

"Section 6: Claims Filing" (*Vol. 1, General Information*).

A complete list of POA exempt diagnosis codes can be found on the CMS website.

Claims for inpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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In Block 44 of the UB-04 CMS-1450, enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim.

Hospitals may submit information only claims to TMHP when one of the following situations exists. Hospitals must use TOB 110 to file these claims:

- Inpatient 30-day spell of illness benefit is exhausted.
- Payment made by a third party resource or other insurance exceeds the Medicaid allowed amount.

Additional claims information can be found within individual topic areas in this section.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*).

"Section 6: Claims Filing" (*Vol. 1, General Information*).

The Claim Form Examples page on the TMHP website at www.tmhp.com.

3.7.3 Inpatient Claims Submission

Inpatient hospital claims for traditional Medicaid clients must be submitted to TMHP if the client is enrolled in traditional Medicaid at the time of service or during the time of the admission.

3.7.4 Inpatient Reimbursement

3.7.4.1 Prospective Payment Methodology

Inpatient hospital stays except state-owned teaching hospitals, and psychiatric facilities (CCP) are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to Texas Medicaid's UR requirements.

The DRG reimbursement includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. The technical services are not billable to Texas Medicaid clients.

Texas Medicaid does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all Medicaid inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, Texas Medicaid requires that only one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 paper claim form, to be considered for payment.

The number of days of care charged to a beneficiary for inpatient hospital or skilled nursing facility (SNF) care services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for reporting purposes even if the hospital or SNF uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a patient returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

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Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims may be subject to retrospective review, which may result in recoupment. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

A new provider is given a reimbursement inpatient interim rate of 50 percent until a cost audit has been performed. A default standard dollar amount (SDA) rate is assigned for newly enrolled providers or newly constructed facilities.

Payment is calculated by multiplying the SDA for the hospital's payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Hospital reimbursement is made in accordance with the following TAC rules:

- 1 TAC §355.761 - Reimbursement Methodology for Institutions of Mental Diseases (IMD)
- 1 TAC §355.8052 - Inpatient Hospital Reimbursement
- 1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology
- 1 TAC §355.8058 - Inpatient Direct Graduate Medical Education (GME) Reimbursement
- 1 TAC §355.8060 - Reimbursement Methodology for Freestanding Psychiatric Facilities
- 1 TAC §355.8061 - Outpatient Hospital Reimbursement
- 1 TAC §355.8065 - Disproportionate Share Hospital Reimbursement Methodology
- 1 TAC §355.8066 - Hospital-Specific Limit Methodology

Medicaid providers that are cost-reimbursed are subject to cost reporting, cost reconciliation, and cost settlement processes, as defined in the following TAC rules:

- 1 TAC §355.8061 (a)(2) - Outpatient Hospital Remibursement
- 1 TAC §355.8052 (i)(i) - Inpatient Hospital Reimbursement
- 1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology

3.7.4.2 Client Transfers

3.7.4.2.1 Admission Dates

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date on which the client was admitted into each facility in Block 12 on the UB-04 CMS-1450.

3.7.4.2.2 Continuous Stays – Client Transfers and Readmissions

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be submitted as one admission under the NPI and taxonomy code. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Admissions submitted inappropriately are identified and denied during the UR process and may result in intensified review.

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of either the mean length of stay for the DRG or the eligible days in the facility. The DRG modifier, PT, on the R&S Report indicated per diem pricing related to a client transfer. Services must be medically necessary and are subject to Texas Medicaid's UR requirements.

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HHSC performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date that the client was admitted into each facility in Block 12 on the UB-04 CMS-1450. Inpatient authorization requirements are based on the requirements that are specified by the program in which the client is enrolled on the date of the original admission. Providers must adhere to the authorization requirements for claims to be considered for reimbursement. Providers are reimbursed at the rate in effect on the date of discharge.

3.7.4.3 Observation Status to Inpatient Admission

The dates of the inpatient admission must be reported as follows:

- *Date of inpatient admission*: The date of admission must reflect the date that the client was admitted to the hospital as an inpatient.
- *Dates of service*: The from date of service (FDOS) must reflect the date that the client first presented at the hospital for services including, but not limited to, emergency room (ER), observation, labor and delivery, or inpatient services.

If services that are rendered before the inpatient admission must be submitted on the inpatient claim, the number of preadmission days that are related to the inpatient admission cannot exceed the days of allowed for the rendered services:

Services	Days Allowed	Units
Emergency room (ER) services	One day (24 hours) before the inpatient admission	Submitted per day
Observation services	Up to two days (48 hours) before the inpatient admission	Submitted in hours
Labor and Delivery	Up to three days before the inpatient admission	Submitted per day

Diagnosis-Related Group (DRG) hospital claims allow for a total of three days of pre-admit services. Non-DRG hospital claims are allowed one day of pre-admit services, and a second day if additional observation hours occurred.

> ***Note:*** *If the client is admitted as an inpatient more than 24 hours after presenting in the ER without being placed in observation status or more than 48 hours after being placed in observation status, the ER and observation services may be reimbursed separately as outpatient services and must not be included on the inpatient claim.*

3.7.4.4 Outliers

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients who are 20 years of age and younger as of the date of the inpatient admission. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Providers can view their day and cost outlier payment information for inpatient hospital claims on the Electronic Remittance and Status (ER&S) Report. The R&S Report reflects the outlier reimbursement payment and defines the type of outlier paid. To view the day and cost outlier payment information, providers, facilities, and third party vendors may need to update their 835 electronic file format. For information about how to update the 835 electronic file format, refer to the revised electronic data interchange (EDI) companion guide (ANSI ASC X12N 835 Healthcare Claim Payment/Advice-Acute Care Companion Guide) on the TMHP website at www.tmhp.com.

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3.7.4.4.1 Day Outliers

All of the following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the mean length of stay (MLOS) by more than two days.
- Inpatient days must exceed the DRG day threshold for the specific DRG.

Once the outlier payment criteria are met:

- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 60 percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

In compliance with 1 TAC §355.8052, all DRG inpatient hospital day outlier payments must not exceed the allowed cost for the service. All hospitals except in-state children's hospitals, both day and cost outlier payments have been reduced by 10 percent.

TMHP calculates payments as follows:

1) Calculate the day outlier.

   Calculate the allowed cost for the service (i.e., the cap amount) by taking the difference between the Tax Equity and Fiscal Responsibility Act (TEFRA) and DRG-payable amounts.

   Take the lesser of the day outlier or the cap amount.

   Reduce the day outlier by 10 percent for all hospitals except in-state children's hospitals.

2) Calculate the cost outlier:

   Reduce the cost outlier by 10 percent for all hospitals except in-state children's hospitals.

Reimbursement is made for day or cost outliers on claims that qualify. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Example

Calculations	Example amount
Day Outlier Calculation: ([SDA x DRG relative weight / Mean Length of Stay] x Outlier Days) x 0.6 = day outlier amount	$500.00
Apply Cap and Reduce by 10 Percent Calculate the allowed cost for the service (i.e., the cap amount) by taking the difference between the TEFRA and DRG payable amounts (in this example, $600.00). Take the lesser of the day outlier or the cap amount (in this example it would be the day outlier of $500.00). Reduce by 10 percent.	$450.00
Calculation1: Cost Threshold 11.14 x Universal Mean ($10,161.08) = <amount A> 11.14 x SDA = <amount B> 1.5 x DRG Relative Weight x SDA = <amount C> Cost threshold = The greater of <amount C> compared with (the lesser of <amount A> and <amount B>)	$550.00

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Calculations	Example amount
Calculation2: Cost Outlier Allowed amount x reimbursement rate = TEFRA amount TEFRA amount - cost threshold x 0.6 percent = cost outlier amount Reduce by 10 percent.	$495.00

The calculations in this example would result in one of the following payments:

- If the claim qualifies for the day outlier payment only, payment will be made up to $450.00.
- If the claim qualifies for the cost outlier payment only, payment will be made up to $495.00.
- If the claim qualifies for both the day outlier and cost outlier payment, the payment will be made up to $495.00, which is the greater of the day outlier or the cost outlier payment.

3.7.4.5 Maternal Level of Care Designation for Inpatient and Outpatient Services

Hospitals enrolled in Texas Medicaid may be reimbursed for inpatient and outpatient maternal services only if the hospitals have received a maternal level of care designation from the Department of State Health Services in accordance with 25 Texas Administrative Code §§133.201-133.210. The maternal level of care designation applies to Texas Medicaid and Texas Medicaid Managed Care Organizations.

Providers can refer to the DSHS website for more information for Maternal Level of Care Designation.

3.7.4.6 Hospitals That Do Not Meet Minimum Requirements for Maternal Level of Care Designation

A hospital that does not meet the minimum requirements for any level of care designation for maternal services will not be reimbursed for inpatient and outpatient maternal services rendered to Texas Medicaid and Medicaid MCO clients. Hospitals without a maternal level of care designation may be reimbursed for emergency services provided or reimbursed under state or federal law to stabilize the mother prior to transport to a facility capable of providing the appropriate level of care.

Note: *Maternal LOC Designation is not required for state-owned providers.*

Claims for inpatient and outpatient maternal services submitted by hospitals that do not have a maternal level of care designation on file will be denied. Providers can appeal the claim with documentation of the emergency services required.

If maternal inpatient and outpatient services are rendered by a facility which has applied for (but not yet received) a maternal designation, the facility must still adhere to existing claim filing deadlines (95 days from the date of discharge) and is also responsible for keeping their claim appeals active while awaiting maternal level of care designations to adhere to the 120-day claim appeal deadline.

Requirements to obtain a maternal level-of-care designation only apply to facilities located in Texas. Those entities physically located outside of Texas but enrolled in Texas Medicaid (i.e., out-of-state or border state facilities) are exempt from requiring a maternal level of care designation for inpatient and outpatient services rendered to maternal clients.

Note: *When submitting paper claims for inpatient and outpatient maternal services rendered at a facility with an address that is different from the provider's billing address, providers must enter the address of the facility where services were rendered in the remarks field.*

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3.7.4.7 Other Requirements

The submitted facility address on the claim must match the physical address of the location that has been issued a maternal level of care designation. If the facility address is not included on the claim, the submitted billing address must match the physical address of the location that was issued a maternal level of care designation.

Important: *Claims will be denied if the address submitted on the claim does not match the physical address of the location that was issued a maternal level of care designation. For example, numbers must be spelled out as words or left numeric on the claim to match the address on the maternal level of care designation on file. "Street" or "avenue" must either be spelled out or abbreviated, etc.*

3.7.4.7.1 Inpatient Hospital Claims for $10 Million or More

Providers should split fee-for-service inpatient claims for $10 million or more into separate interim claims. The interim claims should each total less than $10 million and be submitted with the following type of bill (TOB) for appropriate processing:

- First interim claim (TOB 112): Covers most of the inpatient stay
- Subsequent claims (TOB 113): Cover any subsequent inpatient stay charges, if applicable
- Final discharge claim (TOB 114): Covers the remaining days billed and charges

Providers should submit at least a first interim claim and the final discharge claim. Subsequent claims can include any additional charges.

3.7.4.8 Crossover Claims for Dual-eligible Clients

Maternal level of care designation requirements will also apply for maternal inpatient and outpatient crossover claims.

3.7.4.9 Neonatal Level of Care Designation for Inpatient Services

Hospitals enrolled in Texas Medicaid may be reimbursed for inpatient neonatal services only if the hospitals have received a neonatal level of care designation from DSHS in accordance with Title 25 Texas Administrative Code §§133.181-133.190.

A neonatal service is any inpatient hospital service rendered to a client who is 28 days of age or younger.

Refer to: The DSHS website for more information on Neonatal Level of Care Designation.

3.7.4.10 Hospitals that Do Not Meet Minimum Requirements for Neonatal Level of Care Designation

A hospital that does not meet the minimum requirements for any level of care designation for neonatal services will not be reimbursed for inpatient neonatal services rendered to Texas Medicaid and CSHCN Services Program clients. Hospitals without a neonatal level of care designation may be reimbursed for emergency services to stabilize an infant prior to transport to a facility capable of providing the appropriate level of care.

Claims for inpatient neonatal services submitted by hospitals that do not have a neonatal level of care designation on file will be denied. Providers can appeal claims by providing documentation that emergency services were required.

If neonatal inpatient services are rendered by a facility that has applied for (but not yet received) a neonatal designation, the facility must still adhere to existing claim filing deadlines (95 days from the date of discharge). While awaiting neonatal level of care designation the facility is responsible for maintaining active claims appeals to adhere to the 120-day claim appeal deadline.

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Requirements to obtain a neonatal level of care designation only apply to facilities located in Texas. Those entities that are physically located outside of Texas and enrolled in Texas Medicaid (i.e., out-of-state or border state facilities) are exempt from requiring a neonatal level of care designation for inpatient services rendered to neonatal clients.

Note: *When submitting paper claims for inpatient neonatal services rendered at a facility with an address that is different from the provider's physical address, providers must enter the address of the facility where services were rendered in the remarks field.*

Refer to: "Section 7: Appeals" (*Vol. 1, General Information*) for more information.

3.7.4.11 Other Requirements

The submitted facility address on the claim must match the physical address of the location that has been issued a neonatal level of care designation. If the facility address is not included on the claim, the submitted billing address must match the physical address of the location that was issued a neonatal level of care designation.

Important: *The hospital address on the health facilities license must match the address billed on the claim. Claims will be denied if the address submitted on the claim does not match the address on file. Providers should refer to the DSHS approval letter to verify the correct address.*

Refer to: The DSHS website for more information for more information on address updates.

3.7.4.12 Transfers

When Texas Medicaid or CSHCN Services Program clients are 28 days of age and younger on the date of admission and are subsequently transferred to another facility, neonatal level of care designation requirements will apply to all facilities involved in that client's continuous inpatient stay.

3.7.4.13 Crossover Claims for Dual Eligible Clients

Neonatal level of care designation requirements will also apply to services rendered to a client who is less than 28 days old and has dual Medicare and Medicaid eligibility on the date of admission.

3.7.4.14 Children's Hospitals

Children's hospitals are reimbursed using the prospective payment methodology based on APR-DRG methodology.

With the exception of designated children's hospitals, hospitals that are reimbursed by APR-DRG payment methodology receive one SDA rate.

Designated children's hospitals receive two SDA rates:

- One rate for obstetric delivery services rendered to clients who are 18 years of age and older.
- One rate for all other services rendered to clients who are 18 years of age and older and all services rendered to clients who are 17 years of age and younger, including obstetric delivery services.

3.7.4.15 Potentially Preventable Complications (PPC) and Potentially Preventable Readmissions (PPR)

Potentially Preventable Complications (PPCs)

By definition, potentially preventable complications (PPCs) are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from the natural progression of the underlying illness. A PPC is an inpatient hospital complication that was potentially preventable based on criteria such as hospital characteristics, reason for admission, procedures, and the interrelationships between underlying medical conditions.

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S.B. 7, Chapter 526, the 82nd Texas Legislature, 2011, establishes the authority of HHSC, and Texas Government code 543A.0151 requires HHSC to identify PPCs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. A statewide average PPC rate is calculated for all hospitals within Texas. Each hospital has an individual rate. Hospitals are able to compare their rate of PPC to the statewide average.

The PPC analysis is performed in accordance with TAC, §354.1446 Potentially Preventable Complications.

Potentially Preventable Readmission (PPRs)

By definition, potentially preventable readmissions (PPRs) are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up.

Texas Medicaid uses a 15 day readmission interval.

Section 531.913, House Bill (H.B.) 1218, 81st Legislature, 2009, Texas Government Code 543A.0151, requires the HHSC to identify PPRs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC delivers an annual, confidential report of the results to each hospital that is enrolled in Texas Medicaid, and each of those hospitals must distribute the information to their care providers. HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. Patients are never identified in the reports.

PPR Analysis

The PPR analysis is performed in accordance with TAC, §354.1445 Potentially Preventable Readmissions.

Refer to: The HHS website at www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events for more information on Potentially Preventable Events (PPE).

3.7.4.16 * State-owned Teaching Hospitals

Inpatient hospital stays in designated state-owned teaching hospitals are reimbursed according to the TEFRA payment methodology.

State-owned teaching hospitals are defined specifically in 1 TAC §355.8052 as the following hospitals:

- [Revised] University of Texas Medical Branch (UTMB)
- [Revised] University of Texas Health Center Tyler
- [Revised] University of Texas at San Antonio
- [Revised] University of Texas Southwestern Medical Center (UTSW)
- [Revised] M.D. Anderson Hospital

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3.7.4.17 Payment Window Reimbursement Guidelines

3.7.4.17.1 Guidelines for Services Preceding an Inpatient Admission

The following payment window reimbursement guidelines apply to services that are rendered by the hospital or an entity that is wholly owned or operated by the hospital. The three-day (or one-day) payment window does not apply if:

- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100 percent owner of the entity.

Texas Medicaid inpatient hospital providers must submit, as part of the client's inpatient hospital claim, all related professional and outpatient services that were rendered on the date of the client's inpatient admission or one of the following dates immediately before admission:

- Within three calendar days before the client's inpatient admission for hospitals that receive DRG reimbursement, with the exception of children's hospitals.
- Within one calendar day before the client's inpatient admission for hospitals that receive reimbursement other than DRG.
- Within one calendar day before the client's inpatient admission for children's hospitals.

Professional and outpatient services that must be submitted as part of the inpatient hospital claim include the following services if they are rendered by the hospital or an entity that is wholly owned or operated by the hospital:

- Diagnostic services. Diagnostic services include outpatient laboratory and radiology services that are related to the inpatient admission and submitted by physician and outpatient hospital providers. Affected services will include the total and technical components. The professional interpretation component will not be included in the payment windows identified above.
- Non-diagnostic services. Non-diagnostic services include surgeries and other non-diagnostic procedures and services that are related to the inpatient admission and submitted by physician, outpatient hospital, or other providers.

Important: *Related professional and outpatient services that were rendered within the specified time frames must be submitted on the inpatient hospital claim and not on an outpatient hospital claim. An outpatient hospital claim for these services will be denied as part of the payment for the inpatient hospital stay.*

3.7.4.17.2 Exceptions

The following services are excluded from the payment window and may be submitted and reimbursed separately from the inpatient admission:

- Services rendered by federally qualified health center (FQHC) providers
- Services rendered by rural health clinic (RHC) providers
- Professional services that are rendered in the inpatient hospital setting (place of service 3)
- Non-emergency and emergency ambulance services

The outpatient emergency and maintenance renal dialysis procedure codes in the tables below are also exceptions to the one-day payment window reimbursement guidelines:

Procedure Codes									
G0257									
ESRD Physician Services									

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Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970
Physician Services for Hemodialysis or Other Dialysis Procedures									
71010	71020	78300	78305	78306	80069	81050	82040	82310	82374
82435	82565	83615	83735	84075	84100	84132	84155	84295	84450
84520	85004	85007	85008	85014	85018	85025	85027	85041	85345
85347	85610	87340	90935	90937	90945	90947	93005		
Equipment and Supplies									
A4216	A4217	A4651	A4652	A4657	A4660	A4663	A4670	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	E0439
E0441	E0442	E0443	E0444	E1510	E1520	E1530	E1540	E1550	E1560
E1570	E1575	E1580	E1590	E1592	E1594	E1600	E1620	E1630	E1632
E1635	E1637								

3.7.4.17.3 Professional and Outpatient Claims for Services Related to the Inpatient Admission

Professional and outpatient services that are rendered on the date of admission, or within one of the one-day or three-day timeframes indicated above by the hospital or an entity that is wholly owned or operated by the hospital, are considered part of the inpatient stay. Professional and outpatient claims submitted for services that are related to the inpatient admission will be denied or recouped if they are submitted with the specified payment window.

When modifier PD is appended to a professional or outpatient service, the modifier indicates that the service is related to the inpatient admission. The total and technical components for professional and outpatient services that are related to the inpatient admission will be denied when submitted with modifier PD.

Note: *The professional interpretation component for professional and outpatient services that are related to the inpatient stay may be reimbursed separately even if accompanied by PD modifier.*

3.7.4.17.4 Professional and Outpatient Claims for Services Unrelated to the Inpatient Admission

Professional and outpatient services that are rendered within the specified timeframe by the hospital or an entity that is wholly owned or operated by the hospital may be reimbursed if they are identified as unrelated to the inpatient admission as follows:

- Professional and outpatient claims for diagnostic services that are unrelated to the inpatient admission must be submitted with modifier U4, which indicates the service is unrelated to the inpatient admission.
- Professional claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the professional claim to the principal inpatient diagnosis. Professional services must be submitted with modifier U4 if the services are unrelated and up to six digits of the referenced professional diagnosis code match the principle inpatient diagnosis code.

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- Outpatient claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the outpatient claim to the principal inpatient diagnosis. The outpatient services must be submitted with condition code 51 if the services are unrelated and up to six digits of the referenced outpatient diagnosis code match the principle inpatient diagnosis code.

Unrelated services that are denied as part of the inpatient admission can be appealed with modifier U4 or condition code 51, which indicates that the service is unrelated to the inpatient admission.

Note: *Claims that are submitted with modifier U4 or condition code 51 will be subject to retrospective review and may be recouped if there is not sufficient documentation to indicate the service was unrelated to the inpatient admission.*

These benefit changes do not impact services rendered by providers that are not wholly owned or operated by the hospital.

3.7.4.18 Potentially Preventable Readmissions (PPR)

H.B. 1218, 81st Legislature, Regular Session 2009, requires that HHSC identify potentially preventable readmissions (PPRs) in the Medicaid population and report results confidentially to each hospital. The law also requires each hospital to distribute the information to its care providers.

3.7.5 Provider Cost and Reporting

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient and outpatient costs in the cost reports submitted annually. The provider must prepare one copy of the applicable CMS Cost Report Form along with the required PCCM supplemental worksheets. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet, available from CMS, and the Outpatient PCCM D, Part V worksheet. A sample of the Outpatient PCCM D, Part V is available on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2.2, "Cost Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

If a change of ownership or provider termination occurs, the cost report is due within five months after the date of the change in ownership or termination. Any request for an extension of time to file must be made on or before the cost report due date and sent to TMHP Medicaid Audit at the address indicated under "Written Communication With TMHP" in the "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*). For questions or assistance, call TMHP Medicaid Audit at 1-512-506-7630 or email audit.costreport@tmhp.com.

Annual cost reports must be filed as follows:

- Submit one copy of the cost report to TMHP Medicaid Audit within five months of the end of the hospital's fiscal year along with any amount due to Texas Medicaid.
- TMHP Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to Texas Medicaid or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.
- Field audits are conducted when necessary.
- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary. The provider must send TMHP a copy of one of the following:
  - Audited or settled without audit Medicare Cost Report
  - Medicare Notice of Amount of Program Reimbursement
  - Medicare Audit Adjustment Report, if applicable

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Medicaid hospitals may request copies of their claim summaries for their cost reporting fiscal year. The summaries for tentative settlements include three additional months of claim payments for the fiscal year. The summaries for final settlements include ten months of claim payments for the fiscal year. TMHP Medicaid Audit uses this data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data are only generated once each month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs are submitted within 30 days after the fiscal year-end. Final settlement log requests are submitted within nine months after the fiscal year-end.

The Medicaid logs can be requested through the provider's administrator account on the TMHP website at www.tmhp.com. Medicaid logs can also be requested by calling 1-512-506-7630, by emailing audit.costreport@tmhp.com, or by sending a written request to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Allow 45 days for receipt of these logs.

3.7.6 Third Party Liability

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

Other Insurance Form on the TMHP website at www.tmhp.com.

Tort Response Form on the TMHP website at www.tmhp.com.

4 Outpatient Hospital (Medical and Surgical Acute Care Outpatient Facility)

This section contains benefit, limitation, authorization, and claims filing information for outpatient hospital facility emergency, observation, and other services.

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more comprehensive information about claims filing and appeals.

"Section 7: Appeals" (*Vol. 1, General Information*) for more comprehensive information about claims filing and appeals.

Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.

4.1 General Information

Outpatient diagnostic, therapeutic, and surgical services that are rendered in an acute care hospital setting are services that are provided to clients by or under the direction of a physician.

Outpatient hospital services include those services that are rendered:

- In the emergency room (ER)
- As day surgery
- In the observation room
- By ancillary departments such as the laboratory, radiology, physical or occupational therapy, cardiac rehabilitation, hyperbaric chamber, infusion services, and other areas able to provide services in the outpatient setting.

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4.1.1 Drugs and Supplies

4.1.1.1 Self-Administered Drugs

Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements.

These drugs that are provided by the hospital during an outpatient hospital visit are included in the hospital reimbursement and are not reimbursed separately. The client cannot be billed for self-administered drugs that are provided by the hospital during an outpatient hospital stay.

4.1.1.2 Take-Home Drugs and Supplies

Benefits do not include drugs and biologicals provided by the hospital and taken home by the client. Supplies provided by a hospital for use in physicians' offices are not reimbursable.

Take-home drugs and supplies are a benefit for services rendered to clients in the outpatient setting when supplied by prescription through the VDP.

4.1.2 Outpatient Services Provided Without Charge

Texas Medicaid pays the clinic registration fee in lieu of other benefits when a hospital provides outpatient services without charge, and if the registration fee is less than the allowed Medicaid payment.

Refer to: TAC Rule §354.1073 for information about authorized outpatient hospital services.

Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about noncovered items or services.

4.1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in this handbook for additional information about the payment window reimbursement guidelines.

4.2 Services, Benefits, Limitations, and Prior Authorization

4.2.1 Prior Authorization Requirements

The hospital is responsible for requesting prior authorization for the non-emergency transport to the client's home or to a nursing home after a non-scheduled outpatient visit.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

4.2.2 Emergency Department Services

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

Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state.

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All claims that are submitted by outpatient hospital providers must include a procedure code with each revenue code for services that are rendered to Texas Medicaid clients. This procedure code must be listed on the same claim detail line as the emergency department revenue code.

The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered in the hospital's emergency department.

Emergency department reimbursement may include room charges and ancillary charges. Emergency department room charges may be submitted using the following revenue codes:

Revenue Code	Description
450	Emergency room
451	Emergency room-EMTALA emergency medical screening
456	Emergency room, urgent care
459	Emergency room, other

Emergency department ancillary services include, but are not limited to, the following:

- Laboratory services
- Radiology services
- Respiratory therapy services
- Diagnostic studies (including, but not limited to, ECGs, computed tomography (CT) scans, and supplies)

The administration of the injection will not be reimbursed to outpatient hospital providers. An injection or infusion administered by a nurse is included in the emergency room charge and is not reimbursed separately to the outpatient facility.

Ancillary services must be submitted on the UB-04 CMS-1450 paper claim form using the appropriate procedure codes or revenue codes for rendered services.

If a client visits the emergency room more than once in one day, the times must be given for each visit.

If the client ultimately is admitted as an inpatient within 48 hours of treatment in the ER or clinic, the ER or clinic charges must be submitted on the inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the ER or clinic.

According to the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986, if any individual presents at the hospital's emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination and stabilization services within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists.

EMTALA medical screening code (451) may be considered for reimbursement when submitted as a stand-alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement. Services beyond screening (451) can be submitted with the appropriate corresponding emergency services code (450).

Medicaid claims administrators are prohibited from requiring prior authorization or primary care provider notification for emergency services including those needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition.

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Texas Medicaid provides that certain undocumented aliens and legalized aliens who require treatment of an emergency medical condition or emergency behavioral health condition are eligible to receive that treatment. After the emergency condition requiring care is stabilized and is no longer an emergency, the coverage ends. If the alien continues to receive ongoing treatment after the emergency ceases, the ongoing treatment is not a benefit.

Texas Medicaid provides for medical services for eligible clients while out-of-state. The attending physician or other provider must document that the client was treated for an emergency condition. Out-of-state emergency services are also a benefit when the client's health would be in danger if he or she were required to travel back to Texas.

Emergency department services are subject to retrospective review.

In instances of sudden illness or injury, the client may receive treatment in the ER and be discharged, placed on observation status, or admitted as an inpatient.

4.2.2.1 Emergency Department Payment Reductions

Nonemergent and nonurgent evaluation and management (E/M) services rendered in the emergency room may be reimbursed at 125 percent of the adult, physician office visit fee for procedure code 99202. Reimbursement is based on the E/M procedure code submitted on the same line item as the emergency room revenue code.

Imaging services rendered by outpatient hospital providers are reimbursed at the flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code.

Note: *Evaluation and management services that are rendered in the emergency room for critically ill or critically injured Texas Medicaid clients of any age, are not subject to reduction in payment.*

Exception: *Rural hospitals, nonemergent and nonurgent E/M services rendered in the emergency room may be reimbursed at 55 percent of the allowed rate.*

4.2.3 Day Surgery

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

These procedures are for clients who are scheduled for a day surgery procedure and are not inpatient at the time the day surgery is performed.

4.2.3.1 Inpatient Admissions for Day Surgeries

If a client is admitted for a day surgery procedure—whether scheduled or emergency—one of the following classifications may be considered an inpatient procedure.

- ASA Classification of Physical Status of III (P3), IV (P4), or V (P5)
- Classification of Heart Disease IV

The day surgery services must be submitted on an inpatient claim (TOB 111) using the hospital's NPI and taxonomy code. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the procedure must be included on one inpatient claim.

Refer to: The Anesthesia standards at www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system for a description of the ASA classes of physical status.

The descriptions for ASA classes of physical status are as follows:

- *Class I.* A normal healthy patient, without organic, physiological, or psychiatric disturbance.

  Example: *Healthy patient with good exercise tolerance.*

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- *Class II.* A patient with mild systemic disease, controlled medical conditions without significant systemic effects.

  Example: *Controlled hypertension or diabetes mellitus without system effects, cigarette smoking without evidence of chronic obstructive pulmonary disease (COPD), anemia, mild obesity, age less than 1 or greater than 70 years, or pregnancy.*

- *Class III.* A patient exhibiting severe systemic disturbance that may or may not be associated with the surgical complaint and that seriously interferes with the patient's activities.

  Example: *Severely limiting organic heart disease, severe diabetes with vascular complications; moderate to severe degrees of pulmonary insufficiency; angina pectoris or healed myocardial infarction.*

- *Class IV*. A patient exhibiting extreme systemic disturbance that may or may not be associated with the surgical complaint, that interferes with the patient's regular activities, and that has already become life-threatening.

  Example: *Organic heart disease with marked signs of cardiac insufficiency present (for example, cardiac decompensation); persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency present.*

- *Class V*. The rare person who is moribund (in a dying state) before operation, whose pre-operative condition is such that he or she is expected to die within 24 hours even if not subjected to the additional strain of operation.

  Example: *Burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure; massive embolus.*

The Classification of Heart Disease consists of four classes:

- *Class I.* No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
- *Class II.* Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
- *Class III.* Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.
- *Class IV*. Unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, may be present even at rest. If any physical activity is undertaken, discomfort occurs.

4.2.3.2 Complications Following Elective or Scheduled Day Surgeries

If a condition of the scheduled day surgery requires additional care beyond the recovery period, the client may be placed in outpatient observation (stay less than 48 hours). The observation period must be submitted on an outpatient claim (TOB 131) using the hospital's NPI and taxonomy code. If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement (excluding the surgical procedure) must be included on the inpatient claim (TOB 111) using the hospital's NPI and taxonomy code. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must still be submitted as an outpatient procedure under the HASC NPI and taxonomy code.

4.2.3.3 Inpatient Admissions After Day Surgery

If a complication occurs for which the client requires inpatient admission immediately following the day surgery (no observation period), the day surgery must be submitted as an outpatient procedure (TOB 131), using the appropriate hospital or HASC NPI and taxonomy code. The inpatient admission is to be

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submitted as an inpatient claim (TOB 111), using the hospital's NPI and taxonomy code. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must not be included on the inpatient claim. The inpatient admission must be medically necessary and is subject to retrospective review.

4.2.3.4 Emergency or Unscheduled Day Surgeries

These procedures are for clients who require an unscheduled (emergency) day surgery procedure and are not inpatient at the time the day surgery is performed.

If a client is first treated in the ER and then requires emergency surgery as an outpatient, claims for emergency, unscheduled outpatient surgical procedures must be filed itemizing each service, such as room charge, laboratory, radiology, anesthesia, and supplies. Providers must submit claims for unscheduled day surgery procedures and emergency services as outpatient procedures using the hospital NPI and taxonomy code. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status. The observation period must be submitted on the same outpatient claim.

Providers must submit claims for the unscheduled day surgery procedures and emergency services as outpatient procedures (TOB 131) using the hospital's NPI and taxonomy code. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status (stay less than 48 hours). The observation period must be submitted on the same outpatient claim (TOB 131) using the hospital's NPI and taxonomy code.

4.2.3.5 Complications Following Emergency or Unscheduled Day Surgery

If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation status (excluding surgical procedures and emergency services) must be included on the inpatient claim (TOB 111) using the hospital's NPI and taxonomy code. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery and emergency services must not be included on the inpatient claim since they are to be submitted using TOB 131 as outpatient procedures under the hospital's NPI and taxonomy code.

4.2.3.6 Incomplete Day Surgeries

Facilities must use either diagnosis codes Z5309, Z5329, Z538, or modifiers 73 (Discontinued outpatient procedure prior to anesthesia administration) or 74 (Discontinued outpatient procedure after anesthesia administration) to indicate that a surgical procedure, type of service (TOS) "F," was not completed. Claims billed with Z5309, Z5329, Z538, or modifiers 73 or 74 will be suspended for review of the medical documentation submitted with the claim.

Providers must submit the following documentation with the claim:

- The operative report
- The anesthesia report
- The reason that the operation was not complete

Reimbursement to HASC facilities for canceled or incomplete surgeries because of patient complications, is made according to the following criteria, depending on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of HASC payment for a procedure that is terminated for nonmedical or medical reasons before the facility has expended substantial resources.
- Reimburse at 33 percent of HASC payment up to the administration of anesthesia.
- Reimburse at 67 percent of HASC payment after the administration of anesthesia but before incision.

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- Reimburse at 100 percent of HASC payment after incision.

Surgeries canceled because of incomplete pre-operative procedures are not reimbursed.

4.2.4 Outpatient Observation Room Services

Observation care is defined by the CMS as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital's nursing or other ancillary staff to evaluate the client's condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services (revenue codes 760, 761, 762, and 769) are a benefit only when medically necessary and when provided under a practitioner's order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
  - Laboratory, radiology, or other testing is necessary to assess the client's need for an inpatient admission.
  - The treatment plan is not established or, based on the client's condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.
- The medical necessity for inpatient treatment is unclear, that is:
  - The client's medical condition requires careful monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary
  - There is a delayed or slow progression of the client's signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.
  - The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.
- The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours.

Medically necessary services that do not meet the definition of observation care should be submitted separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay. Claims

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for observation services may be denied in their entirety if the services should have initially been inpatient admissions or if a reason for an inpatient admission developed, but the observation stay was not converted to inpatient.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner's expectation of the care that the client will require.

4.2.4.1 Direct Outpatient Observation Admission

A client may be directly admitted to outpatient observation from the evaluating practitioner's office without being seen in the emergency room by a hospital-based practitioner. The practitioner's order should clearly specify that the practitioner wants the client to be admitted to outpatient observation status. An order for "direct admission" will be considered an inpatient admission unless otherwise specified by the practitioner's orders.

Brief observation periods following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., a breathing treatment) would be more appropriately coded as a treatment room visit.

4.2.4.2 Observation Following Emergency Room

A client may be admitted to outpatient observation through the emergency room if the client presents to the facility with an unstable medical condition and the evaluating practitioner determines that outpatient observation is medically necessary to determine a definitive treatment plan. An unstable medical condition is defined as one of the following:

- A variance in laboratory values from what is considered the generally accepted, safe values for the individual client.
- Clinical signs and symptoms that are above or below those of normal range and that require extended monitoring and further evaluation.
- Changes in the client's medical condition are anticipated, and further evaluation is necessary.

If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be submitted on a separate detail on the same claim as the observation room charges.

Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit.

4.2.4.3 Observation Following Outpatient Day Surgery

If a medical condition or complication of a scheduled day surgery requires additional care beyond the routine recovery period, the client may be placed in outpatient observation. The observation period should be submitted as an outpatient claim.

Reimbursement for outpatient observation after a scheduled day surgery is limited to situations in which the client exhibits an unusual reaction to the surgical procedure and requires monitoring or treatment beyond what is normally provided in the immediate post-operative period. Examples include, but are not limited to:

- Difficulty in awakening from anesthesia.
- A drug reaction.
- Other post-surgical complications.

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4.2.4.4 Observation Following Outpatient Diagnostic Testing or Therapeutic Services

A client may be admitted to outpatient observation if the client develops a significant adverse reaction to a scheduled outpatient diagnostic test or to a therapeutic service, such as chemotherapy, that requires further monitoring. Observation services begin when the reaction occurred and end when the practitioner determines that the client is stable for discharge, or that an inpatient admission is appropriate.

4.2.4.5 Documentation Requirements for Outpatient Observation

Documentation that supports the medical necessity of the outpatient observation services must be maintained by the facility in the client's medical record. Documentation must include:

- The order of the ordering practitioner for admission to observation care, which must be dated and timed.
- The practitioner's admission and progress notes, which must be dated and timed, confirm the need for observation care, and outline the client's condition, treatment, and response to treatment.
- Nurse's notes, which must be dated and timed, reflect the time at which the client was admitted to the observation bed, and the reason for the observation stay.
- All supporting diagnostic and ancillary testing reports, including orders for the testing or any preadmission testing.
- Procedure notes and operative notes that address any complication that would support admission to observation status and must be dated and timed.
- Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must be dated and timed and detail orders and any complications that require admission to observation status.
- Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.
- All of the client education that was provided during the observation stay.
- The order for discharge from observation care, which must be signed, dated, and timed.
- The discharge notes, including nurse's notes that reflect the date and time at which the client was discharged from observation.

The client must be in the care of a practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are dated, timed, written, and signed by the practitioner.

Claims submitted for outpatient procedures in which the original intention was to keep the client for an extended period of time, such as overnight or for a 48-hour period, will be denied unless significant medical necessity is documented.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the outpatient observation services. Medical records will be evaluated to determine whether the practitioner's order (practitioner intent) and the services that were actually provided were consistent.

The medical records must clearly support the medical necessity of the outpatient observation services and must include a timed order for observation services that will support the number of hours that the client was under observation care and the hours that were submitted for payment.

4.2.4.6 Reporting Hours of Observation

Providers must submit the number of observation hours the client was under observation care.

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Observation time begins at the clock time documented in the client's medical record. This time should coincide with the time that the client is placed in a bed for the purpose of initiating observation care in accordance with the practitioner's order.

Observation time ends when all medically necessary services related to observation care are completed. The end time of observation services may coincide with the time the client is actually discharged from the hospital or is admitted as an inpatient.

Hospitals should round clock times for the beginning and end of observation to the nearest hour and submit the total number of hours for the observation stay on the claim. For the purposes of submitting claims for observation services, one unit equals one hour. Partial units or hours should be rounded up or down to the nearest hour. Claims submitted with observation room units exceeding 48 hours will be denied.

Any service that was ordered within the observation period may be included on the outpatient claim if a practitioner's order for the service was made within the observation period time frame but hospital scheduling limitations prevented the service from being performed before the 48 hours expired. Any services ordered after 48 hours must not be included on the outpatient claim nor billed to the client. If a period of observation spans more than one calendar day (i.e., extends past midnight), all of the hours for the entire period of observation must be included on a single line, and the date of service for that line is the date on which the observation care began.

Observation time may include medically necessary services and follow-up care that is provided after the time the practitioner writes the discharge order, but before the client is discharged. Reported observation time does not include the time the client remains in the observation area after treatment is completed for reasons such as waiting for transportation home.

Observation services must not be submitted concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure. In situations where a diagnostic or therapeutic procedure interrupts the observation stay, hospitals should record for each period of observation services the beginning and ending times of the observation period and add the lengths of time for the periods of observation services together to reach the total number of units reported on the claim.

Recovery room hours that are associated with an outpatient procedure must not be submitted simultaneously with hours of observation time.

Revenue code 761 will be denied if it is submitted for the same date of service by the same provider as revenue code 760, 762, or 769.

4.2.4.7 Client Status Change

When a client's status changes from outpatient observation to inpatient admission within the allowed 48-hour observation period, both the outpatient observation service and the inpatient admission must be submitted as separate details on the same inpatient claim.

The inpatient claim must include:

- The provider must submit the correct FDOS and Date of Admission (DOA) on the claim header.
- Charges for the observation room on the inpatient claim may be coded using the appropriate revenue code (760, 761, 762, or 769).
- The observation services are considered part of the facility's DRG payment, and are not separately reimbursed.

The practitioner's order for a change in client status from outpatient observation to inpatient admission must be written, dated, and timed before the outpatient observation claim is submitted for reimbursement.

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4.2.4.8 Inpatient Admission to Outpatient Observation

When a client is admitted to the hospital as an inpatient and a subsequent internal utilization review (UR) determines that the services did not meet inpatient criteria, the hospital may change the client's status from inpatient to outpatient observation. The order to change from an inpatient to outpatient observation admission is effective for the same date and time as the inpatient order. This practice is acceptable under Texas Medicaid if all of the following conditions are met:

- The change in client status is made before the claim is submitted.
- The hospital has not submitted a claim for the inpatient admission.
- The practitioner responsible for the care of the client concurs with the hospital UR determination to change to outpatient status.
- The practitioner's concurrence with the UR decision is documented in the client's medical record.

Note: *When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care.*

Reimbursement for emergency room (ER) and observation services are considered part of the inpatient DRG payment and must be submitted as separate details on the inpatient claim when the client is admitted as an inpatient under one or both of the following circumstances:

- The client has spent fewer than 24 hours after presenting in the ER without being placed in observation status.
- The client has spent fewer than 48 hours in observation status after presenting in the ER.

The date of admission on the inpatient claim must reflect the date the client presents at the hospital.

If the client is admitted as an inpatient more than 24 hours after presenting in the ER without being placed in observation status or more than 48 hours after being placed in observation status, the ER and observation services may be reimbursed separately as outpatient services.

Examples

The following examples indicate the appropriate dates of admission and claim submissions for different scenarios:

Scenario 1

In scenario 1, the ER and outpatient observation services must be submitted on the inpatient hospital claim, because the ER services are within 24 hours of the observation services, and the observation services are within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (12:30 a.m.)	40 minutes later, patient is placed in observation status
5/3/12 (12:00 a.m.)	23.5 hours later, after placement is in observation status, patient is admitted as an inpatient

Claims submissions are as follows:

- *ER visit:* Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- *Observation services:* Submitted on the inpatient claim as a separate detail (part of the DRG payment)

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- *Date of inpatient admission:* May 1, 2012

Scenario 2

In scenario 2, the ER service was more than 24 hours before the observation period began and must be submitted on an outpatient hospital claim. The observation service must be billed on the inpatient hospital claim because the service was within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient was placed in observation status.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (11:55 p.m.)	24 + hours later, patient is placed in observation status
5/3/12 (4:00 a.m.)	4 hours later, patient admitted as an inpatient

Claims submissions are as follows:

- *ER visit:* Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services
- *Observation services:* Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- *Date of inpatient admission:* May 2, 2012

Scenario 3

In scenario 3, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the observation service was more than 48 hours before the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (12:30 a.m.)	40 minutes later, patient placed in observation status
5/4/12 (12:45 a.m.)	48 + hours later patient admitted as an inpatient

Claims submissions are as follows:

- *ER visit:* Submitted on an outpatient claim and reimbursed as part of the outpatient observation services
- *Observation services:* Submitted on the outpatient claim and reimbursed separately from the inpatient services
- *Date of inpatient admission:* May 4, 2012

Scenario 4

In scenario 4, the ER service may be reimbursed separately because it was more than 24 hours before the client was placed in observation status. The observation service may be reimbursed separately because it was more than 48 hours before the client was admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

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Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (11:55 p.m.)	24 + hours later, patient is placed in observation status
5/4/12 (12:00 p.m.)	48 + hours later, patient admitted as an inpatient

Claims submissions are as follows:

- *ER visit:* Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services.
- *Observation services:* Submitted on an outpatient claim and reimbursed separately from the inpatient services.
- *Date of inpatient admission:* May 4, 2012

Scenario 5

In scenario 5, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the client was discharged and sent home without being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER after being discharged and sent home 14 hours earlier.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (12:30 a.m.)	40 minutes later, patient is placed in observation status.
5/2/12 (10:00 a.m.)	9.5 hours later, patient is discharged and sent home
5/3/12 (12:05 a.m.)	14 hours later, patient presents at the ER again and is admitted as an inpatient

Claims submissions are as follows:

- *ER visit:* Submitted on an outpatient claim and reimbursed as part of the observation services
- *Observation services:* Submitted on the outpatient claim and reimbursed separately from the inpatient services
- *Date of inpatient admission:* May 3, 2012

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be submitted as an outpatient episode of care.

4.2.4.9 Observation Services that are not a benefit

Outpatient observation services that are not medically necessary or appropriate are not benefits of Texas Medicaid, including, but not limited to, services provided under the following circumstances:

- As a substitute for an inpatient admission.
- Without a practitioner's order, including services ordered as inpatient services by the ordering practitioner, but submitted as outpatient by the billing office.
- For clients awaiting transfer to another facility, such as for nursing home placement.
- For clients with lack of or delay in transportation.
- As a convenience to the client, client's family, the practitioner, hospital, or hospital staff.

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- For routine preparation before, or recovery after, outpatient diagnostic or surgical services.
- When an overnight stay is planned before diagnostic testing.
- To medically stable clients who need diagnostic testing or outpatient procedures that are routinely provided in an outpatient setting.
- Following an uncomplicated treatment or procedure.
- As standing orders for observation following outpatient surgery.
- For postoperative monitoring during a standard recovery period of four to six hours, which is considered part of the recovery room service.
- For outpatient blood or chemotherapy administration and concurrent services.
- For services that would normally require an inpatient admission.
- Beyond 48 hours from the time of the observation admission.
- For a medical examination for clients who do not require skilled support.

4.2.5 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate. One of the following modifiers must be submitted for general medical services: AH, AJ, AM, SA, TD, TE, or U7.

The services listed below must be submitted using the RHC NPI and the appropriate benefit code:

- THSteps medical checkups
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations provided in hospital-based RHCs

These services must be submitted with an AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the Prospective Payment System (PPS) reimbursement methodology.

When submitting a claim on the CMS-1500 paper claim form, providers must use the appropriate national POS (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be submitted using the individual or group physician NPI and taxonomy code.

Hospital-based RHCs must submit claims for pneumococcal and influenza vaccines as non- RHC services, under their hospital NPI and taxonomy code.

> ***Note:*** *A visit is a face-to-face encounter between an RHC client and a physician, PA, nurse practitioner (NP), certified nurse-midwife (CNM), visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:*

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The RHC client has a medical visit and an other health visit.

An other health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

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4.2.6 Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Outpatient cardiac rehabilitation is considered reasonable and necessary for clients who have had one of the following within 12 months of beginning the cardiac rehabilitation program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

Note: *A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms to a remote site is not covered by Texas Medicaid.*

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (i.e. oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use. If no clinically significant arrhythmia is documented during the first three weeks of the program, the provider may have the client complete the remaining portion without telemetry monitoring by the physician's order.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program conducted by non-physician personnel who are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease, and provide the services under the direct supervision of a physician.

Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs. Outpatient cardiac rehabilitation begins after the client has been discharged from the hospital. A physician's prescription is required after the acute convalescent period and after it has been determined that the client's clinical status and capacity will allow for safe participation in an individualized progressive exercise program. Outpatient cardiac rehabilitation requires close monitoring and direct supervision by a physician and includes:

- Medical evaluation performed by the physician responsible for prescribing the client's rehabilitation program and includes a clinical examination, a medical history, and an initial plan or goal.
- An education and counseling program to modify risk factors (nutritional counseling, stress reduction, smoking cessation, weight loss, etc.).
- Prescribed exercise concurrent with and without electrocardiogram (ECG) monitoring.
- Services performed in an approved facility by trained professionals.

Note: *Direct supervision is met when the services are performed on hospital premises or within 250 yards of the hospital.*

Cardiac rehabilitation will be limited to a maximum of 2 one-hour sessions per day and 36 sessions over 18 weeks per rolling year.

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Providers must obtain prior authorization for additional cardiac rehabilitation sessions, which will be limited to a maximum of 36 sessions in an extended period of time in a 52-week period from the date of authorization of additional sessions.

To confirm that a continuation of cardiac rehabilitation is at the request of, and coordinated with the attending physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and either the medical director or the referring physician. If the physician responsible for such follow-up is the medical director, then his or her notes must be evident in each client's medical record.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the medical record contains documentation that the client has had another cardiac event, or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Medical necessity documentation must include the following:

- Progress made from the beginning of the cardiac rehabilitation period to the current service request date, including progress towards previous goals
- Information that supports the client's capability of continued measurable progress
- A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs

Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department. Providers must send prior authorization requests, along with documentation to support medical necessity, to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be submitted with modifier 25 appended to the E/M code when supporting documentation in the medical record demonstrates a separately identifiable E/M service was provided on the same day by the same provider who renders the cardiac rehabilitation.

Physical and occupational therapy will not be reimbursed separately when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition requiring such therapy.

Example: *If a client is recuperating from an acute phase of heart disease and has had a stroke that requires physical or occupational therapy, the physical or occupational therapy for the stroke may be reimbursed separately from the cardiac rehabilitation services for the acute phase of heart disease.*

When provided as part of the cardiac rehabilitation program, client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity to assist the client in adjusting living habits because of the cardiac condition, will not be separately reimbursed.

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Procedure code S9472 (cardiac rehabilitation program nonphysician provider per diem) is used for hospitals submitting claims for cardiac rehabilitation, and it must be submitted with revenue code 943 (other therapeutic services-cardiac rehabilitation) and one of the following diagnosis codes:

Diagnosis Codes							
I110	I160	I161	I169	I201	I202	I208	I209
I2101	I2102	I2109	I2111	I2119	I2121	I2129	I213
I214	I219	I21A1	I21A9	I220	I221	I222	I228
I229	I2720	I2721	I2722	I2723	I2724	I2729	I2783
I501	I5020	I5021	I5022	I5023	I5030	I5031	I5032
I5033	I5040	I5041	I5042	I5043	I50810	I50811	I50812
I50813	I50814	I5082	I5083	I5084	I5089	I509	I5A
Z941	Z943	Z951	Z952	Z953	Z954	Z955	Z9861
Z98890							

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for clients who have documentation of acute myocardial infarction, coronary artery bypass surgery (CABG), percutaneous transluminal coronary angioplasty or coronary stenting heart valve repair/replacement, major pulmonary surgery, sustained ventrical tachycardia or fibrillation, class III or class IV congestive heart failure, or chronic stable angina within the past twelve (12) months prior to the beginning of the program.

4.2.7 Chemotherapy Administration

Hospitals must submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy.

Revenue code 636 may be reimbursed for the technical component of prolonged infusion of chemotherapeutic agents. The most appropriate chemotherapy procedure code must be billed with revenue code 636.

4.2.8 Colorectal Cancer Screening

Fecal occult blood tests, multi-targareted stool DNA (mt-sDNA) tests, screening colonoscopies, and sigmoidoscopies evidence-based methods of colorectal cancer screening.

4.2.8.1 Fecal Occult Blood Tests

Procedure codes G0328 (with modifier QW) and 82270 may be reimbursed one service per rolling year for clients who are 45 years of age and older.

4.2.8.2 MT-sDNA Tests

Procedure code 81528 may be reimbursed once every 3 years for clients who are 45 years of age and older for services rendered in the laboratory setting.

4.2.8.3 Sigmoidoscopies

Procedure code G0104 may be reimbursed once every 5 years and is limited to one of the following diagnosis codes:

Diagnosis Codes							
Z0000*	Z0001*	Z1210	Z1211	Z1213	Z859	Z86002	Z86003
Z86004	Z86006	Z86007	Z860100	Z860102	Z860109		

***Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the U.S. Preventive Services Task Force (USPSTF).**

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4.2.8.4 Colonoscopies

Procedure code G0105 may be reimbursed once every two years for clients who meet the definition of high-risk. Procedure code G0105 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5120	K51211	K51212	K51213	K51214	K51218	K5130
K51311	K51312	K51313	K51314	K51318	K5180	K51811	K51812
K51813	K51814	K51818	K5190	K51911	K51912	K51913	K51914
K51918	K51919	K523	K5281	K5282	K52831	K52832	K52838
K52839	K5289	K529	Z800	Z83710	Z83711	Z83718	Z83719
Z8372	Z85038	Z85048	Z859	Z86002	Z86003	Z86004	Z86006
Z86007	Z860101						

Refer to: Subsection 9.2.15.1.1, "Colorectal Cancer Screening" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.8.5 Exclusions

Barium enemas for colorectal cancer screening are not a benefit of Texas Medicaid.

4.2.9 Computed Tomography and Magnetic Resonance Imaging

Prior authorization is required for all outpatient nonemergent (i.e., those that are scheduled) CT, computed tomography angiography (CTA), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) studies before services are rendered. Authorization is not required for the emergency department or inpatient hospital radiology services. Retroactive authorization may be required for some outpatient emergent studies.

Reimbursement for procedures with descriptions that specify "with contrast" include payment for contrast materials. Some diagnostic radiopharmaceuticals are benefits of Texas Medicaid. Outpatient hospitals may submit the total component of the following procedure codes:

Procedure Codes									
77371	77372	77373	77422	77423	77520	77525	G0339		

Procedure code 77399 may be submitted as either the total component or the technical component.

Providers can refer to the OFL or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid. OFL and static fee schedules available on the TMHP website display fees after applicable rate reductions have been applied. Previously, the OFL and static fee schedules did not reflect all rate reductions, and providers were required to calculate the 1- and 2-percent reductions implemented.

Refer to: Subsection 4.2.9, "Computed Tomography and Magnetic Resonance Imaging" in this handbook for additional information about prior authorization requirements.

Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about emergency outpatient imaging services.

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4.2.10 Electrodiagnostic (EDX) Testing

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as EDX testing, must be medically indicated and may be reimbursed to outpatient hospitals. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

NCS and EMG studies are diagnosis restricted and may require prior authorization.

Refer to: Subsection 9.2.26.7, "Esophageal pH Probe Monitoring" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.11 Fluocinolone Acetonide

The fluocinolone acetonide intravitreal implant may be reimbursed for services rendered to clients who are 12 years of age and older. Procedure code J7311 is only payable with a posterior uveitis diagnosis of more than six months duration and the condition has been unresponsive to oral or systemic medication treatment.

4.2.11.1 Prior Authorization for Fluocinolone Acetonide

To request prior authorization, providers must submit requests by fax or mail to the SMPA Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

4.2.12 Fetal Nonstress Testing and Contraction Stress Test

Claims for nonstress and contraction stress testing conducted in the outpatient setting must be submitted with revenue code 729. Services during an inpatient hospital stay are reimbursed under the hospital's DRG.

Refer to: Section 4.1.1, "Antepartum and Fetal Invasive Procedures" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.13 Hyperbaric Oxygen Therapy (HBOT)

HBOT is a type of therapy that increases the environmental oxygen pressure to promote the movement of oxygen from the environment into the client's body tissues. Such treatment may be a benefit of Texas Medicaid when it is performed in specially constructed hyperbaric chambers, pressurized to 1.4 atmosphere absolute (atm abs) or higher, which may hold one or more clients (sea-level pressure is equal to 1 atm.abs). Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, this use of oxygen is not considered hyperbaric oxygen treatment in itself.

HBOT procedure codes 99183 and G0277 require prior authorization before the date that service is initiated.

The number of billable units of procedure code G0277 is based upon the time that the client receives treatment with hyperbaric oxygen.

In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, air breaks, and ascent, (in minutes), as follows:

- The first unit is for the time spent in the chamber receiving hyperbaric oxygen and must be for a minimum of 16 minutes.

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- To bill for a second (or subsequent unit), all previous units of time must have been for the full thirty minutes, and the last unit must be fore 16-30 minutes.

Procedure code 99183 equates to one total treatment (one professional session).

Procedure code G0277 must be billed with revenue code B-413 on the same claim. If procedure code G0277 is not on the same claim as revenue code B-413, the claim will be denied.

Refer to: Subsection 9.2.33, "Hyperbaric Oxygen Therapy (HBOT)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

4.2.14 Laboratory Services

Routine laboratory services, directly related to the surgical procedure being performed, are not reimbursed separately. Claims for nonroutine laboratory services provided with emergency conditions may be submitted separately with documentation that the complicating condition arose after the initiation of the surgery. Outpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory.

Exception: *Hospital laboratories may submit claims for all the tests performed on a specimen if some but not all the tests are done by another laboratory on referral from the hospital submitting the claim.*

The billing hospital must enter the name and NPI and taxonomy code of the performing laboratory in Block 80 of the UB-04 CMS-1450 paper claim form and must enter the performing laboratory's NPI and taxonomy code next to the service provided by the performing laboratory.

Hospitals may submit claims for a handling fee (procedure code 99001) for collecting and forwarding a specimen to a referral laboratory when the laboratory handling fee is not being billed through other methods. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

Refer to: The *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.14.1 Clinical Laboratory Improvement Amendments (CLIA)

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about CLIA.

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

4.2.15 Lung Volume Reduction Surgery (LVRS)

LVRS surgery must be performed in a facility that meets at least one of the following requirements:

- Certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission on Accreditation of Health Care Organization (JCAHO)
- Approved by Medicare as a lung or heart-lung transplant facility

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The surgery must be both preceded and followed by a program of diagnostic and therapeutic services that are consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the client's potential to successfully undergo and recover from surgery. The program must meet all of the following requirements:

- Include a 6-to 10-week series of at least 16, and no more than 20, pre-operative sessions, each lasting a minimum of 2 hours
- Include at least 6, and no more than 10, post-operative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks after the LVRS
- Be consistent with the care plan that was developed by the treating physician following the performance of a comprehensive evaluation of the client's medical, psychosocial, and nutritional needs
- Be arranged, monitored, and performed under the coordination of the facility where the surgery takes place. Prior authorization is required for the LVRS procedure. However; prior authorization is not required for the pre-operative and post-discharge pulmonary services

LVRS must be prior authorized and is limited to clients who have severe emphysema, disabling dyspnea, and evidence of severe air trapping. Prior authorization is not required for the associated preoperative pulmonary surgery services for preparation of LVRS (procedure codes G0302, G0303, and G0304) or the associated postdischarge pulmonary surgery services after LVRS (procedure code G0305).

LVRS and post-discharge LVRS are restricted to the following eemphysema diagnosis codes:

Diagnosis Codes				
J430	J431	J432	J438	J983

Procedure codes 32491, G0302, G0303, G0304 and G0305 are limited to one per rolling year per client any provider.

Procedure code G0305 may be reimbursed only if a claim for LVRS (procedure code 32491) has been submitted within the past 12 months.

Refer to: Subsection 9.2.44, "Lung Volume Reduction Surgery (LVRS)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.16 Magnetoencephalography (MEG) Services

Inpatient and outpatient hospitals must use revenue code 860 or 861 for reimbursement of magnetoencephalography (MEG) services. The appropriate MEG procedure code must be listed on the claim.

Note: *Reimbursement to an outpatient hospital will be based on the submitted procedure code.*

Refer to: Subsection 9.2.66, "Magnetoencephalography (MEG)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.17 Neurostimulators

Neurostimulators may be a benefit in the outpatient hospital setting when medically necessary. All procedures require prior authorizations.

Refer to: Subsection 9.2.46, "Neurostimulators" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.2.17.1, "Prior Authorization for Neurostimulators" in this handbook.

4.2.17.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator device require prior authorization. Requests for prior authorization must be submitted to the SMPA Department.

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Refer to: Subsection 9.2.46.15, "Prior Authorization of Neurostimulator Devices Procedure Codes" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.18 Occupational and Physical Therapy Services

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about therapy services.

4.2.19 Radiation Therapy Services

Take-home drugs given during the course of therapy can be reimbursed separately through the VDP.

Hospitals use revenue code 333, Radiation therapy, on the UB-04 CMS-1450 paper claim form when submitting charges for these services.

The following radiation therapy services provided in an outpatient setting are allowed only once per day unless documentation of medical necessity supports the need for repeated services:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavity radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization, and radioisotope therapy

4.2.19.1 Radiopharmaceuticals

Radiopharmaceuticals may be considered for separate reimbursement when used for therapeutic treatment.

The following procedure codes are payable to outpatient hospitals:

Procedure Codes									
79403*	A9513	A9542	A9543	A9563	A9564	A9600	A9699		
***Total or technical component**									

Strontium-89 chloride may be billed using procedure code A9600 and will be limited to a total of 10 mci intravenously injected every 90 days, any provider.

Strontium-89 chloride is reimbursed as one service per 90 days for any provider.

Strontium-89 chloride will be considered when submitted with diagnosis code C7951 or C7952.

Sodium phosphate p-32, therapeutic, will be considered when submitted with one of the following diagnoses:

Diagnosis Codes							
C7951	C7952	C9110	C9112	C9192	C91Z2	C9292	C92Z2

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Diagnosis Codes							
C9512	C9592	D45					

Chromic phosphate p-32 suspension will considered when submitted with diagnosis code C782 (secondary malignant neoplasm of the pleura) and diagnosis code C786 (secondary malignant neoplasm of the retroperitoneum and peritoneum).

Refer to: Subsection 9.2.64, "Radiation Therapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Prior Authorization for Therapeutic Radiopharmaceuticals

Procedure codes A9542 and A9543 require prior authorization. Ibritumomab tiuxetan will be considered when submitted with one of the following diagnosis codes:

Diagnosis Codes							
C8259	C8399	C8499	C84A9	C84Z9	C8519	C8529	C8589
C8599							

Prior authorization is required for procedure codes A9542 and A9543, which will be considered with documentation of all of the following:

- A diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy.
- Marrow involvement is less than 26 percent.
- Platelet count is 100,000 cell/mm3 or greater.
- Neutrophil count is 1,500 cells/mm3 or greater.
- Client has failed a trial of rituximab.

Lutetium lu 177 dotatate (Lutathera) intravenous injection (procedure code A9513) is indicated for the treatment of clients who are 18 years of age or older with a diagnosis of gastroenteropancreatic-neuroendocrine tumors. For all other indications, Lutetium lu 177 dotatate (Lutathera) injection for intravenous use is not proven to be medically effective and is considered experimental.

Lutetium lu 177 dotatate (Lutathera) procedure code A9513 must be administered under the control of an oncologist or a nuclear medicine specialist who is licensed and authorized to administer radiopharmaceuticals in an outpatient setting. Prior authorization requests must be submitted to the Special Medical Prior Authorization (SMPA) department at TMHP using the Special Medical Prior Authorization (SMPA) Request Form.

An SMPA Request Form must be completed, signed, and dated by the prescribing provider. The SMPA form will not be accepted after 90 days from the date of the prescribing provider's signature.

The completed SMPA Request Form must be maintained by the prescribing provider in the client's medical record and is subject to retrospective review.

Section C of the SMPA Request Form under the Statement of Medical Necessity must contain the following:

- Documentation of the client's dosage
- The administration schedule
- The number of injections to be administered during the prior authorization period
- The requested units and millicuries per injection

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- The dosage calculation

Prior authorization must be requested through the SMPA department with appropriate documentation. Requests can be mailed or faxed to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

Refer to: Subsection 9.2.78.2, "Other Limitations on Therapeutic Radiopharmaceuticals" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

4.2.20 Respiratory Services

4.2.20.1 Aerosol Treatment

Nebulized aerosol treatments with short-acting beta-agonists provided in the outpatient setting are considered medically necessary for certain acute medical problems when breathing is compromised. Authorization is not required for aerosol treatments.

Outpatient facilities must submit claims for aerosol treatments using revenue code 412 and the appropriate beta-agonist procedure code.

4.2.20.2 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement provided in the physician's office or outpatient hospital setting is considered medically necessary as an adjunct to the established clinical and laboratory assessments for diagnosing and assessing asthma, predicting exacerbations, and evaluating the response of a patient with asthma to anti-inflammatory therapy.

Claims for nitric oxide treatments may be submitted using procedure code 95012. Hospital providers must include the following when submitting claims for procedure code 95012:

- Revenue code 419 must appear on the same line as procedure code 95012.
- The claim must have a line item for either procedure code 94010 or 94060. This line item must also indicate revenue code 419.

Note: *Procedure code 94010 or 94060, when submitted in conjunction with procedure code 95012, may only be reimbursed in an office or outpatient hospital setting, and is not reimbursed for critical care, emergency care, or anesthesiology.*

4.2.20.3 Pulmonary Function Studies

Pulmonary function studies considered for reimbursement to outpatient hospitals include, but are not limited to, the following procedures when submitted with the total component (TOS 5):

Procedure Codes									
94010	94060	94070	94150	94200	94375	94450	94452	94453	94617
94618	94619	94621	94726	94727	94728	94729	95012		

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High Altitude Simulation Test (HAST) procedure codes 94452 and 94453 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
E840*	E8411	E8419*	E848*	E849*	I270*	I271*	I2720
I2721	I2722	I2723	I2724	I2729	I2781*	I2783	I27840
I27841	I27848	I27849	I2789*	I279*	J410*	J411*	J418*
J42*	J430*	J431*	J432*	J438*	J439*	J440*	J441*
J4489*	J449*	J471*	J479*	J60*	J700*	J701	J708*
J709*	J8281	J8282	J8283	J8289	J8401	J8402	J8403
J8409	J8410	J84170	J84178	J849	J9610	J9611	J9612
J982	P270*	P271*	P278*	Q332*	Q334	Q336	

Note: *When billing for HAST (procedure code 94452 or 94453) with one of the diagnosis codes indicated in the table with an asterisk (*), evidence of hypoxemia must be documented in the client's medical record.*

When multiple procedure codes are submitted, the most inclusive code of the related codes will be reimbursed and all other related codes will be denied.

When unrelated pulmonary function studies are submitted together, each will be considered for reimbursement.

4.2.21 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Refer to: Subsection 9, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including hospital services. Hospital services are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

4.4 Outpatient Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

TMHP is responsible for a comprehensive integrated review process to identify misuse and inappropriate claim submission patterns by outpatient hospitals and HASCs. All providers are subject to TMHP's UR monitoring. Providers are selected for review based on a comparison of their individual resource utilization with a peer group of similar specialty and geographic locality. The main goal of the required utilization control is to identify those providers whose practice patterns are aberrant from their peers and provide the necessary educational actions to help the provider achieve Texas Medicaid compliance. An analysis of UR data is completed by a registered nurse analyst for review by the medical director and staff. If the analyst substantiates that a provider's practice and claim submission patterns are inconsistent with the federal requirements and Texas Medicaid's scope of benefits, a TMHP repre-

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sentative contacts the provider. The purpose of the contact is to discuss appropriate claim submission guidelines and to assist the provider in resolving the inappropriate claim submission patterns identified in the review.

TMHP uses the following criteria when reviewing all hospital outpatient medical records. Services must be:

- Medically necessary.
- Ordered by a physician, signed, and dated. Signature stamps are valid if initialed and dated by the physician.
- Submitted in the quantities ordered and documented as provided.
- Program benefits.
- Specifically identified on the charge tickets or itemized statement submitted with the claim or by the HCPCS procedure code on the claim.
- Indicated by the documentation in the medical record.
- Submitted to Texas Medicaid only after other medical insurance resources have been exhausted.

Refer to: Subsection 4.1.1, "Your Texas Benefits Medicaid Card" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

The determination of the TMHP UR process may result in the following:

- Educational letters and visits
- Mail-in of medical records for review
- On-site medical record review (outpatient, HASC, or inpatient records not reviewed)
- Referral of questionable claims to HHSC or HHSC OIG
- Recoupment
- Prepayment review

The intent of these actions is to ensure the most effective and appropriate use of available services and facilities and provide appropriate, cost-effective care to clients with Medicaid coverage.

4.5 Claims Filing and Reimbursement

4.5.1 Outpatient Claims Information

Claims for scheduled procedures that are performed in a HASC must be submitted using the HASC NPI and taxonomy codewith type of bill (TOB) 131. Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital NPI and taxonomy code and appropriate revenue and HCPCS code (if required) with TOB 131.

Claims for outpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form.

Freestanding ambulatory surgical centers must submit claims on the CMS-1500 claim form. The performing surgeon or referring physician name and number must be identified in Block 17. Identification of outpatient charges must be in Block 44 if submitting by HCPCS code. If appropriate, the revenue code must be indicated in Block 42. Texas Medicaid recommends the use of specific procedure codes for claim submission. Do not use the revenue code description in Block 43; the HCPCS narrative description must be identified in this block. For example, when submitting charges for physical therapy, do not use the description associated with revenue code 420. To receive reimbursement for physical therapy services, providers must identify the specific modality used (e.g., gait training).

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Examples:

- *Emergency Room.* Submit as "Emergency room" or "Emergency room charge per use." If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 13, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. Claims for emergency CT, CTA, MRI, or MRA studies provided in the emergency department must have the appropriate corresponding emergency services revenue code (450, 451, 456, or 459) to be considered for payment.
- *Observation Room.* Submit as "observation room." (Revenue code 762).
- *Operating Room.* Submit as "Operating Room." (Revenue code 360, 361, or 369).
- *Recovery Room.* Submit as "Recovery Room" or "Cast Room" as appropriate. (Revenue code 710 or 719).
- *Injections.* Must have "Inj.-name of drug; route of administration; the dosage and quantity" or the injection code.
- *Drugs and Supplies.* The drug description must include the name, strength, and quantity. Take-home drugs and supplies are not a benefit of Texas Medicaid:
  - Take-home drugs must be submitted with revenue code 253.
  - Take-home supplies must be submitted with revenue code 273.
  - Self-administered drugs must be submitted with revenue code 637.
- *Radiology.* Facilities must submit claims using the most appropriate revenue and HCPCS code. The physician must submit claims for professional services by a physician separately. The license number of the ordering physician must be in Block 83. If the client receives the same radiology procedure more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 13, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.
- *Laboratory.* Provide a complete description or use the procedure codes for the laboratory procedures. The physician must submit claims for professional services by a physician separately. Blocks 78–79 must have the license number of the ordering physician. If laboratory work is sent out, enter the name of the test and name and address or Medicaid number of the laboratory where the work was forwarded. If the client receives the same laboratory procedure more than once in one day, give the time for each visit. The time of the first visit must be identified in Block 13, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.
- *Nuclear Medicine.* Provide a complete description.
- *Day Surgery.* Day surgery must be submitted as an inclusive charge using TOS F. Providers must not submit claims for separate services that were provided in conjunction with the surgery (e.g., lab, radiology, and anesthesia). File claims for unscheduled emergency outpatient surgical procedures with separate charges (e.g., lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital's NPI and taxonomy code.

Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital NPI and taxonomy code and appropriate revenue and HCPCS code (if required) with TOB 131.

Refer to the ambulatory surgical center/hospital-based ambulatory surgical center (ASC/HASC) section for information on scheduled procedures.Additional claims information can be found within individual topic areas within this section.

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Charges on claims must be itemized on the face of the UB-04 CMS-1450 paper claim form instead of submitting attachments or charge details. TMHP uses information attached to the claim for clarification purposes only.

If a claim contains more than 28 details, continue the claim on additional UB-04 CMS-1450 paper claim forms or electronic equivalent. Total each claim form as a stand-alone claim. If you do not total each page, your claim may be denied for being over the limitation, and must be resubmitted with 28 or less details.

Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Outpatient hospital services must be itemized by date of service. Procedures repeated over a period of time must be submitted for each separate date of service. Do not combine multiple dates of service on the same line detail.

4.5.2 Outpatient Reimbursement

Outpatient services are reimbursed on a reasonable cost based on a percentage of the hospital's most recent tentative Medicaid cost report settlement.

The reimbursement rate for non-high-volume hospitals is as follows with the application of the hospital specific interim rate:

Non-high-volume Provider	Current Allowable Rate
Children's hospitals	72.27 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	72.27 percent of the allowable charges
Other hospitals	68.44 percent of the allowable charges

The reimbursement rate for high-volume hospitals is as follows with the application of the hospital specific interim rate:

High-volume Provider	Current Allowable Rate
Children's hospitals	76.03 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	76.03 percent of the allowable charges
Other hospitals	72 percent of the allowable charges
ASCs/HASCs that qualify as high-volume providers	Additional 5.2 percent increase in payment rates

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High-volume providers are eligible for additional payments on Texas Medicaid fee-for-service claims. A high-volume outpatient hospital provider is defined as one that was paid at least $200,000 during calendar year 2004.

All clinical laboratory services are reimbursed at a percentage of the prevailing charge. Hospitals that are identified by Medicare as sole community hospitals are reimbursed at a higher percentage of the prevailing charges for services that are provided to clients in the outpatient setting.

Clinical pathology consultations are also allowed for reimbursement.

Refer to: The HHSC Rate Analysis web page at pfd.hhs.texas.gov/hospitals-clinic-services for additional information about hospital reimbursement.

Subsection 3.7.5, "Provider Cost and Reporting" in this handbook for more information about the calculation of the interim rate.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

4.5.3 Provider Cost and Reporting

Refer to: Subsection 3.7.5, "Provider Cost and Reporting" in this handbook.

4.5.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4.5.5 Outpatient Hospital Revenue Codes

UB-04 CMS-1450 revenue codes must be used to submit claims for outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing:

Revenue Code	Description	Comments
Special Charges – Canceled Surgery		
220	Special Charges	Procedure code required
Pharmacy		
250	General classification	
251	Generic drugs	
252	Nongeneric drugs	
253	Take-home drugs	Not a benefit
254	Drugs incident to other diagnostic services	
255	Drugs incident to radiology	
256	Experimental drugs	Not a benefit
257	Nonprescription drugs	
258	IV solutions	
259	Other pharmacy	
260	General classification	

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Revenue Code	Description	Comments
261	Infusion pump	
262	IV therapy/pharmacy services	
263	IV therapy/drug/supply delivery	
264	IV therapy/supplies	
269	Other IV therapy	
Medical/Surgical Supplies and Devices		
270	General classification	
271	Nonsterile supply	
272	Sterile supply	
273	Take-home supplies	Not a benefit
274	Prosthetic/orthotic devices	Not a benefit
275	Pacemaker	
276	Intraocular lens	
277	Oxygen take-home	Not a benefit
278	Medical/surgical supplies and devices- other implants	Procedure code required
279	Medical/surgical supplies and devices- other	Procedure code required
280	General Classification	
289	Other oncology	
300	Laboratory	Procedure code required
301	Laboratory- chemistry	Procedure code required
302	Laboratory- immunology	Procedure code required
303	Laboratory- renal patient (home)	Procedure code required
304	Laboratory- non-routine dialysis	Procedure code required
305	Laboratory- hematology	Procedure code required
306	Laboratory- bacteriology/microbiology	Procedure code required
307	Laboratory- urology	Procedure code required
309	Laboratory- other	Procedure code required
Laboratory – Pathological		
310	Laboratory- pathological	Procedure code required
311	Laboratory- pathological cytology	Procedure code required
312	Laboratory- pathological histology	Procedure code required
314	Laboratory- pathological biopsy	Procedure code required
319	Laboratory- pathological other	Procedure code required
Radiology – Diagnostic		
320	Radiology- diagnostic	Procedure code required
321	Radiology- diagnostic angiocardiography	Procedure code required
322	Radiology- diagnostic, arthrography	Procedure code required
323	Diagnostic, arteriography	Procedure code required
324	Chest X-ray	Procedure code required

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Revenue Code	Description	Comments
329	Other diagnostic radiology	Procedure code required
Radiology – Therapeutic		
330	General classification	Procedure code required
331	Chemotherapy-injected	Procedure code required
332	Chemotherapy-oral	Procedure code required
333	Chemotherapy-radiation therapy	Procedure code required
335	Chemotherapy-IV	Procedure code required
339	Other therapeutic radiology	Procedure code required
Nuclear Medicine		
340	General classification	Procedure code required
341	Nuclear medicine- diagnostic	Procedure code required
342	Nuclear medicine- therapeutic	Procedure code required
349	Nuclear medicine- other	Procedure code required
Computed Tomography (CT) Scan		
350	General classification	Procedure code required
351	CT scan- head scan	Procedure code required
352	CT scan- body scan	Procedure code required
359	CT scan- other CT scans	Procedure code required
Operating Room Services		
360	Operating room services	
361	Minor surgery	
369	Other operating room services	
Anesthesia		
370	Anesthesia	
371	Anesthesia incident to radiology	
372	Anesthesia incident to other diagnostic services	
374	Acupuncture	Not a benefit
379	Other anesthesia	
380	Blood	Procedure code required
381	Blood- packed red cells	Procedure code required
382	Blood- whole blood	Procedure code required
383	Blood- plasma	Procedure code required
384	Blood- platelets	Procedure code required
385	Blood- leucocytes	Procedure code required
386	Blood- other components	Procedure code required
387	Blood- other derivatives (cryoprecipitates)	Procedure code required
389	Other blood	Procedure code required
Blood Storage and Processing		
390	Blood storage and processing	
391	Blood administration	Not a benefit

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Revenue Code	Description	Comments
399	Other blood storage and processing	Not a benefit
Other Imaging Services		
400	Other imaging services	Procedure code required
401	Other imaging services- diagnostic mammography	Procedure code required
402	Other imaging services- ultrasound	Procedure code required
403	Other imaging services- screening mammography	Procedure code required
404	Other imaging services- positron emission tomography	Procedure code required
409	Other imaging services- other	Procedure code required
Respiratory Services		
410	Respiratory services	
412	Inhalation services	
413	Hyperbaric oxygen therapy	
419	Other respiratory services	Procedure code required
Physical Therapy		
420	Physical therapy	Procedure code required
421	Physical therapy- visit charge	Procedure code required
422	Physical therapy- hourly charge	Procedure code required
423	Physical therapy- group rate	Procedure code required
424	Physical therapy- evaluation/reevaluation	Procedure code required
429	Physical therapy- other	Procedure code required
Occupational Therapy		
430	Occupational therapy	Procedure code required
431	Occupational therapy- visit charge	Procedure code required
432	Occupational therapy- hourly	Procedure code required
433	Occupational therapy- group rate	Procedure code required
434	Occupational therapy- evaluation/reevaluation	Procedure code required
439	Occupational therapy- other	Procedure code required
Speech-Language Pathology		
440	Speech-language pathology	
441	Speech-language pathology- visit charge	Procedure code required
442	Speech-language pathology- hourly charge	Procedure code required
443	Speech-language pathology- group rate	Procedure code required
444	Speech-language pathology- evaluation/ reevaluation	Procedure code required
449	Speech-language pathology- other	Procedure code required
Emergency Room		
450	Emergency room	Procedure code required
451	EMTALA emergency medical screening services	
456	Urgent care	Procedure code required
459	Other	Procedure code required

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Revenue Code	Description	Comments
Pulmonary Function		
460	Pulmonary function	Procedure code required
469	Pulmonary function- other	Procedure code required
Audiology		
470	Audiology	Procedure code required
471	Audiology- diagnostic	Procedure code required
472	Audiology- treatment	Procedure code required
479	Audiology- other	Procedure code required
Cardiology		
480	Cardiology	Procedure code required
481	Cardiology- cardiac cath lab	Procedure code required
482	Cardiology- stress test	Procedure code required
483	Unassigned procedure code	Procedure code required
489	Cardiology- other	Procedure code required
Clinic		
510	Clinic	
511	Chronic pain center	
512	Dental clinic	
513	Psychiatric clinic	
514	Obstetrics-Gynecology (OB/GYN) clinic	
515	Pediatric clinic	
516	Urgent care clinic	
517	Family practice clinic	
519	Other clinic	
Freestanding Clinic		
520	Freestanding clinic	
523	Family practice clinic	
526	Urgent care clinic	
529	Other freestanding clinic	
Skilled Nursing (Home Health)		
550	Skilled nursing	Procedure code required
551	Skilled nursing- visit charge	Procedure code required
552	Skilled nursing- hourly charge	Procedure code required
559	Skilled nursing- other	Procedure code required
Medical Social Services (Home Health)		
560	Medical social services	Procedure code required
561	Medical social services- visit charge	Procedure code required
562	Medical social services- hourly charge	Procedure code required
569	Medical social services- other	Procedure code required
Home Health Aide (Home Health)		

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Revenue Code	Description	Comments
570	Home health aide	Procedure code required
571	Home health aide- visit charge	Procedure code required
572	Home health aide- hourly charge	Procedure code required
579	Home health aide- other	Procedure code required
Other Visits (Home Health)		
580	Other visits (home health)	Procedure code required
581	Other visits (home health)- visit charge	Procedure code required
582	Other visits (home health)- hourly charge	Procedure code required
589	Other visits (home health)- other	Procedure code required
Magnetic Resonance Technology (MRT)		
610	Magnetic resonance imaging- general classification	Procedure code required
611	Magnetic resonance imaging- brain (incl brain stem)	Procedure code required
612	Magnetic resonance imaging- spinal cord (incl spine)	Procedure code required
619	Magnetic resonance imaging- other MRI	Procedure code required
Drugs Requiring Specific Identification		
630	Drugs requiring specific identification	
631	Drugs requiring specific identification, single source drug	
632	Drugs requiring specific identification, multiple source drug	
633	Drugs requiring specific identification, restrictive prescription	
634	Drugs requiring specific identification, erythro-poietin (EPO) less than 10,000 units	
635	Drugs requiring specific identification, erythro-poietin (EPO) 10,000 or more units	
636	Drugs requiring specific identification, drugs requiring detailed coding	
Hospice Service		
650	Hospice services	
651	Routine home care	
652	Continuous home care - 1/2 (at least 8 but less than 16 hrs care)	
655	Inpatient respite care	
656	General inpatient care/non-respite	
657	Physician	
659	Hospice services - other	
Cast Room		
700	General classification	
709	Other cast room	

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Revenue Code	Description	Comments
Recovery Room		
710	General classification	
719	Other recovery room	
Labor Room/Delivery		
720	General classification	
721	Labor	
722	Delivery	
723	Circumcision	
724	Birthing center	
729	Other labor room/delivery	
Electrocardiogram (EKG/ECG)		
730	General classification	Procedure code required
731	Holter monitor	Procedure code required
732	Telemetry	Procedure code required
739	Other EKG/ECG	Procedure code required
Electroencephalogram (EEG)		
740	General classification	Procedure code required
741	Other EEG	Procedure code required
Gastrointestinal Services		
750	General classification	
759	Other gastrointestinal	
Treatment or Observation Room		
760	General classification	
761	Treatment room	
762	Observation room	
769	Other treatment/observation room	
Preventive Care Services		
770	General classification	Procedure code required
771	Vaccine administration	Procedure code required
779	Other preventive care services	Procedure code required
Lithotripsy		
790	General classification	Not a benefit
799	Other lithotripsy	Not a benefit
Miscellaneous Dialysis		
880	Miscellaneous dialysis	Procedure code required
881	Ultrafiltration	
Other Diagnostic Services		
920	General classification	Procedure code required
921	Peripheral vascular lab	Procedure code required
922	Electromyelogram	Procedure code required

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Revenue Code	Description	Comments
923	Pap smear	Procedure code required
924	Allergy test	Procedure code required
925	Pregnancy test	Procedure code required
929	Other diagnostic service	Procedure code required
943	Cardiac rehabilitation	Procedure code required

Refer to: The National Uniform Billing Committee (NUBC) website at www.nubc.org for additional information.

4.5.6 Third Party Liability

Refer to: Subsection 3.7.1, "Medicaid Relationship to Medicare" in this handbook.

"Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

Other Insurance Form on the TMHP website at www.tmhp.com.

Tort Response Form on the TMHP website at www.tmhp.com.

5 Lung Cancer Screening

5.1 Services, Benefits, and Limitations

Lung Cancer Screening is a benefit of Texas Medicaid and include the preventive service of lung cancer screening utilizing annual Low Dose Computed Tomography (LDCT) screening.

Preventive lung cancer screening that uses low dose computed tomography (LDCT) (procedure code 71271) is a benefit of Texas Medicaid once per year for asymptomatic high-risk clients meeting screening criteria. Screening may be initiated by a referral from a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). Physicians, PAs, NPs, and CNSs can order radiological procedures appropriate to their licensure.

Procedure code 71271 is a radiological procedure that provides high-resolution three-dimensional images of the lungs to detect lung nodules, which may indicate lung cancer in an asymptomatic high-risk client.

Lung cancer is commonly diagnosed in most clients when the disease is in an advanced stage and when the chances of curative therapy can be lower. Screening for early lung cancer detection can decrease mortality in high-risk clients. When used as a component of routine preventive screening, this might result in a more favorable treatment outcome.

Lung cancer commonly develops because of smoking for a greater number of years and many packs per day. A calculation derived from these numbers is referred to as pack years. A pack year of smoking history is defined as twenty cigarettes smoked daily for one year.

Potential risks that may be associated with LDCT lung cancer screening are false-positives and over-diagnosis that could result in further testing follow-ups. Additional risks include low dose cumulative exposure to low dose ionizing radiation over multiple years.

5.1.1 Client Eligibility

High-risk clients should be informed of tobacco smoking cessation counseling and that the annual lung cancer screening is not a substitute for smoking cessation.

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The United States Preventive Services Task Force (USPSTF) has determined LDCT lung cancer screening to be a component of an annual routine health screening for clients who meet the high-risk category. Before the first annual LDCT lung cancer screening, the client should complete a counseling and shared decision-making visit with the provider, per the USPSTF Guidelines.

A high-risk client must meet all the following eligibility criteria for LDCT lung cancer screening, per the USPSTF:

- Be 50 through 80 years of age
- Have at least a 20-pack year smoking history
- Be a current smoker or have quit smoking within the previous 15 years
- Be asymptomatic (no signs or symptoms of lung cancer)
- Be engaged in shared decision-making about screening with their provider, including discussion of its potential health benefits, limitations, and harms
- Receive a referral for LDCT lung cancer screening, preferably to a facility with experience and expertise in lung cancer screening

A client that does not meet the USPSTF criteria for LDCT lung cancer screening but presents with chronic obstructive pulmonary disorder and associated symptoms (such as cough and shortness of breath), may also qualify for LDCT lung cancer screening.

A client is no longer eligible to receive annual LDCT lung cancer screening after meeting one or more of the following criteria, per the USPSTF:

- Non-smoker for 15 years
- Life expectancy is substantially limited
- The client is not willing or able to have curative lung surgery

Clients with signs or symptoms of lung cancer are not eligible to receive LDCT lung cancer screening. Symptomatic clients should undergo a diagnostic work up that is appropriate to their clinical presentation. Presumptive lung cancer signs or symptoms that are not attributable to other causes may include the following:

- An unexplained cough
- A cough producing blood (hemoptysis)
- Unexplained weight loss of greater than 15 pounds in the last 12 months
- Abnormal chest x-ray, presence of bony or soft tissue masses in combination with abnormally enlarged or changed consistency of the lymph nodes (lymphadenopathy)

5.1.2 Prior Authorization and Documentation Requirements

Prior authorization must be obtained before performing LDCT lung cancer screening (procedure code 71271). Approved prior authorization requests will be valid for up to 90 days.

The client's ordering provider must submit a prior authorization request on the Radiology Prior Authorization Request Form, which must include all the following documentation:

- The client's diagnosis
- A statement confirming that the patient meets all the eligibility criteria for LDCT lung cancer screening
- Client's current smoking status — current smoker or non-smoker with less than 15 years since their quit date

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Prior authorization requests for procedure code 71271 may only be approved for clients with one of the following diagnosis codes, which must be included on the Radiology Prior Authorization Request Form:

Diagnosis Codes						
F17210	F17211	F17213	F17218	F17219	F17290	F17291
F17293	F17298	F17299	Z720	Z87891		

Prior authorization for LDCT lung cancer screening is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the service and must be maintained in the client's medical record, both by the ordering physician and the performing facility.

Refer to: Subsection 4.2.6.2, "Request Form and Documentation" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) and Subsection 4.2.6.3, "Methods of Submission" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about submitting prior authorization requests for CT services.

5.1.3 Exclusions

Annual LDCT lung cancer screening is not covered for any indications other than the possibility of lung cancer.

The following services are not a benefit of Texas Medicaid:

- Screening for clients who do not meet the high-risk criteria
- Positron emission tomography (PET), which is considered investigational and experimental for lung cancer screening and is therefore excluded as a lung cancer screening benefit since the effectiveness of PET for lung cancer screening has not been established
- Chest radiography and sputum cytology, which are not valid methods for lung cancer screening and are not covered benefits for lung cancer screening
- LDCT lung cancer screening using the following methods of testing:
  - Computer-aided detection with physician review and interpretation of digital film or radiographic images of chest
  - Computed tomography of thorax without contrast
- LDCT lung cancer screening for the following diagnosis codes: F17200, F17201, F17203, F17208, F17209, F17220, F17221, F17223, F17228, F17229, or Z77090

6 Ambulatory Surgical Center and Hospital Ambulatory Surgical Center

6.1 Enrollment

To enroll in Texas Medicaid, an ASC must:

- Meet and comply with applicable state and federal laws, rules, regulations, and provisions of the state plan under Title XIX of the Social Security Act.
- Be enrolled in Medicare.
- Meet and comply with state licensure requirements for ASCs.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

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All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an HASC provider number at the time of enrollment.

An out-of-state provider may enroll in Texas Medicaid if it is the customary or general practice for clients in a particular locality to use medical resources in another state. An out-of-state provider located within 50 miles of the Texas border is automatically considered to meet this criterion.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

6.2 Services, Benefits, Limitations, and Prior Authorization

ASCs, both freestanding and hospital-based, provide same day elective surgery for clients who do not require a hospital admission and who are not expected to require extensive postoperative care.

6.2.1 Drugs and Supplies

Outpatient prescribed medications are a benefit to eligible clients when obtained through a pharmacy contracted with the Texas Vendor Drug Program. Prescribed take-home supplies are a benefit to eligible clients when obtained through Medicaid durable medical equipment (DME).

Refer to: Section 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*)) for information about this program.

Subsection 2.2.4, "Medical Supplies" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*).

6.2.2 Incomplete Surgical Procedures

Refer to: Subsection 4.2.3.6, "Incomplete Day Surgeries" in this handbook for information about incomplete surgical procedures.

6.2.3 Complications Following Day Surgery Requiring Outpatient Observation or Inpatient Admission

If the client is placed in outpatient observation or inpatient status following an HASC day surgery, the day surgery procedure must still be submitted as an outpatient procedure under the HASC NPI and taxonomy code.

Refer to: Subsection 4.2.3.2, "Complications Following Elective or Scheduled Day Surgeries" in this handbook.

Subsection 4.2.3.4, "Emergency or Unscheduled Day Surgeries" in this handbook in this handbook.

6.2.4 Planned Admission for Day Surgery

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

6.2.5 Cochlear Implants

A cochlear implant is a benefit of Texas Medicaid when medically indicated. ASC and HASC providers may be reimbursed for the implantation procedure using procedure code 69930, and for the cochlear implant devices using procedure code L8614. L8614 will process as part of another service for ASC and HASC providers since payment will be applied to the procedure code 69930 for the global rate.

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Refer to: Subsection 9.2.22, "Cochlear Implants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.6 Colorectal Cancer Screening

Procedure codes G0104, G0105, and G0121 are a benefit of Texas Medicaid in the ASC or HASC setting.

6.2.6.1 Sigmoidoscopies

Procedure code G0104 may be reimbursed once every 5 years and is limited to one of the following diagnosis codes:

Diagnosis Codes							
Z0000*	Z0001*	Z1210	Z1211	Z1213	Z859	Z86002	Z86003
Z86004	Z86006	Z86007	Z860100	Z860102	Z860109		

***Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.**

6.2.6.2 Colonoscopies

Procedure code G0121 may be reimbursed once every ten rolling years for clients who are 45 years of age and older. Procedure code G0121 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
Z0000*	Z0001*	Z1210	Z1211	Z1213			

***Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.**

Procedure code G0105 may be reimbursed once every two years for clients who meet the definition of high-risk. Procedure code G0105 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5120	K51211	K51212	K51213	K51214	K51218	K5130
K51311	K51312	K51313	K51314	K51318	K5180	K51811	K51812
K51813	K51814	K51818	K5190	K51911	K51912	K51913	K51914
K51918	K51919	K523	K5281	K5282	K52831	K52832	K52838
K52839	K5289	K529	Z800	Z8371	Z83710	Z83711	Z83718
Z83719	Z8372	Z85038	Z85048	Z859	Z86002	Z86003	Z86004
Z86006	Z86007	Z860101					

Refer to: Subsection 9.2.15.1.1, "Colorectal Cancer Screening" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.7 Dental Therapy Under General Anesthesia

Facilities must use procedure code G0330 to submit claims for dental therapy under general anesthesia. Prior authorization is not required for ASCs and HASCs unless the client is enrolled in a Medicaid managed care organization.

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Refer to: Subsection 3.2.29.2.1, "Dental Therapy Under General Anesthesia" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.2.24, "Hospitalization and ASC/HASC" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

6.2.8 Fluocinolone Acetonide

Procedure code 67027 for implantation may be reimbursed to HASCs. This benefit is limited to clients who are 12 years of age and older and requires prior authorization.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

Subsection 4.2.11, "Fluocinolone Acetonide" in this handbook.

6.2.9 Implantable Infusion Pumps

Implantable infusion pumps are a benefit of Texas Medicaid. Implantable infusion pumps may be medically necessary in the following circumstances:

- Administration of intrathecal or epidural antispasmodic drugs to treat refractory intractable spasticity
- Administration of intrathecal, epidural, or central venous analgesic (opioid or non-opioid) drugs for treatment of severe chronic intractable pain
- Administration of intrahepatic chemotherapy for primary liver cancer or metastatic cancer with metastases limited to the liver

An IIP is not a benefit for the following uses:

- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

Providers may be reimbursed for implantable infusion pumps using procedure codes E0782, E0783, and E0786.

If procedure codes E0782 and E0783 are billed with the same date of service, only one may be reimbursed.

Refer to: Subsection 9.2.40, "Implantable Infusion Pumps" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.9.1 Prior Authorization for Implantable Infusion Pump

Implantable infusion pumps (procedure codes E0782, E0783, and E0786) require prior authorization.

Prior authorization is not required for the physician services associated with the insertion, revision, removal, refilling, or maintenance of the IIP.

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Providers must request prior authorization for the implantable infusion pump through the SMPA department with the supporting documentation for medical necessity. Send authorization requests to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Note: *ASCs are paid based on a global fee, with the exception that certain pieces of equipment may be reimbursed separately from the ASC or HASC global rate.*

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

Refer to: Subsection 9.2.40.0.1, "Prior Authorization for Implantable Infusion Pumps" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.10 Brachytherapy

The following procedure codes are payable to ASC and HASC facilities:

Procedure Codes								
19296	19297	19298	31643	55860	55874	55875	57155	58346

Prior authorization is not required for brachytherapy services.

Refer to: Subsection 9.2.64, "Radiation Therapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.11 Neurostimulators

Neurostimulators are a benefit of Texas Medicaid when medically necessary. All procedures require prior authorization.

Refer to: Subsection 9.2.46, "Neurostimulators" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Neurostimulator devices may be reimbursed separately from the global fee.

Refer to: The Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for procedure codes that may be reimbursed to ASC providers.

6.2.12 Prior Authorization

Some procedures require the performing provider to obtain prior authorization. When prior authorization is required, providers can mail or fax the request to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

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6.2.13 Gynecological and Reproductive Health and Family Planning Services

The following gynecological and reproductive health services and family planning services procedure codes may be reimbursed to ASC and HASC providers:

Procedure Codes									
11976	11981	11982	11983	55250	56620	56805	57335	57410	58260
58262	58353	58356	58541	58545	58546	58550	58552	58555	58558
58559	58560	58561	58562	58563	58565	58600	58615	58670	58671
58673	58674	59150	59151	59840	59841				

Refer to: The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about these procedure codes.

The Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for additional information about procedure codes that may be reimbursed to ASC providers.

The online fee lookup (OFL) or the static fee schedules for on the TMHP website at www.tmhp.com for additional information about rate information for individual procedure codes.

6.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including ASC and HASC services. ASC and HASC services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement.

6.4 Claims Filing and Reimbursement

6.4.1 Claims Information

Freestanding ASC claims must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Hospital-based ASCs must submit claims to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form.

Claims must contain the billing provider's complete name, address, and a NPI and taxonomy code. When completing a UB-04 CMS-1450 or a CMS-1500 paper claim form, providers must include all required information on the claim; TMHP does not key any information from claim attachments. Providers must purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

Scheduled procedures performed in a HASC must be submitted for reimbursement using the HASC NPI and taxonomy code with TOB 131. Emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted for reimbursement using the hospital NPI and taxonomy code with TOB 131.

To submit claims for services performed by certified registered nurse anesthetists (CRNAs), an ASC must enroll as a CRNA group provider and indicate the CRNA performing NPI and taxonomy code on claims for those services.

Refer to: Section 4, "Certified Registered Nurse Anesthetist (CRNA)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for specific billing instructions for CRNA services.

"Section 6: Claims Filing" (*Vol. 1, General Information*).

Section 11, "Claim Form Examples" in this handbook.

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6.4.2 Reimbursement

Reimbursement is limited to the lesser of the amount reimbursed to an ASC for similar services, the hospital's actual charge, or the allowable cost determined by HHSC. When multiple surgical procedures are performed on the same day, only the procedure with the highest reimbursement rate on the fee schedule will be reimbursed.

Claims for physician and CRNA services performed in an ASC or HASC must be submitted under the physician or CRNA NPI and taxonomy code and are reimbursed separately.

6.4.2.1 ASC and HASC Global Services

The ASC or HASC payment represents a global payment and includes room charges and supplies. Covered services provided are submitted as one inclusive charge. All facility services provided in conjunction with the surgery (e.g., laboratory, radiology, anesthesia supplies, medical supplies) are considered part of the global payment and cannot be itemized or submitted separately.

Routine X-ray and laboratory services directly related to the surgical procedure being performed are not reimbursed separately. All nonroutine laboratory and X-ray services provided with emergency conditions may be submitted separately with documentation that the complicating condition arose after the initiation of the surgery.

Medical and prosthetic devices such as intraocular lenses may be supplied by the ASC or HASC and implanted, inserted, or otherwise applied during a covered surgical procedure and is considered part of the global surgical fee.

Exception: *Certain pieces of equipment may be reimbursed separately from the ASC or HASC global rate.*

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 4.2.3, "Day Surgery" in this handbook for information about HASCs.

6.4.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

7 Military Hospitals

7.1 Military Hospital Enrollment

To enroll in Texas Medicaid, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veterans Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.

Military hospital providers must comply with CLIA rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

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7.2 Services, Benefits, Limitations and Prior Authorization

7.2.1 Military Hospital Inpatient Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to the Medicaid "spell of illness." The spell of illness is defined as "30 days of inpatient hospital care, which may accrue intermittently or consecutively."

After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. Exceptions are made in the following instances:

- THSteps-eligible clients do not have a 30-day spell of illness limitation, if medically necessary conditions exist (covered under THSteps-CCP).

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.1.2, "Spell of Illness" in this handbook.

Hospitals may submit information only claims to TMHP when one of the following situations exists:

- The inpatient 30-day spell of illness benefit is exhausted.
- Payment that was made by a third party resource or other insurance exceeds the Medicaid allowed amount.

For clients who are 21 years of age and older, there is an inpatient expenditure cap of $200,000 per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments exceeding $200,000 will be recouped.

It is appropriate to submit information only claims using TOB 110.

The following hospital services must be medically necessary and are subject to the utilization review requirements of Texas Medicaid. Medicaid reimbursement for services cannot exceed the limitations of Texas Medicaid.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons, as certified by the physician. Additionally, the hospital must document the medical necessity for a private room, such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information is included in Block 80 or attached to the claim.
- Whole blood and packed red cells that are reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary services or supplies ordered by a physician.

Medicaid benefits are not available for take-home or self-administered drugs or personal comfort items except when received by prescription through the VDP.

Only inpatient claims that have an emergency diagnosis on the claim are considered for reimbursement.

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7.2.2 Military Hospital Outpatient and Physician Services

Although Medicare reimburses for emergency outpatient and inpatient services, Medicaid does not reimburse for either outpatient or physician services. Military hospitals are not reimbursed for outpatient day surgery.

7.2.3 Prior Authorization

Prior authorization is not required for services rendered in military hospitals.

7.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including military hospital services. Military hospital services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement.

7.3.1 Documentation for Nursing Facility Admissions

The admission Minimum Data Set (MDS) must be used for admissions to a nursing facility. There are instances in which hospital social workers and discharge nurses might also complete the admission MDS, such as:

- If the client is in a long-term care acute center.
- If the potential receiving nursing facility wants a better clinical picture of the client, a paper copy of the admission MDS is completed by the hospital staff before the client is accepted for admission into the nursing facility.

Refer to: The Long Term Care Program page on the TMHP website at www.tmhp.com for additional information, including instructions for all forms and assessments.

7.4 Claims Filing and Reimbursement

7.4.1 Military Hospital Claims Information

If TOB 110 is used to submit a claim, all charges must be noncovered and the claim will finalize with EOB 217, "Payment reduced through hospital action."

It is appropriate to submit information only claims using TOB 110.

Military hospitals may submit total charges in one line with appropriate accommodation revenue codes. Emergency hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Providers may purchase claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claims supplements.

Refer to: Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Military Hospital (Emergency Inpatient) on the TMHP website at www.tmhp.com for a claim form example.

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7.4.2 Military Hospital Reimbursement

Reimbursement is limited to claims submitted for emergency inpatient care only.

Allowed inpatient hospital stays are reimbursed according to a prospective payment methodology based on DRGs. The reimbursement method itself does not affect inpatient benefits and limitations. Texas Medicaid requires that one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. Providers must submit only one claim per inpatient stay to Medicaid, regardless of the diagnosis, to ensure accurate payment. The DRG reimbursement includes all facility services provided to the client while registered as an inpatient.

Reimbursement to hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). This limitation does not apply to services related to certain organ transplants or services to clients who are 20 years of age and younger and covered by the CCP.

Military hospitals should keep a Medicaid client as an inpatient for only the length of time necessary to stabilize the client. The Medicaid client, once stabilized, should be transferred to the nearest Medicaid acute care hospital facility for further treatment.

When more than one hospital provides care for the same client, the hospital that furnishes the most significant amount of care receives consideration for a full DRG payment.

The other hospital is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility.

Client transfers within the same facility or readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are considered one continuous stay. These readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be included in one submission under the NPI and taxonomy code. Admissions that were submitted inappropriately are identified and denied during the utilization review process and may result in an intensified review.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine if the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

The inpatient DRG reimbursement includes payment for all radiology and laboratory services, including those sent to referral laboratories.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

8 Claims Resources

Refer to the following sections and forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)

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Resource	Location
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

9 Contact TMHP

Note: *The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.*

10 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Hospital Report (Newborn Child or Children) (Form 7484)
Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information
Non-emergency Ambulance Prior Authorization Request
Psychiatric Inpatient Extended Stay Request Form
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)

11 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Ambulatory Surgical Center
Hospital-Based ASC
Hospital Inpatient
Military Hospital (Emergency Inpatient)

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Medicaid Managed Care Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

November 2026

TEXAS
Health and Human Services

MEDICAID MANAGED CARE HANDBOOK

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1 General Information

The information in this handbook is intended for Texas Medicaid managed care providers, including providers who are enrolled in a managed care organization (MCO) that is contracted by Texas Medicaid to provide managed care coverage for Texas Medicaid clients.

This handbook provides information about the following managed care programs and services:

- STAR
- STAR+PLUS
- STAR Kids
- STAR Health
- Children's Medicaid Dental Services

Refer to: The Medicaid and CHIP Programs page of the HHS website at hhs.texas.gov.

2 Overview of Medicaid Managed Care

Texas Medicaid, which is administered by the Texas Health and Human Services Commission (HHSC), operates Medicaid managed care under the authority of federal waivers and state plan amendments that were approved by the Centers for Medicare & Medicaid Services (CMS).

Medicaid managed care is administered by MCOs and dental maintenance organizations (DMOs) that are contracted by HHSC to provide services for Medicaid managed care clients. The Medicaid managed care MCOs and DMOs provide most of the same benefits that Texas Medicaid provides for Medicaid fee-for-service clients. Some plans may also offer value-added services.

Refer to: Subsection 8, "Carve-Out Services" in this handbook.

The principal objectives of Medicaid managed care are early intervention and improved access to quality care, which significantly improve health outcomes for clients, with a special focus on prenatal and well-child care.

In Medicaid managed care, clients assume responsibility for their personal health care by choosing a health plan and primary care provider and by making use of preventive primary care services. Eligible clients may also choose a DMO and a main dentist. This collaborative approach to health-care delivery helps to reduce costs by eliminating duplicate services and unnecessary emergency and inpatient care.

Medicaid managed care uses MCOs to cover services in 13 service areas (SAs).

Medicaid managed care consists of the following programs:

- The STAR program uses MCOs to cover acute care services for children, newborns, pregnant women, and some families. STAR is available statewide, and clients have the choice of at least two STAR MCOs in each SA. The STAR program operates under a federal 1115 waiver.
- The STAR Kids program uses MCOs to cover integrated acute care and long-term services and supports (LTSS) for children and adults who are 20 years of age or younger and have a disability. STAR Kids is available statewide, and clients have the choice of at least two STAR Kids MCOs in each SA. The STAR Kids program operates under a federal 1115 waiver.
- The STAR+PLUS program uses MCOs to cover integrated acute care and LTSS for adults who are 65 years of age or older (including those who are dually eligible for Medicare and Medicaid) and adults who are 21 years of age or older and have a disability. STAR+PLUS also serves those who are

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eligible for Medicaid for Breast and Cervical Cancer (MBCC). The STAR+PLUS program is available statewide, and clients have the choice of at least two STAR+PLUS MCOs in each SA. The STAR+PLUS program operates under a federal 1115 waiver.

- The STAR Health program uses one MCO to deliver health-care and dental services to children who are in foster care throughout the state. STAR Health is administered by Superior HealthPlan and operates under federal 1915(a) authority. The STAR Health program manages the health and dental care of most children in foster care.
- Children's Medicaid dental services are administered by DMOs that process dental authorization requests and claims for most Medicaid fee-for-service and Medicaid managed care clients who are 20 years of age or younger regardless of their medical benefit plan.

Refer to: Section 7, "Children's Medicaid Dental Services" in this handbook for exceptions and additional information.

The Medicaid Managed Care page of the Provider section of the TMHP website at www.tmhp.com for a current list of managed care service areas.

2.1 Managed Care Services

MCOs and DMOs administer most of the services that are rendered to Medicaid managed care clients, including, but not limited to:

- Professional, inpatient facility, and outpatient facility medical services.
- Prescription drug/pharmacy services.
- Children's Medicaid dental services for most clients who are 20 years of age or younger.
- Orthodontia services.
- Services rendered to Medicaid managed care SSI clients.
- Value-added services that an individual MCO or DMO elects to provide.

Administrative procedures, such as prior authorization, precertification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

2.1.1 Medical Services

Most medical service benefits including professional, inpatient, and outpatient services rendered to Medicaid managed care clients are administered by individual MCOs. Medical services include all those administered by TMHP for fee-for-service clients as well as any value-added services covered by the individual MCOs.

Some services rendered to Medicaid managed care clients are considered "carve-out" services. Carve-out services are administered and paid by TMHP and not by the client's MCO.

Refer to: Section 8, "Carve-Out Services" in this handbook.

2.1.2 Prescription Drug/Pharmacy Services

The client's MCO administers and pays for pharmacy services.

Pharmacy providers must first be enrolled by the Medicaid or Children's Health Insurance Program (CHIP) Vendor Drug Program before they can enroll with an MCO.

Refer to: Subsection 2.2, "Provider Enrollment and Responsibilities" in this handbook.

Generally, there is no monthly prescription limit for managed care clients.

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Refer to: The MCO that administers the client's Medicaid managed care benefits for information about prescription drug and pharmacy benefits.

Each MCO contracts one Pharmacy Benefit Manager (PBM). The MCOs and PBMs must adhere to Medicaid preferred drug list (PDL) and HHSC Medicaid and CHIP formularies. HHSC manages the Texas Medicaid and CHIP formularies.

Important: *MCOs and PBMs cannot require clients to use a mail-order pharmacy.*

The MCOs must:

- Perform drug utilization review for managed care clients.
- Monitor pharmacy providers for compliance.
- Establish help lines for providers and clients.
- Ensure that all clients have access to a minimum of one network pharmacy:
  - Within 15 miles of the client's residence.
  - With 24-hour coverage within 75 miles of the client's residence.
- Provide e-prescribing abilities to:
  - Verify client eligibility.
  - Review medication history.
  - Review formulary and PDL information.
- Process correct pharmacy claims that are submitted electronically within 18 days of submission.

2.1.2.1 Prescription Drug Prior Authorizations

Prescribers may be required to request prior authorization for a prescription drug. The prescriber must contact the client's MCO or PBM and follow MCO or PBM guidelines and procedures for prior authorization requests.

Important: *TMHP does not have access to the MCOs' or PBMs' guidelines and procedures for prior authorizations. The provider must contact the MCOs of PBMs for information. Individual PBMs will have their own PA processes and telephone lines.*

The MCO must notify the prescriber's office of a prior authorization approval or denial:

- Within 24 hours of a request submitted by fax or web.
- Immediately for telephone requests.

Prior authorization is required for non-preferred drugs or any drug requiring a clinical prior authorization.

If the pharmacy cannot dispense the client's prescription because prior authorization is required butit has not been requested, the pharmacy should contact the MCO or PBM to request prior authorization. The prescribing provider is required to submit certain prior authorization requests including, but not limited to, non-preferred drug prior authorizations.

2.1.2.1.1 Emergency 72-Hour Prescriptions

If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72-hour prescription. The request for an emergency 72-hour prescription claim should not be used for routine and continuous overrides.

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A 72-hour emergency prescription will be paid in full to pharmacy providers and does not count toward the three-prescription limit for adults who have not already received their maximum prescriptions for the month.

Reminder: *There is no prescription limit for clients who are 20 years of age or younger.*

Federal and Texas law allow a 72-hour emergency supply of prescribed medication to be dispensed any time a prior authorization is not available and the prescription must be filled without delay for a medical condition. This rule applies to non-preferred drugs on the Preferred Drug list and any drug for which prior authorization must be requested by the prescribing physician.

2.1.2.1.2 Formulary

The MCOs or PBMs are responsible for informing network providers about how to access the formulary and PDL.

Refer to: The Medicaid and CHIP formularies on the VDP website at www.txvendordrug.com and at www.epocrates.com for more information.

MCOs may also selectively contract with pharmacies for specialty drugs.

2.1.3 Service and Care Coordination

Texas Medicaid has different types of service and care coordination. Clients who are enrolled in Medicaid may receive service or care coordination from MCOs or providers.

2.1.3.1 Service Coordination in STAR Kids and STAR+PLUS

In STAR Kids and STAR+PLUS, service coordination is specialized care management. Service coordination is provided by STAR Kids and STAR+PLUS MCOs and is available to all clients.

MCO service coordinators:

- Identify physical health, mental health, and LTSS needs and develop a service plan.
- Help clients get timely access to providers and covered services.
- Coordinate covered services with non-managed care programs, such as FFS waivers.

2.1.3.2 Service Coordination in STAR and CHIP

In STAR, service coordination is an administrative service that is provided by STAR and CHIP MCOs. Service coordination is available to STAR and CHIP clients who have special health care needs.

MCO service coordinators:

- Work with clients to develop a service plan and coordinate services with the client's primary care provider, specialty providers, and non-medical providers.
- Help clients get access to and use appropriately medically necessary covered services, services with non-managed care programs, such as FFS waivers, and other services and supports.

2.1.3.3 STAR Health Service Coordination and Service Management

In STAR Health, service coordination and service management have distinct functions that are different from the other managed care programs.

STAR Health defines service coordination and service management as follows:

- Service coordination is an administrative service that helps caregivers manage information, such as medical information for court hearings, and coordinate services with non-managed care programs, such as FFS waivers. Service coordination is available to STAR Health clients who have a medical or behavioral need or as requested.

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- Service management is a clinical service that is provided to clients who have a complex medical or behavioral need. Service management helps the client implement a service plan, and it coordinates services between the client's primary care provider and specialty care providers to ensure that the client has access to and appropriately uses medically necessary covered services. Service management may also be requested.

2.1.3.4 Provider Administered Care Coordination

Several types of care coordination are administered at the provider level. These services do not duplicate the service coordination or service management provided by MCOs.

Care coordination services include targeted case management for:

- Early Childhood Intervention (ECI).
- Individuals with intellectual or developmental disabilities.
- Clients who have a mental illness.
- Children and pregnant women.
- Community Living Assistance and Support Services (CLASS) and Deaf Blind with Multiple Disabilities (DBMD).
- Home- and Community-Based Services (HCBS)-Adult Mental Health (AMH) recovery management.

2.2 Provider Enrollment and Responsibilities

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

2.2.1 Enrollment, Contracting, and Credentialing

Providers must be enrolled in Texas Medicaid before they can be enrolled by an MCO or DMO. Individual MCOs and DMOs have their own guidelines for contracting providers.

All Medicaid MCOs must use the Texas Association of Health Plans' (TAHP's) contracted credentialing verification organization (CVO) as part of its credentialing and recredentialing process regardless of membership in the TAHP.

Important: *Enrollment in Texas Medicaid does not guarantee that an MCO or DMO will contract enroll or credential a particular provider.*

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Providers must refer all questions about enrollment to the MCO or DMO that administers the clients' managed care benefits. TMHP does not have access to the enrollment requirements for the individual MCOs and DMOs.

All questions about Texas Medicaid enrollment can be referred to the TMHP Contact Center.

Note: *Providers who render only carve-out services are not required to enroll in Medicaid MCOs and DMOs.*

Refer to: Section 8, "Carve-Out Services" in this handbook for a list of services that are carved out of the Medicaid Managed Care program.

Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

2.2.2 Online Provider Lookup (OPL)

Clients can search for providers using a particular county, SA, or name to find providers who participate in a managed care area. Providers that participate in MCOs and DMOs are responsible for declaring themselves as managed care providers on the OPL. Clients can search for providers that are enrolled in Medicaid managed care on the OPL. The OPL has links to the websites of the MCOs and DMOs, which allows clients to search each MCO's and DMO's network of participating providers.

2.2.3 Terminated Enrollment

Texas Medicaid monitors provider claim activity. Providers that have not submitted a claim to Texas Medicaid or a Medicaid MCO or DMO within an 18-month period are notified that their Texas Medicaid enrollment will be terminated at 24 months if they have not submitted any claims.

If a provider's Texas Medicaid enrollment is terminated, the provider's Medicaid managed care contracts with individual MCOs or DMOs will also be terminated.

To reactivate an NPI that has been terminated, the provider must complete the Texas Medicaid Provider Re-enrollment Application.

2.2.4 Excluded Entities and Providers

Title 42 Code of Federal Regulations (CFR) §1003.400(a)(2) states that civil monetary penalties may be imposed against MCOs that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid clients. No Medicaid payments can be made to an MCO for any items or services directed or prescribed by an excluded physician or other authorized person if the MCO either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded.

2.2.5 Accounts Receivable

Providers that have outstanding accounts receivables on their weekly Remittance & Status (R&S) reports must settle them with TMHP even if they no longer submit claims to TMHP.

Payments from the MCOs and DMOs may be held until the debt with TMHP is resolved. Providers can refund payments to TMHP as follows:

- If the provider no longer receives claim payments from TMHP, the provider must issue a check for the refund amount to TMHP. Payment options may be available. If a refund check is mailed to TMHP, the provider must also submit Form 7.2, "Texas Medicaid Refund Information Form."
- If the provider continues to receive claim payments from TMHP, a recoupment of the funds may be requested through the paper appeal process. If the provider requests a recoupment through the paper appeal process, the provider must not issue a check to TMHP. The refund amounts will be deducted from future payments, and the deductions will appear on the provider's R&S Reports.

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2.2.6 Educating Clients about Managed Care

Providers cannot enroll Medicaid clients; however, providers are encouraged to educate clients about Medicaid managed care.

Providers that participate in one or more Texas Medicaid managed care plans should follow these rules when educating clients:

- Providers may not influence clients to choose one MCO or DMO over another.
- Providers must inform clients of all Medicaid managed care health plans and DMOs in which the providers participate.
- Providers and subcontractors may only directly contact potential clients with whom they have an established relationship.
- Providers may inform clients of special services offered by all Medicaid managed care health and DMOs in which the providers participate.
- Providers may inform clients of particular hospital services, specialists, or specialty care available in all plans in which the providers participate.
- Providers may assist a client by contacting a plan (or plans) to determine if a particular specialist or service is available, if the client requests this information.
- Providers may not influence clients based on reimbursement rates or methodology used by a particular plan.
- At the client's request, providers can provide the necessary information for the client to contact a particular plan but cannot promote any plan over another.
- In no instances can providers stock, reproduce, assist in filling out, or otherwise handle the enrollment form. Information can be provided as outlined on the previous page, and clients can be reminded that they can easily enroll over the telephone with the enrollment broker. However, the call must be made by the client, not by the provider or the provider's agent.
- Providers may assist clients with completing the Medicaid application.
- Providers may display stickers that indicate that they participate in a particular Medicaid managed care health or DMO as long as they do not indicate anything more than "(health plan or DMO) is accepted or welcomed here" (provided the sticker meets Medicaid/CHIP Marketing Guide- lines regarding size limitations).
- Providers may display state-approved, health-related marketing materials in their offices, provided it is done equally for all MCOs and DMOs in which they participate. MCO and DMO providers cannot give out or display plan-specific marketing items or giveaways to clients.

Important: *Providers must comply with their applicable licensing agency's laws and regulations, including any related to marketing and advertising, and any applicable state and federal laws and regulations, contractual requirements, and other guidance documents. Providers are encouraged to review the Texas Provider Marketing Guidelines document on the HHS website.*

2.3 General Information About Client Enrollment in Managed Care

Most of the clients who have been determined to be eligible for Texas Medicaid are first enrolled in fee-for-service. Specific client groups within the Texas Medicaid population are eligible for managed care based on certain established criteria. If the client is eligible for Medicaid managed care, the client will choose an MCO and primary care provider or a DMO and main dentist or both. The managed care enrollment date is generally separate from the Medicaid eligibility date. In most cases, Medicaid managed care enrollment is not retroactive.

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Refer to: Section 3, "STAR Program" in this handbook.

Section 4, "STAR Kids Program" in this handbook.

Section 5, "STAR+PLUS Program" in this handbook.

Section 6, "STAR Health Program" in this handbook.

Claim and authorization transactions for services rendered during the client's fee-for-service eligibility must be submitted to TMHP, and claim and authorization transactions for services rendered during the client's Medicaid managed care enrollment must be submitted to the appropriate entity (i.e., TMHP for carve-out services and the MCO or DMO for managed care services).

If a client loses Medicaid eligibility and then regains eligibility within a certain amount of time, the client is automatically reassigned to the same health plan and primary care provider or DMO that the client had before the client lost Medicaid eligibility.

Refer to: Subsection 2.4, "Primary Care Provider/Main Dentist Guidelines for Medicaid Managed Care Clients" in this handbook.

"Section 4: Client Eligibility" (*Vol. 1, General Information*).

2.3.1 Client Enrollment in Managed Care Programs

Each MCO contracts with primary care providers, hospitals, and other providers to create a healthcare delivery network. Medicaid clients who are eligible for STAR, STAR Kids, or STAR+PLUS choose an MCO and a primary care provider, those eligible for STAR Health choose only a primary care provider, and those eligible for Children's Medicaid Dental Services choose a DMO and a main dentist.

To maximize enrollment, clients may enroll in Medicaid managed care in any of the following ways:

Method of Enrollment	Description
Telephone	STAR, STAR Health, STAR+PLUS, Children's Medicaid Dental Services: 800-964-2777 STAR Kids Helpline: 877-782-6440 (TTY 711 or 800-735-2989) Telecommunications device for the deaf (TDD): 800-267-5008 The Help Line (enrollment broker) is available 8 a.m. to 6 p.m., Central Time, Monday through Friday. A customer care representative will provide essential education about the program and details needed for enrollment.
Mail	Clients can enroll by completing an enrollment form and sending the form to the address on the postage-paid, self-addressed envelope provided with the form. Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider listings for each health plan.
Onsite	Clients can meet with a Medicaid customer care representative at any of the following locations: • Local HHSC offices • Women, Infants, and Children (WIC) classes • Community facilities • Enrollment events

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Method of Enrollment	Description
Default	Clients may be enrolled through an assignment process. If a client does not exercise the right to choose an MCO and primary care provider, the client will be assigned to a health plan and primary care provider. The following factors are considered when processing a default enrollment: • Client's past claims history, taking into account an established relationship with a participating primary care provider • Client's age, sex, and geographic proximity to the primary care provider If a client does not exercise the right to choose a DMO and main dentist, the client will be assigned to a DMO. After the default assignment is made, the DMO will assign the client a Main Dentist.

2.3.1.1 Managed Care Enrollment Timeline

Example 1

Benefits under Medicaid managed care usually begin on the first day of the next month following the client's selection of a managed care plan and primary care provider. The following example shows the managed care enrollment date for a client who selects a health plan and primary care provider before the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and primary care provider (before the 15th of the month)	January 10
Managed care benefits begin	February 1

Example 2

The following example shows the managed care enrollment date for a client who selects a health plan and primary care provider after the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 10
Medicaid benefits begin	January 10
Client selects health plan and primary care provider (after the 15th of the month)	January 20
Managed care benefits begin	March 1

2.3.1.2 Eligibility Verification Resources

The provider must verify the client's eligibility before providing services except in cases of emergency. If emergency care is provided, the provider should determine the client's MCO and primary care provider as soon as possible. The provider must also verify and abide by the prior authorization and administrative requirements established by the MCO or DMO.

STAR MCOs provide their clients with an MCO identification card. Providers should check the MCO identification card and the Your Texas Benefits Medicaid card to determine whether the client is a managed care client.

Refer to: "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information.

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The client's MCO and DMO enrollment information can be verified by:

- Checking the client's MCO or DMO ID card (if applicable).
- Visiting the client's Medicaid MCO or DMO's website.
- Calling the client's MCO or DMO.
- Visiting TexMedConnect, accessing the Medicaid Client Portal for Providers, or calling the TMHP Contact Center at 800-925-9126.

The client's managed care eligibility can also be verified using:

- The TMHP Automated Inquiry System (AIS) at 800-925-9126.
- Third-party software that uses the TMHP EDI Gateway.
- National Council for Prescription Drug Programs (NCPDP) Eligibility Verification (E1) transaction. The E1 transaction is submitted through a pharmacy's point-of-sale system.
- The Vendor Drug Eligibility Verification Portal (EVP). EVP is a browser-based application that is free for all contracted pharmacy providers.

2.3.2 Enrollment in Managed Care for Specific Groups

2.3.2.1 Expedited Enrollment of Pregnant Women (Program Type 40)

If a pregnant woman applies for program type 40 and is eligible for Medicaid managed care, she has 15 days from the date on which the Enrollment Broker receives the eligibility determination to choose an MCO that participates in her managed care program. If she does not choose an MCO, one will be chosen for her.

The Enrollment Broker contacts the client to begin the enrollment process and helps the client select an MCO. The client can also contact the Enrollment Broker directly. To protect continuity of care and client choice, the Enrollment Broker will work with each pregnant woman to select an MCO that includes her current prenatal care provider or to choose an obstetrical care provider that meets her needs.

Clients will be covered under Texas Medicaid fee-for-service until their Medicaid MCO coverage begins. To ensure proper billing, providers should call the Enrollment Broker to obtain the name of the client's health plan. However, client eligibility should always be verified at the time the service is rendered.

Women who are certified as Medicaid program type 40 may be retroactively enrolled in managed care. Women who are certified as Medicaid program type 40 on or before the 10th of the month will be enrolled in managed care beginning on the first day of the month of certification. Those who are certified after the 10th of the month will be enrolled in Texas Medicaid fee-for-service for the month of certification and will be enrolled in managed care beginning on the first day of the month following the month of certification.

There are exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in managed care on the first day of the following month (prospective enrollment).
- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in managed care on the first day of the following month (prospective enrollment).
- Women who are not identified as a candidate for program type 40 within three days of certification after her enrollment has been processed will be enrolled in managed care prospectively.

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- In cases where the Medicaid effective date is a future date, prospective enrollment rules will be used.

Important: *Providers must verify the client's plan and primary care provider information.*

The following examples show when benefits begin in relation to certification:

Example 1: Woman Certified in Her 6th Month	
Client certified for Texas Medicaid	August 1
Medicaid benefits begin	August 1
Managed care start date	August 1

Example 2: Woman Certified in Her 6th Month	
Client certified for Texas Medicaid	August 12
Medicaid benefits begin as fee-for-service	August 1
Managed care start date	September 1

Example 3: Woman Certified in Her 9th Month	
Client certified for Texas Medicaid	August 5
Medicaid benefits begin as fee-for-service	August 1
Managed care start date	September 1

Note: *Expedited enrollments of pregnant women (program type 40) into Medicaid managed care may be retroactive.*

2.3.2.2 Newborn Enrollment

The effective date of the newborn's enrollment is the same as the newborn's date of birth. Claims for services provided to newborns should be filed with the mother's MCO. Health-care providers should file newborn claims using the newborn's Medicaid identification number as soon as the number is made available. Providers that file claims for services provided to newborns are still responsible for meeting the Medicaid filing deadlines, which, in most cases, is within 95 days of the date of service.

MCOs must pay providers for labor- and delivery-related inpatient and professional services that are rendered to mothers for:

- Up to 48 hours following an uncomplicated vaginal delivery.
- Up to 96 hours following an uncomplicated Caesarian delivery.

MCOs must provide neonatal care for newborn clients until the time of discharge. Prior authorizations and primary care provider assignments cannot be a reason to deny claims.

MCOs must notify providers involved in the care of mothers and newborn clients, including out-of-network providers and hospitals, of the MCO's prior authorization requirements. MCOs cannot require prior authorization for services provided to a mother or newborn client for a medical condition that requires emergency services, regardless of when the emergency condition arises.

Authorization requests, utilization review questions, and claim status inquiries and appeals should be directed to the MCO in which the client is enrolled.

Note: *Telephone numbers and addresses for MCO claims submission and appeals can be found in the appropriate MCO provider policies and procedures manual for the appropriate service.*

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In the STAR Program, newborns are automatically assigned to the STAR MCO the mother is enrolled with at the time of the newborn's birth for at least 90 days following the date of birth unless the mother requests a plan change as a special condition. The effective date of the newborn's enrollment is the same as the newborn's DOB.

STAR MCOs are responsible for all covered services provided to newborn clients.

STAR Example

Enrollments of newborns born to mothers who are enrolled in STAR are retroactive to the newborn's date of birth. The following example shows the managed care enrollment date for a newborn:

Task	Date
Client's date of birth (mother enrolled in STAR)	January 3
Client certified for Texas Medicaid	February 1
Medicaid benefits begin	January 3 (retroactive to DOB)
STAR enrollment begins (mother's STAR plan at time of birth)	January 3 (retroactive to DOB)

Children born to STAR+PLUS or STAR Kids clients will be automatically enrolled with the STAR MCO in the SA operated by the same STAR+PLUS or STAR Kids MCO, if available. If the STAR+PLUS or STAR Kids MCO does not also operate a STAR MCO in the SA, the newborn will be enrolled in Texas Medicaid fee-for-service, and the mother will be given the opportunity to choose a STAR MCO for the newborn. Children born to STAR Health clients will be automatically enrolled in the STAR Health MCO. The effective date of the newborn's enrollment is the same as the newborn's date of birth. The newborn will remain enrolled for at least 90 days following the date of birth unless the mother requests a plan change as a special condition.

2.3.2.2.1 Timely Notification and Assignment of Medicaid ID for Newborns

There may be a delay of up to several months from the DOB for a newborn to receive a Medicaid ID number. Providers should check with each MCO to determine the claim filing requirements for newborns who do not yet have a Medicaid client number. Medicaid MCOs must adjudicate claims for services provided to newborns in accordance with HHSC's claims processing requirements using the proxy ID number or state-issued Medicaid ID number. The MCO cannot deny claims based on a provider's non-use of state-issued Medicaid ID number for a newborn. The MCO must accept provider claims for newborn services based on the mother's name or Medicaid ID number with accommodations for multiple births, as specified by the MCO.

Hospitals that submit their birth certificate information using the DSHS Vital Statistics Unit (VSU) electronic Certificate Manager software and the Hospital Report (Newborn Child or Children) (Form 7484), receive a rapid and efficient assignment of a newborn Medicaid ID number. This process expedites reimbursement to hospitals and other providers involved in newborn care, including pharmacies that provide outpatient prescription benefits for medically needy newborns.

Note: *The enrollment of newborns that are born to mothers who are enrolled in an MCO on the date of birth are retroactive to the newborn's date of birth (DOB).*

2.3.2.3 Breast Pump Claims Filing for MCO Services

Texas Medicaid and CHIP cover breast pumps and equipment after a baby is born when they are medically necessary.

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Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps when medically necessary for newborns when the mother does not have coverage under CHIP. The breast pump must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps when medically necessary for CHIP Perinatal newborns. Breast pump equipment must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, STAR Kids, and STAR+PLUS cover breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	Medicaid FFS, STAR, STAR Kids, and STAR+PLUS cover breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.

*** CHIP Perinatal clients who have household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.**

**** These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.**

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Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR Health	STAR Health	STAR Health	STAR Health covers breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps when medically necessary for the newborn when the mother does not have coverage. The breast pump must be billed under the newborn's Medicaid ID.

*** CHIP Perinatal clients who have household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.**

**** These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.**

Refer to: Section 3, "Breastfeeding Support Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about breast pump coverage.

2.3.2.4 Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC)

Medicaid for Former Foster Care Children (FFCC) covers Medicaid clients who are 18 years of age or older and were receiving Medicaid when they aged out of foster care, but would otherwise not be eligible to continue Medicaid coverage. FFCC clients are automatically enrolled in STAR Health through the last day of the month in which they turn 21 years of age. FFCC clients may opt out of STAR Health for STAR, which allows clients to choose their MCO.

Medicaid clients who were receiving Medicaid and SSI when they aged out of foster care are automatically enrolled in STAR Kids.

Eligibility for STAR Health and STAR Kids ends on the last day of the month in which they turn 21 years of age and then coverage transfers to STAR unless the client is eligible for STAR+PLUS.

Medicaid for Transitioning Foster Care Youth (MTFCY) covers former foster care youth who were not receiving Medicaid when they aged out of foster care at 18 years of age. MTFCY clients are eligible through the last day of the month in which they turn 21 years of age to receive services through the fee-for-service or managed care models.

2.3.3 Client Rights

In Texas, Medicaid managed care clients have defined rights and responsibilities. Each health plan and primary care provider share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

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Medicaid managed care clients have the right to:

- Be treated fairly and with dignity and respect.
- Know that their medical records and discussions with their providers will be kept private and confidential.
- Request changes to their medical records (if incorrect).
- A reasonable opportunity to choose a health-care plan and primary care provider (the doctor or health-care provider they will see most of the time and who will coordinate their care) and to change to another plan or provider in a reasonably easy manner. These opportunities include the right to:
  - Be informed of available health plans and primary care providers in their areas.
  - Be informed of how to choose and change health plans and primary care providers.
  - Choose any health plan that is available in their area and choose a primary care provider.
  - Change their primary care provider at any time for any reason.
  - Change health plans without penalty.
  - Be educated about how to change health plans or primary care providers.
  - Know that doctors, hospitals, and others who provide care can advise clients about their health status, medical care, and treatment. The health plan cannot prevent them from giving clients this information, even if the care or treatment is not a covered service.
  - Know that clients are not responsible for paying for covered services. Doctors, hospitals, and others cannot require clients to pay copayments or any other amounts for covered services.
- Ask questions and get answers about anything the client doesn't understand, and that includes the right to:
  - Have their provider explain their health-care needs to them and talk to them about the different ways their health-care problems can be treated.
  - Be told why care or services were denied and not given.
- Consent to or refuse treatment and actively participate in treatment decisions, and that includes the right to:
  - Work as part of a team with their provider in deciding what health care is best for them.
  - Say yes or no to the care recommended by their provider.
- Utilize each available complaint and appeal process through the MCO and through Medicaid, receive a timely response to complaints, appeals, and fair hearings. These processes include the right to:
  - Make a complaint to their health plan or to the state Medicaid program about their health-care, provider, or health plan.
  - Receive a timely answer to their complaint.
  - Access the health plan appeal process and the procedures for doing so.
  - Request a fair hearing from the state Medicaid program and request information about the process for doing so.
- Timely access to care that does not have any communication or physical access barriers. They have the right to:
  - Have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care.

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- Receive medical care in a timely manner.
- Be able to get in and out of a health-care provider's office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the *Americans with Disabilities Act*.
- Have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information.
- Be given an explanation they can understand about their health plan rules, including the health-care services they can get and how to get them.

- Not be restrained or secluded when doing so is for someone else's convenience, or is meant to force them to do something they are unwilling to do, or to punish them.

2.3.3.1 Advance Directives

Federal and state law require providers and MCOs to maintain written policies and procedures for informing and providing written information to all adult clients who are 18 years of age and older about their rights under state and federal law, in advance of their receiving care (*Social Security Act* §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the client's right to refuse, withhold, or withdraw medical treatment advance directives.

These policies and procedures must comply with provisions contained in 42 *Code of Federal Regulations* (CFR) §§434.28 and 489, SubPart I, relating to the following state laws and rules:

- A client's right to self-determination in making health-care decisions.
- The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
  - A client's right to execute an advance written directive to physicians and family or surrogates, or to make a nonwritten directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition.
  - A client's right to make written and nonwritten Out-of-Hospital Do-Not-Resuscitate Orders.
  - A client's right to execute a Medical Power of Attorney to appoint an agent to make health-care decisions on the client's behalf if the client becomes incompetent.
- The Declaration for Mental Health Treatment, Chapter 137, Texas Civil Practice and Remedies Code, which includes a client's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

These policies can include a clear and precise statement of limitation if a participating provider cannot or will not implement a client's advance directive. A statement of limitation on implementing a client's advance directive should include at least the following information:

- A clarification of the provider's conscience objections.
- Identification of the state legal authority permitting a provider's conscience objections to carrying out an advance directive.
- A description of the range of medical conditions or procedures affected by the conscience objection.

A provider cannot require a client to execute or issue an advance directive as a condition for receiving health-care services. A provider cannot discriminate against a client based on whether or not the client has executed or issued an advance directive.

A provider's policies and procedures must require the provider to comply with the requirements of state and federal law relating to advance directives.

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2.3.4 Client Responsibilities

Medicaid managed care health plans and primary care providers should help clients understand their responsibilities. These include the responsibility to:

- Learn and understand each right they have under Medicaid. That includes the responsibility to:
  - Learn and understand their rights under the Medicaid program.
  - Ask questions if they do not understand their rights.
  - Learn what choice of health plan is available in their area.
- Abide by the health plan and Medicaid managed care policies and procedures. That includes the responsibility to:
  - Learn and follow their health plan rules and Medicaid rules.
  - Choose their health plan and a primary care provider.
  - Make any changes in their health plan and primary care provider in the ways established by Medicaid managed care and by the health plan.
  - Keep their scheduled appointments.
  - Cancel appointments in advance when they cannot keep them.
  - Always contact their primary care provider first for nonemergency medical needs.
  - Be sure they have approval from their primary care provider before going to a specialist (except for self-referred services).
  - Understand when they should and should not go to the ER.
- Share information relating to their health status with their primary care provider and become fully informed about service and treatment options. That includes the responsibility to:
  - Tell their primary care provider about their health.
  - Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
  - Help their providers get their medical records.
- Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
  - Work as a team with their providers in deciding what health care is best for them.
  - Understand how the things they do can affect their health.
  - Do the best they can to stay healthy.
  - Treat providers and staff with respect.
  - Talk to their provider about all of their medications.

2.4 Primary Care Provider/Main Dentist Guidelines for Medicaid Managed Care Clients

In Medicaid managed care, eligible Medicaid clients choose a primary care provider or a main dentist who will work with the client to coordinate the client's health care or dental services.

The managed care client's primary care provider/main dentist is responsible for the following:

- Furnishes primary-care related services

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- Arranges for and coordinates referrals for all medically necessary specialty services
- Is available directly or through on-call arrangements 24 hours a day, 7 days a week for urgent or emergency care

Refer to: Subsection 2.4.4, "Continuous Access" in this handbook.

Primary care includes ongoing responsibility for preventive health or dental care, health or dental maintenance, treatment of illness and injuries, and the coordination of access to specialist providers and other services. The primary care provider or main dentist either furnishes or arranges for most of the client's health-care or dental-care needs, including well-checkups, office visits, referrals, outpatient surgeries, hospitalizations, and health- and dental-related services. Primary care providers/main dentists can choose to contract with various MCOs or DMOs.

Although primary care providers are encouraged to help clients access these services, Medicaid managed care enrollees may self-refer for the following services:

- Emergency services
- Family planning services
- THSteps medical services
- Immunizations
- Early Childhood Intervention (ECI)
- Case Management for Children and Pregnant Women
- Obstetric or gynecological services
- School Health and Related Services (SHARS)
- DSHS case management
- HHSC case management
- Behavioral health services (contact client's health plan for specific requirements)
- Vision care (including ophthalmologic or therapeutic optometry)

2.4.1 Enrolling as a Primary Care Provider or Main Dentist

Various providers may be eligible to enroll in Medicaid managed care as primary care providers or main dentist. Providers must contact the individual Medicaid managed care health plans or DMOs for enrollment information.

The following provider types are eligible to serve as primary care providers:

- Pediatricians
- Family/general practitioners
- Internists
- Obstetrician/gynecologists
- Advanced Practice Registered Nurses (APRNs) under the supervision of a physician who qualifies as a primary care provider
- Certified nurse-midwives (CNM) practicing under the supervision of a physician
- Physician assistants (PAs) practicing under the supervision of a physician who qualifies as a primary care provider
- Rural health clinics (RHCs)

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- Federally Qualified Health Centers (FQHCs)
- Community Clinics
- Specialists willing to provide medical homes to clients who have special needs
- The following provider types are eligible to serve as main dentists:
- General dentist
- Pediatric dentist
- Rural health clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

2.4.2 Primary Care Provider Requirements for THSteps Medical Services

THSteps providers must be enrolled with Medicaid to be reimbursed for services provided to clients. THSteps medical services are self-referred. Medicaid MCOs determine how their clients will access THSteps services. The MCO may require the client to go to an in-network THSteps provider or may allow the client to go to any Medicaid THSteps provider, whether or not they are in the MCO's network. Providers that render THSteps services must work in collaboration with the client's primary care provider to ensure continuity of care.

THSteps providers are required to bill claims as an exception to periodicity when the clients visit is outside of the periodicity schedule because of extenuating circumstances.

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about billing an exception-to-periodicity checkup

Subsection 4.3.7, "Exception-to-Periodicity Checkups" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about billing an exception-to-periodicity checkup

Subsection 3.2.13.1, "Exceptions to Periodicity" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about billing an exception-to-periodicity checkup.

2.4.3 Primary Care Provider and Main Dentist Changes

Primary care provider and main dentist changes may be requested or initiated by any of the following:

- A client who is enrolled in a Medicaid MCO or DMO may request a primary care provider or main dentist change at any time and for any reason.
- The MCO or DMO may reassign the client to another primary care provider or main dentist for any of the following reasons:
  - The primary care provider or main dentist is sanctioned by HHSC.
  - The primary care provider or main dentist exhibits a documented pattern of unacceptable quality of care.
  - The primary care provider or main dentist inappropriately reduces the client's right to access specialty services covered under Medicaid managed care.
  - The provider leaves Medicaid, retires, or dies.
- A provider may request a client be reassigned to another primary care provider or main dentist for any of the following reasons:
  - The client is not included in the primary care provider's or main dentist's scope of practice.
  - The client is noncompliant with medical or dental advice.

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- The client consistently displays unacceptable office decorum.
- The client's relationship with the primary care provider or main dentist is not mutually agreeable.

Any request by a provider to reassign a client to another primary care provider or main dentist must be processed through the applicable Medicaid MCO or DMO. Before a request for reassignment can be initiated, reasonable measures must be taken to correct the client's behavior. Reasonable measures may include education or counseling by the MCO or DMO staff. The MCO or DMO will notify the client of the reassignment if all attempts to remedy the situation have failed. Providers should also notify the client about the reassignment in writing and send a copy of the notification to the MCO or DMO.

The MCOs and DMOs can affect a primary care provider or main dentist change immediately if necessary; however, the Medicaid client eligibility verification systems may not immediately reflect the change.

2.4.4 Continuous Access

Continuous access is an important feature of Medicaid managed care. Twenty-four-hour primary care provider and main dentist availability enables clients to access and use services appropriately, instead of relying on ERs for after-hours care.

Continuous access can be provided through direct access to a primary care provider's or main dentist's office or through on-call arrangements with another office or service. Clients should be informed of the primary care provider's or main dentist's normal office hours and should be instructed how to access urgent medical care after normal office hours.

2.4.4.1 After-Hours Guidelines

Primary care providers and main dentists are required to have at least one of the following arrangements in place to provide 24-hour, 7-day a week access for managed care clients:

- The office telephone is answered after-hours by an answering service, which meets language requirements of the major population groups and which can contact the primary care provider, main dentist, or another designated provider. All calls answered by an answering service must be returned within 30 minutes.
- The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the patient to call another number to reach the primary care provider, main dentist, or another provider designated by the primary care provider or main dentist. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the primary care provider, main dentist, or another designated medical practitioner, who can return the call within 30 minutes.

2.4.4.2 Unacceptable Telephone Arrangements

The telephone answering procedures listed below are not acceptable:

- The office telephone is only answered during office hours.
- The office telephone is answered after-hours by a recording that tells clients to leave a message.
- The office telephone is answered after-hours by a recording that directs clients to go to an Emergency Room for any services needed.
- Returning after-hours calls outside of 30 minutes.

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2.5 Cultural Competency and Sensitivity

HHSC values the diversity of the Texas Medicaid population and requires Medicaid managed care to provide programs to support clients from diverse cultural backgrounds. Helplines are staffed by both Spanish- and English-speaking customer service representatives who, at any time, may access a multi-language translation service for assistance.

Providers must comply with the laws concerning discrimination on the basis of race, color, national origin, or sex.

2.5.1 Limited English Proficiency

Medicaid providers are required to provide services in the languages of the major Medicaid population groups they serve and to ensure quality appropriate translations. Title VI, section 601, of the *Civil Rights Act* of 1964 states that "no person in the United States shall on the basis of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

HHSC requires Medicaid providers to ensure persons with limited English proficiency have equal access to the Medicaid services to which they are legally entitled.

Meeting the requirements of Title VI may require the primary care provider or main dentist to take all or some of the following steps at no cost or additional burden to the beneficiary with limited English proficiency:

- Have a procedure for identifying the language needs of patients/clients.
- Have access to proficient interpreters during hours of operation (MCOs or DMOs arrange interpreters).
- Develop written policies and procedures regarding interpreter services (MCOs or DMOs arrange interpreters).
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to persons with limited English proficiency.

To meet interpretation requirements, providers may choose to incorporate into their business practice any of the following (or equally effective) procedures:

- Hire bilingual staff. (Does not apply to MCOs.)
- Hire staff interpreters. (Does not apply to MCOs.)
- Use qualified volunteer staff interpreters. (Does not apply to MCOs.)
- Arrange for the services of volunteer community interpreters—excluding the client's family or friends. (Does not apply to MCOs.)
- Contract with an outside interpreter service. (MCO or DMO must provide.)
- Use a telephone interpreter service.
- Develop a notification and outreach plan for beneficiaries with limited English proficiency.

It is the provider's responsibility to ensure that interpretive services are available to his practice to meet requirements on limited English proficiency and communication disabilities. Interpretive services include language and American Sign Language (ASL) interpreters.

Language Line Services operate 24 hours a day, 7 days a week. Language Line Services provides over-the telephone interpretation, video interpreting, document translation, interpreter testing and training, and other language products as well. Language Line Services charges a fee for the service. For complete details about their billing practices and services, providers should visit the Language Line Services website at www.languageline.com or call 800-752-6096.

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Complaints and reports of non-compliance with Title VI regulations are handled by the Office for Civil Rights (OCR). Additional information, including the complete guidance memorandum on prohibition of discrimination against persons with limited English proficiency issued by the OCR, can be found on the Internet at https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html.

Note: *MCOs are responsible for providing interpreter services.*

2.6 Reimbursement

Providers must read and comply with "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

Reimbursement for benefits that are administered by a Texas Medicaid MCO or DMO is determined by the MCO or DMO. Providers should contact the MCO or DMO for additional information.

Note: *The MCOs and DMOs are not limited to following the Texas Medicaid fee schedules. There may be some differences in reimbursement based on decisions made by the individual health and DMOs.*

Texas Medicaid reimburses carve-out services according to the appropriate reimbursement methodology defined in the applicable Texas Medicaid Provider Procedures Manual handbook and the applicable Texas Medicaid fee schedules, which are available on the TMHP website at www.tmhp.com.

2.6.1 Coinsurance and Deductible Payments for Dual-Eligible Clients

Crossover claims for payment for deductibles or coinsurance according to current payment guidelines are processed by TMHP and not the client's MCO.

For clients who are enrolled in a Medicare Advantage Plan (MAP) and/or Special Needs Plan (SNP), crossover claims for coinsurance and deductible payments are processed by the MAP and/or SNP. These claims are not processed by TMHP.

2.6.2 Third Party Liability (TPL)

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for additional information.

2.6.3 Out-of-Network Reimbursement

MCOs must ensure their clients have access to covered services on a timely basis. They are required to have a defined network of providers to meet client needs, and to provide support to clients who need help finding a doctor or setting up appointments. MCOs must maintain access to network providers based on federal and state requirements. If an in-network provider is not available, the MCO is still required to locate a willing provider to ensure clients have access to medically necessary and appropriate services.

If medically necessary covered services are not available through in-network providers, MCOs must allow a referral to an out-of-network Medicaid provider. The referral must be requested by an in-network provider and within the time appropriate to the circumstances relating to the delivery of the services and the condition of the client but no longer than five business days after the request.

The MCO must fully reimburse the non-network provider in accordance with the out-of-network methodology for Medicaid as defined by HHSC in 1 TAC § 353.4.

MCOs must allow pregnant clients, past the 24th week of pregnancy to remain under their current OB/GYN's care through the client's postpartum checkup, even if the OB/GYN provider is, or becomes, out-of-network.

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For newly enrolled clients, MCOs must pay the existing out-of-network Medicaid providers for medically necessary covered services for up to 90 days, until the client's records and care can be transferred to an in-network provider, or until the client is no longer enrolled with the MCO.

MCOs are not responsible for payment for unauthorized nonemergency services by out-of-network providers, except when that provider is an Indian Health Care Provider (IHCP) enrolled as a FQHC.

2.7 Managed Care Plan Changes

The MCO or DMO changes can be initiated by clients, MCOs, or DMOs.

2.7.1 Client-Initiated Plan Changes

Clients have the right to change plans. Clients must call the Enrollment Broker at 800-964-2777 to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below.

Example	
Request received on or before	Mid-May
Change effective	June 1
Request received after	Mid-May
Change effective	July 1

Note: *All plan change requests must be processed by the Enrollment Broker.*

The STAR Health Program only has one plan choice available. As a result, clients cannot change plans, but may change primary care providers within their assigned STAR Health MCO.

2.7.2 Plan Administrator-Initiated Changes

Each health plan and DMO has a limited right to request that a client be disenrolled without the client's consent. HHSC must approve any request for such disenrollment.

Health plans and DMOs may request that a client be disenrolled for the following reasons:

- The client loans his or her Your Texas Benefits Medicaid card to another person to obtain services.
- The client continually disregards the advice of his primary care provider or main dentist.
- The client repeatedly uses the ER inappropriately.
- Client is disruptive, unruly, threatening, or uncooperative to the extent that client's membership seriously impairs MCO's, DMO's, or provider's ability to provide services to the client or to obtain new patients, and the client's behavior is not caused by a physical or behavioral health condition.
- Client refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow MCO to treat the underlying medical condition).
- For STAR+PLUS MCOs, under limited conditions, the MCO may request disenrollment of clients who are totally dependent on a ventilator or who have been diagnosed with End Stage Renal Disease.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the client's behavior. Reasonable measures may include education or counseling conducted by health plan or DMO staff. HHSC will notify the client in writing of the disenrollment if all attempts to remedy the situation have failed. HHSC will also notify the client in writing of the availability of appeal procedures and the HHSC fair hearing process.

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Health plans, DMOs, and providers can not request a client's disenrollment because of an adverse change in the client's health or the utilization of services that are medically necessary for the treatment of a client's condition.

2.7.3 Managed Care Organization (MCO) Clients Who Transition to Medicaid Fee-For Service (FFS)

When clients transition from an MCO to FFS, providers can request that previously approved authorizations for Comprehensive Care Program (CCP) services, occupational therapy (OT), physical therapy (PT), private duty nursing (PDN), and speech therapy (ST) be transferred from the MCO to FFS.

2.7.3.1 Submission Guidelines

TMHP will consider the reimbursement of claims for services that were rendered on or after the MCO's disenrollment date only when the provider submits a request to TMHP to transfer the previously approved authorization for CCP services. The request to TMHP must be received on or before the end date of the previously approved MCO authorization. Any requests submitted after the MCO's authorization end date will have to meet the regular submission guidelines for the specific service type.

2.7.3.2 Documentation Requirements

All of the requests to transfer the authorizations from the MCO to FFS must include:

- A copy of the previously approved authorization letter.
- All of the documentation that was sent in the original authorization request, including any physician orders that were used to determine the start of care. TMHP will accept the physician orders as the required documentation for the requested services.
- The completed CCP prior authorization form, Special Medical Prior Authorization (SMPA) form, Home Health Plan of Care, or Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form, whichever is applicable for the requested service. The form must include the dates of service and quantities that are being requested from TMHP, which must match the dates of service and quantities that were approved in the original authorization.

Note: *It is not necessary to obtain signatures or dates on the forms listed above when submitted to TMHP for the purpose of transferring an authorization from an MCO to FFS Medicaid.*

Authorizations for services transferred from an MCO to FFS Medicaid are subject to retrospective review.

TMHP will verify the client's eligibility, the dates of service, and the quantities requested.

TMHP will process reimbursement claims as follows:

- Claims for services that were rendered before the date on which the transfer request was received will be denied as a late submission, and the provider will be notified of their administrative appeal rights through the Health and Human Services Commission (HHSC).
- Claims for services that were rendered on or after the date of receipt use the required information from the transferred authorization and will be processed as if the request was received in a timely manner.
- Claims for services that were paid by an MCO and then recouped must contain the recoupment EOB from the MCO for consideration of payment. The claims must meet the 95-day deadline from the recoupment disposition date.

Note: *Letter requests for refunds will not be accepted. A recoupment EOB with a disposition date is required.*

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If a request to transfer an MCO authorization is submitted after the end date of the MCO authorization, or the provider does not have an authorization letter from the MCO, TMHP will process the request to transfer the authorization based on established TMHP authorization submission guidelines for CCP services, PDN, OT, PT, and ST.

All new requests for rendered services must meet the documentation requirements.

2.7.3.3 New Services and Extension of Services

For new services that occur after the client's MCO disenrollment change date, the provider is responsible for submitting all TMHP required paperwork and meeting all established submission guidelines for prior authorization.

Requests for the extension of services that occur after the MCO disenrollment change date must include all of the paperwork that is required by TMHP and meet all established submission guidelines for prior authorization.

2.7.3.4 Loss of Eligibility

If an MCO disenrolled a client and the client also loses Medicaid eligibility, providers must anticipate, if and when Medicaid eligibility is restored, that the client will initially be considered a Medicaid FFS client and will have a retroactive eligibility period.

All requests for services that require prior authorization and that occur during the client's retroactive eligibility period, must be submitted to TMHP following the process that is outlined in subsection 5.1.1, "Prior Authorization Requests for Clients with Retroactive Eligibility" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*).

If a client is retroactively disenrolled by an MCO, all of the services that are rendered by the provider during this retroactive disenrollment period (specifically from the date on which the client was eligible for FFS to the date of the client's MCO eligibility change) will be denied by TMHP, and the provider will be notified of their administrative appeal rights.

Refer to: Subsection 6.4.2.9, "Attachments to Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

TMHP may consider services for the MCO transition beginning on the date of the client's MCO eligibility change date and going forward. TMHP uses the MCO transition process for the submission of paperwork and the processing of provider requests.

2.8 Authorizations for Managed Care Services

MCOs must have a process in place that allows prior authorizations eligible for recertification to be submitted by providers and reviewed by the MCO within the timeframes as outlined in Section 5: Fee-for-Service Prior Authorizations.

Authorization requests for services administered by the client's MCO or DMO must be submitted to the client's MCO or DMO according to the guidelines specific to the plan under which the client is covered.

Health plan prior authorizations do not automatically transfer with a client who moves to another plan.

When a client or provider notifies the new MCO that there is an existing prior authorization, the new MCO must ensure that the client gets a continued authorization of those services for the same amount, duration, and scope. The new MCO must get the continued authorization within the shortest of the following time periods:

- Within 90 Days of the transition to a new MCO
- Until the end of the current authorization period
- Until the MCO has evaluated and assessed the client and issued or denied a new authorization

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If a client who is transitioning from FFS to managed care was receiving a service that did not require a prior authorization in FFS, but does require one in the new MCO, the MCO must ensure that the client receives services for the same amount, duration, and scope. The continued authorization must last for the shortest period of the following:

- Within 90 days of the transition to the new MCO
- Until the MCO has evaluated and assessed the client and issued or denied a new authorization

Dental prior authorizations may transfer from one DMO to another.

2.9 Claims Filing for Managed Care Services

Claims for services administered by an MCO or DMO must be submitted to the client's MCO or DMO. Providers may submit directly to the appropriate MCO or DMO using the methods established by the MCO or DMO.

Providers must contact the appropriate MCO or DMO for information about filing electronic or paper claims directly to the MCO or DMO.

MCOs may also subcontract with behavioral health organizations (BHOs) and pharmacy benefit managers (PBMs). Providers must contact the client's MCO to verify the claims process.

Refer to: The TMHP website at www.tmhp.com/topics/managed-care for additional information, including MCO and DMO contact information.

Important: *Providers must call the client's MCO or DMO who processed the claim for information about the MCO's or DMO's explanation of benefits (EOB), claims payment, claim rejection, how to correct a rejected claim, or any other questions about the MCO or DMO claim guidelines and processes. TMHP does not have any information about the MCO's or DMO's claims, benefits, or processes.*

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions to TMHP.

Reminder: *Claims for Medicaid managed care clients must be submitted to the MCO or DMO in which the client is enrolled at the time of service. Providers can contact the client's MCO or DMO for additional details. Claims for hospital facility charges for inpatient hospital stays for Medicaid managed care clients must be submitted to the program, MCO, or DMO in which the client is enrolled at the time of admission. The responsible party will pay the hospital facility charge until the earlier of either the date of discharge from the hospital, date of transfer, or loss of Medicaid eligibility. Providers must submit the claims with the corresponding prior authorizations for the hospital facility charge to the appropriate entity for reimbursement. Providers can contact the appropriate MCO or DMO for additional details. If Medicaid managed care clients receive other services during an inpatient hospital stay, including hospital professional charges, claims for these services (from the date of hospital admission to the date of release) are submitted to the program, MCO, or DMO in which the client is enrolled at the time of the requested service. The MCO or DMO, as a payor of last resort, does not determine payment based on the primary payor's (i.e., TPR or other primary source of insurance) authorization of services or approval of hospital stays.*

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for additional information.

The TMHP Medicaid Managed Care web page at www.tmhp.com/topics/managed-care for additional information.

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2.9.1 Filing Deadlines

The following table summarizes the filing deadlines that apply for MCO and DMO claim submissions:

Submission	Filing Deadline
Initial submission submitted to the correct plan	95 days from the DOS
Initial submission submitted to the wrong plan	95 days of the date on the Remittance and Status (R&S) Report from the other (wrong) carrier (documentation of timely filing is required)
Initial submission to TPR (not the Medicaid MCO or DMO)	95 days from the date of disposition by the other insurance resource
Initial submission for newborns	Submit to the client's or mother's MCO within 95 days of the DOS

Claims must be submitted to the appropriate entity whether TMHP or the MCO or DMO within 95 days of the date of service. If the claim is not received by the MCO or DMO within 95 days, the claim will be denied.

If the provider files with the wrong plan within the 95 day submission requirement (e.g., State Claims Administrator but not with the MCO or DMO), the provider must resubmit the claim with documentation that shows the claim was submitted within the appropriate time frame but to the wrong plan. The MCO or DMO must honor the initial filing date and process the claim without denying the resubmission for the sole reason of passing the filing timeframe. The provider must file the claim with the correct MCO within 95 days of the date on the Remittance and Status (R&S) Report from the other (wrong) carrier.

When a service is billed to other insurance, the claim must be refiled and received by the Medicaid MCO or DMO within 95 days from the date of disposition by the other insurance resource. The MCO or DMO will determine, as a part of its provider claims filing requirements, the documentation required when a provider refiles these types of claims with the MCO or DMO.

MCOs and DMOs are subject to the requirements related to coordination of benefits for secondary payers in the Texas Insurance Code section 843.349 (e) and (f).

Refer to: Subsection 2.9, "Claims Filing for Managed Care Services" in this handbook for details about managed care claims.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about MCO claims processed by TMHP and not the client's MCO.

2.10 MCO/DMO Appeals, Complaints, and Fair Hearings

Providers can submit their appeals directly to the MCO or DMO that administers the clients' managed care benefits.

Claims that were originally submitted to TMHP for routing to the appropriate MCO or DMO can be appealed to TMHP using TexMedConnect or EDI. The appeals will be routed to the appropriate entity for processing.

2.10.1 Medicaid Managed Care Complaints and Fair Hearings

Medicaid managed care providers may file complaints with HHSC if they find they did not receive full due process from the respective managed care health plan.

Appeals, grievances, or dispute resolution is the responsibility of each MCO or DMO. Providers are encouraged to exhaust the complaints or grievance process with their MCO or DMO before filing a complaint with HHSC.

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Refer to: The respective MCO or DMO for information about specific complaint policies and procedures.

The respective health plan's policies and procedures for information about the MCO appeals and fair hearing process.

Subsection 7.1.5, "Paper Appeals" in "Section 7: Appeals" (*Vol. 1, General Information*) for information about paper appeals.

Once the MCO's or DMO's complaints or grievance process has been exhausted, complaint requests may be sent to HHSC.

Complaints about STAR, STAR+PLUS, STAR Kids, STAR Health, and DMO can be:

- Emailed to HHSC at HPM_Complaints@hhsc.state.tx.us.
- Mailed to HHSC at:

Health and Human Services Commission
MCCO Research and Resolution
PO Box 149030
MC: 0210
Austin, TX 78714-9030

3 STAR Program

The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality care thereby significantly improving health outcomes for the target populations. The special focus of the STAR Program is on prenatal and well-child care.

3.1 STAR Program Clients

Most clients in Texas Medicaid get their coverage through the STAR Program. STAR provides primary care, acute care, behavioral health care, and pharmacy services for pregnant women, newborns, and children and parents with limited income. Some former foster care children and youth are eligible for the STAR Program as well.

STAR is available statewide in 13 service areas (SAs). STAR Medicaid clients can select from at least two MCOs in each service area.

Refer to: Subsection 2.3.2.4, "Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC)" in this handbook.

3.2 STAR Program Benefits

STAR Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:

- Removal of the inpatient spell of illness limitation for adults
- Unlimited medically necessary prescription drugs for adults
- Waiver of the $200,000 individual annual limit on inpatient services

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3.2.1 Spell of Illness

STAR clients are not limited to the 30-day spell of illness. The spell of illness limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. All Medicaid clients who are 20 years of age and younger are already not limited to the 30-day spell of illness.

3.2.2 Prescriptions

STAR clients who are 21 years of age or older receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR allows the provider greater flexibility in treating and managing a client's health-care needs. All Medicaid clients who are 20 years of age or younger already receive unlimited medically necessary prescription drugs.

4 STAR Kids Program

The STAR Kids Program is designed to improve access to care, coordinate care across service areas, improve ease of program participation for clients, managed care organizations, and providers, and achieve cost efficiency and cost containment. The STAR Kids program integrates acute care and long-term services and supports (LTSS) into a Medicaid managed care delivery system for children and adults who are 20 years of age or younger and have a disability.

STAR Kids also provides Medically Dependent Children's Program (MDCP) services for eligible clients.

Refer to: The STAR Kids website at www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/star-kids.

4.1 STAR Kids Clients

STAR Kids is available statewide in 13 service areas (SAs). STAR Kids Medicaid clients can select from at least two MCOs in each service area.

Participation in the STAR Kids program is required for Medicaid clients who are 20 years of age or younger and meet at least one of the following:

- Receive Supplemental Security Income (SSI).
- Receive SSI and Medicare.
- Receive services through the Medically Dependent Children Program (MDCP) waiver.
- Receive services through the Youth Empowerment Services (YES) waiver.
- Live in a community-based intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) or nursing facility.
- Receive services through a Medicaid Buy-In program.
- Receive services through any of the following HHSC intellectual and developmental disability (IDD) waiver programs.
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities (DBMD)
  - Home and Community-based Services (HCS)
  - Texas Home Living (TxHmL)

Children and youth who receive SSI or SSI-related Medicaid or are enrolled in MDCP receive all of their Medicaid services through the STAR Kids program.

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Children and youth who receive services through other 1915(c) waiver programs receive their basic Medicaid health services through STAR Kids, while receiving their LTSS through their waiver program.

Children who are dually eligible receive most of their acute care services through Medicare but receive LTSS and service coordination through STAR Kids.

4.2 STAR Kids Benefits

STAR Kids Program clients receive all the benefits of Texas Medicaid fee-for-service, including Texas Health Steps and Comprehensive Care Program services. STAR Kids clients who have an assessed need for LTSS, identified by the STAR Kids Screening and Assessment Instrument (SK-SAI), may receive services through their STAR Kids MCO.

4.2.1 Spell-Of-Illness

No spell-of-illness limitation exists for THSteps-eligible clients who are 20 years of age or younger when a medically necessary condition exists.

4.2.2 Prescriptions

All Medicaid clients who are 20 years of age or younger receive unlimited medically necessary prescription drugs.

4.2.3 Service Coordination

Refer to: Subsection 2.1.3, "Service and Care Coordination" in this handbook.

The STAR Kids Handbook page of the HHS website at hhs.texas.gov.

5 STAR+PLUS Program

The STAR+PLUS Program is designed to improve access to care, provide care in the least restrictive setting, and provide more accountability and control on costs. The STAR+PLUS program integrates acute care and long-term services and supports (LTSS) into a Medicaid managed care delivery system for SSI-eligible Medicaid clients.

The STAR+PLUS Program serves adults with a disability, clients age 65 and older (including those dually eligible for Medicare and Medicaid), as well as women in the Medicaid Breast and Cervical Cancer Program.

5.1 STAR+PLUS Program Clients

Medicaid clients who are 21 years of age or older and enrolled in any of the following HHSC programs must enroll in STAR+PLUS for acute care benefits, unless the member is dual-eligible for Medicaid and Medicare:

- Community-based Intermediate Care Facility of Individuals with Intellectual Disabilities (ICF-IID)
- Home and Community-based Services (HCS)
- Community Living Assistance and Support Services (CLASS)
- Texas Home Living (TxHmL)
- Deaf Blind with Multiple Disabilities (DBMD)

Enrollment in the STAR+PLUS program is required for clients of Medicaid who meet one or more of the following criteria:

- Receive Supplemental Security Income (SSI) benefits or SSI-related Medicaid
- Qualify for STAR+PLUS Home and Community-Based Waiver Services

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- Are 21 years of age or older and receive Medicaid because they are in a Social Security Exclusion program and meet financial criteria for STAR+PLUS Home and Community-Based Services Program
- Are 21 years of age or older and reside in a nursing facility
- Qualify for Medicaid for Breast and Cervical Cancer (MBCC)
- Former Foster Care Children (FFCC) clients who are 21 years of age through the end of the month of their 26th birthday, who are dual eligible, and who reside in a community-based ICF-IID or receive services under the following Medicaid 1915(c) waivers:
  - HCS
  - CLASS
  - TxHmL
  - DBMD

Exception: *Clients who receive Medicare Part B in addition to Medicaid will remain in FFS for all Medicaid services.*

Refer to: Subsection 4.8, "Medicaid for Breast and Cervical Cancer (MBCC)" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information about the MBCC Program.

After selecting an MCO, STAR+PLUS Program clients who are not dual-eligible are required to select a primary care provider from the MCO provider directory.

5.1.1 Clients who are Ineligible for The STAR+PLUS Program

Clients who meet the following criteria are not eligible to enroll in STAR+PLUS and will remain in Texas Medicaid fee-for-service:

- Residents in a State Supported Living Center
- Residents in an ICF-IID who are dual eligible in Medicare and Medicaid
- Residents of state hospitals or institutions for mental diseases
- Program of All-Inclusive Care for the Elderly (PACE)
- In-Home and Family Support Program Services clients
- Qualified Medicare Beneficiaries (QMBs) that do not receive Medicaid benefits other than Medicare deductible or coinsurance liabilities according to current payment guidelines
- Clients who receive limited Medicaid benefits and do not qualify for participation in the VDP

5.2 STAR+PLUS Program Benefits

STAR+PLUS Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:

- Unlimited medically necessary prescription drugs for adults who are not dual-eligible
- Waiver of the $200,000 individual annual limit on inpatient services

Refer to: Subsection 3.2.2, "Prescriptions" in this handbook for more information about prescription benefits.

Note: *Dual eligible adults continue to be limited to three prescriptions unless they have joined the Medicare MCO also offered by their STAR+PLUS MCO.*

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5.2.1 Prescriptions

STAR+PLUS clients who are 21 years of age and older and do not receive Medicare receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR+PLUS allows the provider greater flexibility in treating and managing a client's health care needs. All Medicaid clients who are 20 years of age and younger already receive unlimited medically necessary prescription drugs.

5.2.2 Spell of Illness

The spell-of-illness limitation applies to clients in the STAR+PLUS Program.

A spell-of-illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

An individual may be discharged from and readmitted to a hospital several times, regardless of the admittance reasons, and still be considered to be in the same spell of illness if 60 days have not elapsed between discharge and readmission.

The spell-of-illness limitation does not apply in the following situations:

- A prior-approved solid organ transplant has an additional 30-day spell of illness, which begins on the date of the transplant.
- No spell-of-illness limitation exists for THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.
- The client is enrolled in the Medicaid managed care STAR program.
- The client is not eligible for Medicare and is admitted to an inpatient facility with a diagnosis of bipolar disorder, major depressive disorder, recurrent depressive disorder, schizoaffective disorder, or schizophrenia.

For confirmation of spell-of-illness limitation contact the client's MCO.

5.2.3 Service Coordination

The MCO must furnish a service coordinator to all STAR+PLUS clients who request one, or when the MCO determines the need for a service coordinator through an assessment. A service coordinator is the person with primary responsibility for providing service coordination and care management to STAR+PLUS clients.

Refer to: Subsection 2.1.3, "Service and Care Coordination" in this handbook.

6 STAR Health Program

The STAR Health program ensures that children and youth in state conservatorship are able to receive all services they need immediately upon entry into conservatorship. Benefits under STAR Health begin the date the client is placed in conservatorship.

HHSC has selected Superior HealthPlan as the MCO for this program. Superior HealthPlan is responsible for assigning a to clients when they are enrolled in the STAR Health Program. Foster care families are given the opportunity to change their primary care provider after this initial assignment.

6.1 STAR Health Program Clients

All Medicaid clients in foster care are placed in this program with the following exceptions:

- Children adjudicated and placed with the Texas Juvenile Justice Department

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- Children from other states who are placed in Texas Children in Medicaid-paid facilities such as children in nursing homes, ICF-IIDs, or State-Supported Living Centers
- Children who are active SSI-related Medicaid clients
- Children who are in state conservatorship who are placed outside of Texas
- Children who are in adoption assistance

Clients who participate in the Medicaid for Transitioning Foster Care Youth (MTFCY) program and the Former Foster Care Children (FFCC) program are eligible for the STAR Health program.

The following table shows the age ranges for clients who may be eligible for the STAR Health program:

Group Clients Belong to	Age Ranges
Client under DFPS conservatorship	DFPS can retain conservatorship through the month of the client's 18th birthday. (Eligibility ends the month conservatorship ends.)
Clients who voluntarily continue in a foster care placement after DFPS conservatorship ends	18 through 21 years of age (Eligibility ends the month of their 22nd birthday.)
Clients who are participating in the MTFCY program	18 through 20 years of age (Eligibility ends the month of their 21st birthday.)
Clients who are participating in the FFCC program	18 through 20 years of age (Eligibility for STAR Health ends the month of their 21st birthday, and then coverage transfers to STAR unless the client is eligible for STAR+PLUS)

STAR Health clients can gain eligibility on any day of the month. To ensure the accurate confirmation of STAR Health eligibility, it is essential that all health-care providers verify eligibility by contacting the STAR Health MCO. The STAR Health MCO receives updated eligibility information on a daily basis, so it will have the most current eligibility information.

The Department of Family and Protective Services (DFPS) Form 2085 as well as the Your Texas Benefits Medicaid card may also be used to verify eligibility in the STAR Health Program.

Newborns born to a mother who is enrolled in the STAR Health program are automatically enrolled in STAR Health.

Newborns that are taken into State conservatorship while still in the hospital will be enrolled in STAR Health on the date the State takes conservatorship.

Refer to: Subsection 2.3.2.4, "Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC)" in this handbook.

Subsection 2.3.2.2, "Newborn Enrollment" in this handbook.

6.2 STAR Health Program Benefits

STAR Health Program clients receive all the benefits of traditional Texas Medicaid as well as service coordination to assist in making appointments and accessing services; and service management to assist with managing the health care of those with ongoing and serious medical needs.

Refer to: Subsection 2.1.3, "Service and Care Coordination" in this handbook.

Most Medicaid foster care claims are capitated services and must be submitted to Superior HealthPlan.

Refer to: Section 8, "Carve-Out Services" in this handbook for the list of non-capitated services that may be reimbursed by TMHP.

All THSteps dental, medical, vision, and mental health providers should submit claims for services rendered to foster care clients to Superior HealthPlan's dental, vision, and mental health contractors.

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For general provider information or authorizations, from STAR Health subcontractors, contact Superior Health Plan.

6.2.1 Spell-Of-Illness

No spell-of-illness limitation exists for THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.

6.2.2 Prescriptions

All Medicaid clients who are 20 years of age and younger receive unlimited medically necessary prescription drugs.

Note: *HIPP program clients who are enrolled in STAR Health should be removed from the HIPP program and continue to receive their benefits under the STAR Health program.*

Refer to: Subsection 4.10, "Health Insurance Premium Payment (HIPP) Program" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information about the HIPP program.

Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

7 Children's Medicaid Dental Services

7.1 Overview

The principal objectives of children's Medicaid managed care dental services are to provide quality, comprehensive dental services in a manner that improves oral health of clients through preventative care, health education, and early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target populations.

7.2 Children's Medicaid Dental Services Model

Clients' primary and preventive Medicaid dental services are provided statewide through Medicaid managed care DMOs. Each Medicaid managed care DMO is responsible for contracting with general dentists, pediatric dentists, and dental specialists to create a delivery network. Clients who receive their dental services through a Medicaid managed care DMO are required to select a DMO and a main dentist (or main dental home provider or dental home). The client selects the main dentist from a provider directory.

A main dentist means a provider who has agreed with a DMO to provide a dental home to clients and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as main dental home providers are general dentist and pediatric dentist. RHCs and FQHCs are also eligible to serve as a Main Dentist.

The First Dental Home Initiative is included in this model.

Refer to: Subsection 3.2.9, "First Dental Home" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

7.3 Client Eligibility

Most children who are 20 years of age and younger will receive their dental services through Medicaid managed care DMO.

Populations that will not receive services through the children's Medicaid managed care DMOs are:

- Medicaid recipients who are 21 years of age or older.

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- Recipients who reside in an institution (i.e. nursing homes, state supported living centers, or ICF-IID).
- Recipients in the STAR Health Program.

7.4 Client Enrollment

Clients choose a DMO and Main Dentist. To maximize enrollment, the children's Medicaid dental services offer four alternative ways that clients can enroll:

- Telephone Enrollment. A client can enroll in a DMO by calling 800-964-2777 (telecommunications device for the deaf (TDD): 800-267-5008) A customer care representative will provide essential education about the program and details needed for enrollment.
- Mail-in Enrollment. If calling is not convenient, a client may enroll by completing the an enrollment form and dropping it in the mail using the postage-paid, self-addressed envelope. Enrollment forms are mailed to all eligible mandatory clients along with information explaining the services and how to choose a Main Dentist.
- Onsite Enrollment. In addition to telephone and mail-in enrollment, clients can enroll by talking with customer care representative at a local HHSC office, at Women, Infants, and Children (WIC) classes, community facilities, or during enrollment events.
- Default Enrollment. The final method of enrollment is through an assignment process. If a client does not exercise the right to choose a dental and Main Dentist, the client will be assigned to a DMO. After the default assignment is made, the DMO will assign the client a Main Dentist.

7.5 Authorizations for Children's Medicaid Managed Care Dental Services (Non-orthodontia Services)

Authorization requests for services administered by the client's DMO must be submitted to the client's DMO according to the guidelines specific to the plan under which the client is covered.

If a client is new to a DMO and has an open authorization for covered dental services from TMHP or another HHSC-contracted Medicaid managed care DMO, the DMO must accept that authorization and cannot require additional authorization or review.

TMHP authorizes and processes dental and emergent orthodontic services for clients who are 20 years of age and younger but have not yet enrolled in a DMO.

TMHP also authorizes services for the following clients:

- Dental services for Medicaid clients who are 21 years of age and older
- Dental and orthodontia services for all Medicaid clients, regardless of age, who reside in Medicaid-paid facilities such as nursing homes, state-supported living centers, or ICF-IIDs

Exception: *STAR Health Foster Care Program clients receive dental and orthodontic services through DentaQuest.*

7.6 Children's Medicaid Dental Orthodontia Services

The Medicaid managed care DMOs will be responsible for authorizing, processing, and reimbursing any orthodontic services rendered to Texas Medicaid managed care clients. Claims for orthodontic services that were initially authorized by TMHP but later transitioned to a managed care DMO will be processed and reimbursed by the DMO. Providers should check client eligibility to identify the managed care DMO in which the client is enrolled.

TMHP will continue to process claims and claims adjustments for orthodontia services claims for clients who are ICF-IID residents.

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If a Medicaid client is enrolled in a DMO for at least one month, is receiving orthodontic treatment, and either ages out of the program or loses eligibility, the DMO is responsible for completion of the course of treatment. The only exception is if the client is disenrolled with cause but is still Medicaid-eligible. For example, if a client goes into a State Supported Living Center, the DMO will no longer be responsible for services rendered.

8 Carve-Out Services

Some services are "carved out" of one or more of the managed care programs. Carved out services are those that are rendered to Medicaid managed care clients but are processed for payment consideration by TMHP rather than an MCO or DMO.

The following tables shows the services that are partially or completely carved out of the MCO and DMO managed care program:

Carve Out	STAR	STAR Kids	STAR+PLUS	STAR Health
Nutritional products through WIC	TMHP	TMHP	TMHP	TMHP
DSHS MH rehabilitation (w/ Modifier HZ)	TMHP	TMHP	TMHP	MCO
County Indigent Health Care Program (CIHCP)	TMHP	TMHP	TMHP	TMHP
Early Childhood Intervention (ECI) case management	TMHP	TMHP	TMHP	TMHP
ECI specialized skills training	TMHP	TMHP	TMHP	TMHP
Family planning services for Dell Children's managed care health plan	TMHP	N/A	N/A	N/A
Texas School Health and Related Services (SHARS)	TMHP	TMHP	TMHP	TMHP
Elevated lead investigation services	TMHP	TMHP	TMHP	TMHP
DSHS TB providers	TMHP	TMHP	TMHP	TMHP
DSHS targeted case management (w/ Modifier HZ)	TMHP	TMHP	TMHP	TMHP
HHSC Blind Children's Vocational Discovery and Development Program	TMHP	TMHP	TMHP	TMHP
Case Management for Children and Pregnant Women	MCO	MCO	MCO	MCO
Community First Choice (CFC) services*	TMHP	MCO	MCO	MCO
Personal Care Services (PCS)	TMHP	MCO	MCO	MCO
Youth Empowerment Services (YES) Waiver	TMHP	TMHP	TMHP	TMHP
Home and Community Based Services Adult Mental Health (HCBS-AMH)	TMHP	TMHP	TMHP	TMHP
*** CFC services are carved out for STAR Kids clients who receive services through CLASS, DBMD, HCS, or TxHmL.**				

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Dental Carve Out	Children's Medicaid Dental	STAR Health
THSteps Dental	DMO	MCO
Orthodontia for most clients who are 20 years of age and younger	DMO	MCO
ICF-IID Dental Services	TMHP	TMHP

Note: *Authorizations and claims for SSI clients who are enrolled in the STAR Program are submitted to the client's MCO or DMO.*

Providers must submit authorization requests and claims for services that are carved out of the managed care program to TMHP according to the fee-for-service guidelines that are established for the same service.

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about applicable authorization request and claims filing guidelines.

8.1 Family Planning Carve-Out Services

Some family planning services are carved-out services for Texas Medicaid clients whose managed care benefits are administered through Dell Children's Health Plan. These carved out services may be considered for payment by Texas Medicaid through TMHP if the service has been denied by the health plan as a family planning service.

All Dell Children's Medicaid providers should submit family planning claims using the CMS-1500 paper claim form, or electronic equivalent, to the client's managed care health plan to receive the health plan's denial.

Important: *Services that are denied by the health plan for any other reason will not be considered for reimbursement by Texas Medicaid.*

8.1.1 Professional and Outpatient Claims

For affected claims to be eligible for reimbursement through TMHP, providers must do the following:

1) Submit the claim to the client's managed care health plan to receive the health plan's denial. Claims that are submitted electronically using TexMedConnect will automatically be forwarded to the client's Medicaid managed care plan.
2) Submit a paper claim to TMHP upon receipt of the health plan's denial. All applicable documentation must be included with the paper claim, including, but not limited to:
   - The health plan's EOB document that indicates the denial code with its description and the date the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.
   - All documentation for family planning services including the Sterilization Consent Form and any other documentation that is required by Texas Medicaid.

   Note: *A paper claim is required because TMHP automatically forwards electronic claims to the client's health plan without processing. Providers must comply with all filing deadlines unless otherwise specified below in this article.*

Refer to: The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for Texas Medicaid guidelines for family planning services.

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8.1.1.1 Claim Forms for Submission to TMHP

After receiving the health plan's denial, Medicaid family planning services providers should submit paper claim forms to TMHP as follows:

- Providers that contract with the HHSC Family Planning Program should submit claims on a 2017 paper claim form along with the health plan's denial.
- Providers that do not contract with the HHSC Family Planning Program should submit claims on a CMS-1500 paper claim form along with the health plan's denial.

Providers should submit the health plan's EOB document that indicates the denial code with its description and the date that the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.

Providers must comply with all filing deadlines.

The initial paper claim will be denied by TMHP. TMHP will automatically reprocess for payment consideration any claim that has been denied only with EOB 00081, "Services billed to TMHP in error. Bill HMO."

TMHP will reprocess only those claims that were denied with EOB 00081 as the only EOB message on the claim. If a claim has been denied with other EOB messages in addition to EOB 00081, the provider must resolve the other reasons for denial through the standard appeals process before TMHP can reprocess the claim for payment of the carved-out services.

8.1.2 Inpatient Claims

For affected claims to be eligible for reimbursement through TMHP, providers must do the following:

1) Submit the claim to the client's managed care health plan to receive the health plan's denial. Claims that are submitted electronically using TexMedConnect will automatically be forwarded to the client's Medicaid managed care plan.
2) Submit a paper claim to HHSC Administrative Appeals upon receipt of the health plan's denial. All applicable documentation must be included with the paper claim, including, but not limited to:
    - The health plan's EOB document that indicates the denial code with its description and the date the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.
    - All documentation for family planning services including Sterilization Consent Forms and Hysterectomy Acknowledgements Forms, and any other documentation that is required by Texas Medicaid.

HHSC Administrative Appeals will send the family planning services inpatient claims to TMHP for reprocessing. Medical portions of the claims will be denied by Texas Medicaid because they are covered under the client's health plan and will not be considered for reimbursement through TMHP. The services that were denied by the health plan as family planning services will be considered for payment according to Medicaid guidelines.

Refer to: The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for Texas Medicaid guidelines for family planning services.

"Section 7: Appeals" (*Vol. 1, General Information*) for additional information about administrative appeals.

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9 Other State Health-Care Programs

The services available under the following programs are administered by TMHP or other state programs and not by the client's MCO or DMO:

- Healthy Texas Women (HTW) program - HHSC/TMHP
- HHSC Family Planning Program contracted services - HHSC/TMHP
- Medicaid Medical Transportation Program (MTP)
- CHIP Perinatal—CHIP Perinatal provides prenatal care to the unborn children of pregnant women who have an income of up to 202 percent of the federal poverty level and who are not eligible for other Medicaid programs or traditional CHIP. CHIP Perinatal covered services include prenatal care, labor with delivery, and two postpartum visits.
  - For CHIP perinates in families that have an income at or below the Medicaid eligibility threshold, facility charges associated with labor and delivery are covered by Emergency Medicaid, and professional charges associated with labor and delivery are covered by the CHIP Perinatal MCO.
  - For CHIP perinates in families that have an income above the Medicaid eligibility threshold, the facility and professional charges associated with labor with delivery are covered by the CHIP Perinatal MCO.
- Health Insurance Premium Payment (HIPP) Program—The HIPP Program reimburses clients for the cost of medical insurance premiums when Medicaid finds it more cost-effective to reimburse a Medicaid client's group health insurance premiums than to reimburse the client's medical bills directly through Medicaid.

Refer to: Subsection 6.19, "Children's Health Insurance Program (CHIP) Perinatal Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

"Section 4: Client Eligibility" (*Vol. 1, General Information*).

Subsection 4.10, "Health Insurance Premium Payment (HIPP) Program" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

Claims and authorization requests for the services listed above must be submitted according to the established guidelines.

10 Dual-Eligible Members in Managed Care

Some STAR+PLUS, STAR Kids, and STAR Health clients are eligible for both Medicare and Medicaid. These clients are called dual-eligible clients. Dual-eligible clients who enroll in Medicaid managed care programs receive most acute care services through their Medicare provider. Dual-eligible clients also receive LTSS and Medicaid-only acute care services through their Medicaid MCO. Medicaid MCOs may also provide additional services, such as value-added services.

Providers must bill:

- Medicare acute care services to the client's Medicare MCO or Medicare FFS insurer, following the rules of the Medicare insurer.
- Medicaid-covered services to the client's Medicaid MCO, following Medicaid billing rules.

If a client enrolls in both a Medicare MCO and a Medicaid MCO, the client uses the Medicare primary care provider. In this situation, the client chooses a Medicaid MCO but does not choose a Medicaid primary care provider. For Medicare-covered services, providers follow the Medicare MCO's medical management requirements, including authorization and concurrent review. For Medicaid-covered

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services, providers follow the Medicaid MCO's medical management requirements, including authorization and concurrent review. Providers must deliver Medicaid services in the same amount, duration, and scope as defined in the *Texas Medicaid Provider Procedures Manual*.

Refer to: Subsection 4.9, "Medicare and Medicaid Dual Eligibility" in "Section 4: Client Eligibility" (Vol. 1, General Information) for more information.

10.1 Medicare Advantage Dual Eligible Special Needs Plan – STAR+PLUS Only

A Dual Eligible Special Needs Plan (D-SNP) is a Medicare managed care delivery model designed for dual-eligible clients. A D-SNP:

- Provides Medicare-covered services in accordance with a contract between the D-SNP and the Centers for Medicare & Medicaid Services.
- Pays providers Medicare cost sharing for dual-eligible clients in accordance with a contract between the D-SNP and HHSC.
- Coordinates both Medicare-covered services and Medicaid-covered services for dual-eligible clients.

11 Contact Information

The following information can be used to communicate with TMHP:

Correspondence	Contact Information
All correspondence for services rendered to clients who are enrolled with a Texas Medicaid health/DMO	Contact the client's health/DMO.
Claims, authorizations, and other TMHP correspondence for transactions that are processed by TMHP.	Volume 1, "Written Communication With TMHP," for the list of post office box addresses that must be used for specific items.
HHSC contact information for clients of STAR+PLUS, STAR, STAR Kids, STAR Health, and Children's Medicaid dental services	800-252-8263
TMHP Contact Center	800-925-9126

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Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

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TEXAS
Health and Human Services

MEDICAL AND NURSING SPECIALISTS, PHYSICIANS, AND PHYSICIAN ASSISTANTS

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1 General Information

The information in this handbook is intended for Texas chiropractors, nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), certified registered nurse anesthetists (CRNA), podiatrists, geneticists, maternity service clinics, physicians, and physician assistants. The handbook provides information about Texas Medicaid's benefits, policies, and procedures.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers may also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.2, "Provider Enrollment and Responsibilities" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

For information on Advanced Practice Registered Nurses (APRNs), refer to:

Section 3, "Certified Nurse Midwife (CNM)" in this handbook.

Subsection 4.1, "Enrollment" in this handbook for information about CRNAs.

Subsection 5.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for information about geneticists.

Subsection 8.1, "Enrollment" in this handbook for information about NPs and CNSs

Section 9, "Physician" in this handbook.

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

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Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Chiropractic Manipulative Treatment (CMT)

2.1 Enrollment

To enroll in Texas Medicaid, a doctor of chiropractic medicine (DC) must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

2.2 Services, Benefits, Limitations, and Prior Authorization

CMT performed by a chiropractor licensed by the Texas State Board of Chiropractic Examiners is a benefit of Texas Medicaid.

CMT is limited to an acute condition or an acute exacerbation of a chronic condition for a maximum of 12 visits in a consecutive 12-month period, and a maximum of one visit per day. The 12-month period consists of 12 consecutive months, beginning with the date the client receives the first treatment.

If the condition persists more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute.

CMT is not a benefit of Texas Medicaid for maintenance therapy when:

- Further clinical improvement cannot reasonably be expected from continuous ongoing care.
- The chiropractic treatment becomes supportive rather than corrective in nature.

CMT may be reimbursed when billed using procedure codes 98940, 98941, or 98942.

Procedure codes 98940, 98941, and 98942 must be submitted with the AT modifier. The AT modifier is used to identify treatment provided for an acute condition or an exacerbation of a chronic condition that persists for 180 days or less from the start date of treatment. Providers may file an appeal for a claim denied beyond the 180 days of treatment with documentation supporting that further clinical improvement can be reasonably expected, maximal improvement has not been reached, and further improvement has not ceased.

Procedure code 98940 will be denied as part of another service when billed for the same date of service as 98941 or 98942 by any provider.

Procedure code 98941 will be denied as part of another service when billed for the same date of service as 98942 by any provider.

Texas Medicaid does not reimburse chiropractors for X-ray services, office visits, injections, supplies, appliances, spinalator treatments, laboratory services, physical therapy, or other adjunctive services furnished by themselves or by others under their orders or directions. Additionally, braces or supports, even though ordered by a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) and supplied by a chiropractor are not reimbursable items.

CMT is reimbursed only for a diagnosis of subluxation of the spine. The level of subluxation must be indicated by the appropriate diagnosis codes listed below:

Diagnosis Codes							
M9900	M9901	M9902	M9903	M9904	M9905	M9908	

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2.2.1 Prior Authorization

Prior authorization is not required for CMT services.

2.3 Documentation Requirements

Manipulations must be provided in accordance with an ongoing, written treatment plan that supports medical necessity of an acute condition or an acute exacerbation of a chronic condition.

Documentation that supports medical necessity for the treatment plan includes all of the following:

- Diagnosis
- Region(s) treated
- Degree of severity
- Impairment characteristics
- Physical examination findings, X-ray, or other pertinent findings
- Specific statements of short- and long-term goals
- A reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and/or the techniques utilized

The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

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

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection , "Section 6: Claims Filing" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement

The Medicaid rates for chiropractic manipulative treatment (CMT) are reimbursed in accordance with 1 TAC §355.8085. See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

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.*

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

3 Certified Nurse Midwife (CNM)

3.1 Provider Enrollment

To enroll in Texas Medicaid, a CNM must be licensed as a registered nurse and as an advanced practice registered nurse (APRN) by the Texas Board of Nursing (BON), and be authorized to practice as a nurse-midwife. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

The American Midwifery Certification Board (AMCB) is responsible for the certification requirements of CNMs.

Refer to: The HHSC website at www.healthytexaswomen.org for information about family planning and the locations of family planning clinics that receive funding from the HHSC Family Planning Program.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

A CNM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. All enrollment and re-enrollments are completed through the Provider Enrollment and Management System (PEMS). PEMS portal and upon initial enrollment and upon re-enrollment, the CNM must complete the Physician's Letter of Agreement form that affirms the CNM's referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician or group of physicians with whom an arrangement is made. This agreement must be signed by the CNM and the physician. The collaborating physician does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1252 (3), if the collaborating physician or group is not a participating provider in Texas Medicaid, the CNM must inform clients of their potential financial responsibility. If the arrangement is changed or canceled, the CNM must notify TMHP and submit a PEMS Existing Enrollment request to update the agreement within 10 business days of the change or cancellation.

CNMs are encouraged to participate in or make referrals to family planning agencies.

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Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment in Texas Medicaid.

Subsection 4.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about enrollment in the THSteps Program.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

3.1.1 Enrollment in Texas Health Steps (THSteps)

CNMs may enroll as providers of THSteps medical checkups for newborns and adolescent females.

3.2 Services, Benefits, Limitations, and Prior Authorization

CNM providers may be reimbursed for family planning, obstetrical, neonatal, and primary care services.

3.2.1 Deliveries

CNM providers may be reimbursed for procedure code 59409, 59410, 59612, or 59614 for delivery services.

Refer to: Section 4, "Obstetric Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for billing requirements.

3.2.2 Newborn Services

Routine newborn care may be reimbursed to CNM providers.

Refer to: Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 9.2.47, "Newborn Services" in this handbook for additional guidelines and limitations.

3.2.3 Prenatal and Postpartum Services

CNM and physician providers are limited to a combined total of 20 outpatient prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation should reflect the need for increased visits and is subject to retrospective review.

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity.

Postpartum care provided after discharge must be billed using procedure code 59430. Only one postpartum visit is allowed per pregnancy.

Refer to: Section 4, "Obstetric Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for billing requirements.

3.2.4 Laboratory and Radiology Services

Laboratory (including pregnancy tests) and radiology services that are rendered during pregnancy must be billed separately from prenatal care visits.

3.2.5 Prior Authorization

Prior authorization is not required for any of these services except delivery in the home. For prior authorization of a home delivery and the related supplies (procedure code S8415), the CNM must submit a written request for prior authorization during the client's third trimester of pregnancy. The CNM must include a statement signed by a licensed physician who has examined the client during the third

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trimester and determined at that time that she is not at high risk and is suitable for a home delivery. Documentation must also include a plan for access to emergency transport for mother and neonate, if needed. Requests for home delivery prior authorizations must be submitted to the TMHP Medical Director at the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

Claims submitted for home deliveries performed by a CNM without prior authorization will be denied.

3.2.6 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including CNM services.

CNM services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.2.7 Claims Filing and Reimbursement

CNMs must bill maternity services in one of two ways: itemizing each service individually on one claim form and filing at the time of delivery (the filing deadline is applied to the date of delivery) or itemizing each service individually and submitting claims as the services are rendered (the filing deadline is applied to each individual date of service).

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

When completing a CMS-1500 claim form all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

According to 1 TAC §355.8161(a), the Medicaid rate for CNMs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

> ***Note:*** *CNM providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps National Provider Identifier (NPI) as the billing provider.*

Physicians who submit a claim using the physician's own NPI for services provided by a CNM must submit modifier SB on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by a CNM if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, and injections provided by a CNM.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

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Refer to: Subsection 4.1, "General Medicaid Eligibility" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for information about crossover payments.

"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

4 Certified Registered Nurse Anesthetist (CRNA)

4.1 Enrollment

To enroll in Texas Medicaid, a CRNA must be licensed as a registered nurse (RN) and as an APRN by the Texas BON and must be currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. An RN under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as acceptable documentation of appropriate licensure and certification for enrollment.

Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. A current copy of the provider's Council on Certification of Nurse Anesthetists or Recertification of Nurse Anesthetists Certificate must be submitted with the Medicaid provider enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Services, Benefits, Limitations, and Prior Authorization

Medically necessary services that are performed by a CRNA are benefits if the services are within the scope of the CRNA's practice as defined by state law; are prescribed, supervised by, and provided under the direction of a supervising physician (MD or DO), dentist, or podiatrist licensed in the state in which they practice and to the extent allowed by state law; and are provided under one of the following conditions:

- There is no physician anesthesiologist on the medical staff of the facility where the services are provided (e.g., rural settings).
- There is no physician anesthesiologist available to provide the services, as determined by the policies of the facility in which the services are provided.
- The physician, dentist, or podiatrist who performs the procedure that requires the services specifically requests the services of a CRNA.
- The eligible client who requires the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services according to the policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

Texas Medicaid does not reimburse the CRNA for equipment, drugs, or supplies.

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Refer to: Subsection 4.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for information about drugs, equipment and supplies.

4.2.1 Prior Authorization

Services performed by a CRNA are subject to the same prior authorization guidelines as services performed by other provider types.

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the services rendered, including CRNA services. CRNA services are subject to retrospective review and recoupment if documentation does not support the service billed.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

All CRNA services must be billed with a CRNA individual NPI or a CRNA group NPI. No payment for CRNA services will be made under a hospital or physician NPI.

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

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 9.2.7.9.3, "CRNA, AA, and Other Qualified Professional Services" in this handbook for more information on billing for CRNA services.

4.4.1.1 Interpreting the R&S Report

The Billed Qty field on the Remittance and Status (R&S) Report reflects only the number of time units TMHP processes. The Relative Value Units (RVUs) assigned for the procedure code are not shown in the Billed Qty field.

4.4.2 Reimbursement

A CRNA is reimbursed the lesser of either the CRNA's billed charges or 92 percent of the reimbursement for the same service paid to a physician (M.D. or D.O.) other than an anesthesiologist in accordance with 1 TAC §355.8221. A CRNA under the supervision of an anesthesiologist is reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

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Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

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.*

Refer to: Subsection 9.2.7.8, "Reimbursement Methodology" in this handbook for more information about flat fees and time based fees.

5 Geneticists

5.1 Enrollment

5.1.1 Geneticists

Geneticists may enroll in Texas Medicaid as both a physician or physician group and as a geneticist. Enrollment as a geneticist allows enhanced reimbursement for specific procedure codes when a claim is submitted using the geneticist NPI.

A provider of genetic services that wishes to enroll in Texas Medicaid as a geneticist must complete the required Medicaid provider enrollment process through PEMS and enter into a written agreement with HHSC.

Prior to enrollment, applicant qualifications for the provision of genetic services are verified and approved by DSHS. Verification and approval are administered through the Newborn Screening Unit. Basic contract requirements are as follows:

- The provider must be a clinical geneticist (MD or DO) who is board eligible or board certified by the American Board of Medical Geneticists (ABMG).

  Note: *Board eligible providers are required to provide documentation reflecting completion of education requirements in a residency program in genetics.*

- The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of professional staff including the clinical geneticist and at least one of the following: nurse, social worker, medical geneticist, or genetic counselor.
- Upon DSHS approval, National Plan and Provider Enumeration System (NPPES) issues an NPI and a performing NPI for the provision of genetic services.
- Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

5.2 Services, Benefits, Limitations, and Prior Authorization

Genetic services may be used to diagnose a condition, optimize disease treatment, predict future disease risk, and prevent adverse drug response. Genetic services may be provided by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and typically include one or more of the following:

- Comprehensive physical exams
- Diagnosis, management, and treatment for clients with genetically-related health problems
- Evaluation of family histories for the client and the client's family members
- Genetic risk assessment

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- Genetic laboratory tests

Refer to: Section 3, "Genetic Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information.

- Interpretation and evaluation of laboratory test results
- Education and counseling of clients, their families, and other medical professionals on the causes of genetic disorders
- Consultation with other medical professionals to provide treatment

5.2.1 Family History

It is important for primary care providers to recognize potential genetic risk factors in a client so that they can make appropriate referrals to a genetic specialist.

Obtaining an accurate family history is an important part of clinical evaluations, even when genetic abnormalities are not suspected. Knowing the family history may help health-care providers identify single-gene disorders or chromosomal abnormalities that occur in multiple family members or through multiple generations. Some genetic disorders that can be traced through an accurate family history include diabetes, hypertension, certain forms of cancer, and cystic fibrosis. Early identification of the client's risk for one of these diseases can lead to early intervention and preventive measures that can delay onset or improve health conditions.

Using a genetics-specific questionnaire helps to obtain the information needed to identify possible genetic patterns or disorders. The most commonly used questionnaires are provided by the American Medical Association and include the Prenatal Screening Questionnaire, the Pediatric Clinical Genetics Questionnaire, and the Adult History Form.

5.2.2 Genetic Counseling

Any genetic testing and screening procedure must be accompanied by appropriate non-directive counseling, both before and after the procedure. Information must be provided to the client and family (if appropriate) about the possible risks and purpose and nature of the tests being performed.

Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to discuss the client's needs.

The interpretation of certain tests, such as nuchal translucency, requires additional education and experience. Texas Medicaid supports national certification standards when available.

For many heritable diseases and conditions, test performance and interpretation of test results require information about client race/ethnicity, family history, and other pertinent clinical and laboratory information. To facilitate test requests and ensure prompt initiation of appropriate testing procedures and accurate interpretation of test results, the requesting provider must be aware of the specific client information needed by the laboratory before tests are ordered.

5.2.3 Genetic Counselors

Genetic counselor services may be billed by a physician when the genetic counselor is under physician supervision and is an employee of the physician. Services provided by independent genetic counselors are not a benefit of Texas Medicaid.

5.2.4 Genetic Evaluation and Counseling by a Geneticist

A provider enrolled in Texas Medicaid as a geneticist may bill the following evaluation and management codes and receive an enhanced reimbursement. All other procedure codes must be billed under the geneticist's individual, group, or laboratory NPI.

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Procedure Code	Limitations
96041	None
99213	None
99214	None
99215	One per year, any provider
99244	One every three years, per provider
99245	One every three years, per provider
99254	One every three years, per provider
99255	One every three years, per provider
99402	One per pregnancy, per provider*
99404	One every three years, per provider
*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies a claim.**	

One office or other outpatient consultation, performed by a geneticist, (procedure code 99244 or 99245) may be considered for reimbursement if procedure code 99244, 99245, 99254, or 99255 has not been submitted by and reimbursed to that geneticist in the previous three years.

Inpatient or observation consultations, performed by a geneticist, (procedure code 99254 or 99255) may be reimbursed once every three years regardless of whether an office consultation has been reimbursed in the previous three years.

5.2.5 Prior Authorization

Prior authorization is not required for services billed by a geneticist.

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including genetic services. Genetic services are subject to retrospective review and recoupment if documentation does not support the service billed.

5.4 Claims Filing and Reimbursement

5.4.1 Claims Information

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

When completing a CMS-1500 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.

TMHP representatives are available for provider questions about genetic services, such as reimbursement rates and procedures. For more information, call the TMHP Contact Center at 1-800-925-9126.

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Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

5.4.2 Reimbursement

Genetic services providers are reimbursed according to the established allowable maximum fee schedule. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

6 Licensed Midwife (LM)

6.1 Provider Enrollment

To enroll in Texas Medicaid, an LM must be licensed as a midwife by the Texas Department of Licensing and Regulation (TDLR).

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

An LM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. All enrollment and re-enrollments are completed through the PEMS portal and upon initial enrollment and upon re-enrollment, the LM must complete the Physician's Letter of Agreement form that affirms the LM's referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician or group of physicians with whom an arrangement is made. This agreement must be signed by the LM and the physician.

If the arrangement is changed or canceled, the LM must notify TMHP and submit a PEMS Existing Enrollment request to update the agreement within 10 business days after the change or cancellation.

The referral physician or group does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1253(c), if the referral physician or group is not a participating provider in Texas Medicaid, the LM must inform clients of their potential financial responsibility.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment in Texas Medicaid.

6.2 Services, Benefits, Limitations, and Prior Authorization

LM providers may be reimbursed for obstetrical and newborn care services provided in a freestanding birthing center that is also enrolled as a Texas Medicaid provider.

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6.2.1 Deliveries

LM providers may be reimbursed for procedure code 59409 for delivery services.

Refer to: Section 4, "Obstetric Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for billing requirements.

6.2.2 Newborn Services

Newborn care procedure codes 99460 and 99463 may be reimbursed to LM providers.

Refer to: Subsection 9.2.47, "Newborn Services" in this handbook for additional guidelines and limitations.

6.2.3 Prenatal Services

LM providers must include modifier TH with the appropriate evaluation and management procedure code (99202, 99211, or 99212) for prenatal services.

LM providers are limited to a total of 20 outpatient prenatal care visits, performed in a birthing center, per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation should reflect the need for increased visits and is subject to retrospective review.

If a client is discharged before delivery, LM providers may submit procedure code 99221, 99222, or 99223 for labor services only. Clinical documentation that clearly demonstrates the level of medical decision-making (i.e., moderate or complex) must be included in the client's medical record. All medical documentation is subject to retrospective review. Services that are not supported by the medical documentation are subject to recoupment.

Refer to: Section 4, "Obstetric Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for billing requirements.

6.2.4 Prior Authorization

Prior authorization is not required for services billed by an LM.

6.2.5 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including LM services.

LM services are subject to retrospective review and recoupment if documentation does not support the service billed.

6.2.6 Claims Filing and Reimbursement

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

When completing a CMS-1500 claim form all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

According to 1 TAC §355.8161 (b), the Medicaid rate for LMs is 70 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

7 Maternity Service Clinics (MSC)

7.1 Provider Enrollment

To enroll in Texas Medicaid, MSCs must submit a complete application and meet the following requirements:

- Must be a facility that is not an administrative, organizational, or financial part of a hospital.
- Must be organized and operated to provide maternity clinic services to outpatients.
- Must comply with all applicable federal, state, and local laws and regulations.
- Must employ or have a contractual agreement or formal arrangement with a licensed MD or DO who assumes professional responsibility for the services provided to the clinic's patients.
- Must adhere to the Bureau of Maternal and Child Health Maternity Guidelines, dated June 20, 1988, and subsequent revisions issued by the Texas Department of State Health Services, unless otherwise specified by the department or its designee.
- Must ensure that services provided to each patient are commensurate with the patient's risk assessment and are documented in the patient's medical record.

The supervising physician's license information must be provided. Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days.

Medicare certification is not a prerequisite for MSC enrollment.

7.1.1 Physician Responsibility

To meet the requirement to assume professional responsibility for the services provided to the clinic's clients, the supervising physician must do the following:

- See the client at least once
- Prescribe the type of care to be provided or approve the client's plan of care (POC)
- Periodically review the need for continued care (if the services are not limited by the prescription)

The physician must base the POC on a risk assessment completed by the physician or by licensed, professional clinic staff. The assessment must be based on findings obtained through a health history, laboratory or screening services, and a physical examination.

7.1.2 Case Management Services to High-Risk Individuals

An MSC that wants to bill and receive reimbursement for case management services to high-risk individuals including infants, pregnant adolescents, and women must meet the eligibility criteria for case management services. To be considered for reimbursement for case management for these clients, the MSC must enroll as a group in Case Management for Children and Pregnant Women, and each eligible case manager must enroll as a performing provider.

Refer to: Section 3, "Case Management for Children and Pregnant Women" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for case management services provider eligibility criteria.

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7.2 Services, Benefits, Limitations, and Prior Authorization

Services billed by an MSC are those provided by a physician or by licensed, professional clinic staff and are determined to be reasonable and medically necessary for the care of a pregnant adolescent or woman during the prenatal period and subsequent 60-day postpartum period. MSC benefits do not include deliveries.

MSCs are limited to 20 prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation must reflect the need for increased visits and is subject to retrospective review.

Procedure codes in the following table are for prenatal and postpartum care visits:

Procedure Codes						
59430*	99202-TH	99203-TH	99204-TH	99205-TH	99211-TH	99212-TH
99213-TH	99214-TH	99215-TH				
*** Procedure code 59430 is not submitted with modifier TH** **Note: The prenatal visits must be billed with modifier TH**						

Providers must bill the most appropriate new or established prenatal visit code or postpartum visit code. New patient codes may be used when the client has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years (36 months).

An MSC may be reimbursed for prenatal and postpartum care visits only. Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for prenatal care and not separately reimbursed. Services other than prenatal and postpartum care visits will be denied. MSCs that are enrolled in Case Management for Children and Pregnant Women as a group may be reimbursed for these services under the group NPI assigned to their facility.

Medical services must be furnished on an outpatient basis by the physician or by licensed, professional clinic staff under the direction of the physician and must be within the staff's scope of practice or licensure as defined by state law. Although the physician does not necessarily have to be present at the clinic when services are provided, the physician must assume professional responsibility for the medical services provided at the clinic and ensure through approval of the POC that the services are medically appropriate. The physician must spend as much time in the clinic as is necessary to ensure that clients are receiving medical services in a safe and efficient manner in accordance with accepted standards of medical practice.

MSCs must follow the procedures outlined throughout this manual. All service, frequency, and documentation requirements are applicable.

Providers submitting charges for high-risk prenatal care must document the high-risk diagnosis on the claim form and document the condition in the client's medical record.

7.2.1 Initial Prenatal Care Visit Components

The following initial prenatal care visit components should be completed as early as possible in the client's pregnancy.

7.2.1.1 History

History includes OB-GYN, present pregnancy, medical and surgical, substance use, environmental, nutritional, psychosocial (including violence), and family support system.

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7.2.1.2 Physical Examination

Physical examination includes height, weight, blood pressure; head, neck, lymph, breasts, heart, lungs, back, abdomen, pelvis, rectum, extremities, and skin; and uterine size, fetal heart rate, and location.

7.2.1.3 Laboratory Tests

The initial hematocrit or hemoglobin and each subsequent hematocrit or hemoglobin is included in the visit fee and is not separately reimbursable to MSCs.

The laboratory services listed may not be billed using the MSC NPI. These services may be ordered by MSC personnel and provided by a reference laboratory.

MSCs must supply the client's Medicaid number and the MSC NPI to the reference laboratory when laboratory services are requested.

The laboratory services requested by an MSC may include, but are not limited to, the following:

- Hemoglobin, hematocrit, or complete blood count (CBC)
- Urinalysis
- Blood type and Rh
- Antibody screen
- Rubella antibody titer
- Serology for syphilis
- Hepatitis B surface antigen
- Cervical cytology
- Other laboratory tests

The following tests may be performed at the initial prenatal care visit, as indicated:

- Pregnancy test
- Gonorrhea test
- Urine culture
- Sickle cell test
- Tuberculosis (TB) test
- Chlamydia test

As stated in the Health and Safety Code §81.090, screening for Hepatitis B virus infection, HIV, and Syphilis must be performed at the initial prenatal care visit. In addition, HIV testing must be performed in the third trimester. HBV and Syphilis must be performed at labor and delivery.

Multiple marker screens for neural tube defects must be offered if the client initiates care between 16 and 20 weeks.

7.2.1.4 Assessment

Assessment includes pregnancy, general health, medical, and psychosocial.

7.2.1.5 Plan

Plan includes pregnancy, preventive health, medical, and referral as indicated.

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7.2.1.6 Education and Counseling

Education and counseling includes pregnancy, delivery, nutrition, breast-feeding, family planning, and preventive health. The education and counseling should also include the need for a medical home and information about THSteps medical and dental checkups for the client.

The complete physical examination may be completed at the second visit if the MSC's routine involves a two-stage initial evaluation.

7.2.2 Subsequent Prenatal Care Visits

The following is a recommended guide for the frequency of subsequent prenatal visits for a regular pregnancy:

- One visit every 4 weeks for the first 28 weeks of pregnancy.
- One visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy.
- One visit per week from 36 weeks to delivery.

More frequent visits may be medically necessary. Physicians, CNMs, and MSCs are limited to 20 prenatal care visits per pregnancy and 1 postpartum care visit per pregnancy after discharge from the hospital, without documentation of a complication of pregnancy.

Each subsequent visit must include the following:

- Interim History
- Problems
- Maternal status
- Fetal status

7.2.2.1 Physical Examination

The physical examination must include the following:

- Weight and blood pressure
- Fundal height, fetal position and size, and fetal heart rate
- Extremities

7.2.2.2 Laboratory Tests

Required laboratory tests include the following:

- Urinalysis for protein and glucose every visit

  Note: *The urinalysis for protein and glucose, hemoglobin, and hematocrit is included in the visit fee and is not separately reimbursable to MSCs.*

- Hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy
- Multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy
- Repeated antibody screen for Rh negative women at 28 weeks (followed by Rho immune globulin administration if indicated)
- Gestational diabetes screen at 24 to 28 weeks of pregnancy, one hour post 50 gram glucose load
- Blood sample for HBsAg screening at the first examination and visit followed by a second blood sample for HBsAg screening on admission for delivery
- Other laboratory tests as indicated by the medical condition of the client

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7.2.3 Postpartum Care Visit

Postpartum care provided by MSCs must be billed using procedure code 59430. A maximum of 1 postpartum visit is allowed per pregnancy.

Refer to: Section 4, "Obstetric Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for billing requirements.

7.2.4 Prior Authorization

Prior authorization is not required for services rendered in MSCs.

7.3 Documentation Requirements

Each client must have a complete and accepted standard medical record with documentation for the initial visit with procedures, as well as each subsequent visit with procedures. Such records must be made available when requested by HHSC or TMHP for utilization and quality assurance reviews as required by federal regulations. The documentation record or a true copy or narrative abstract must be sent to the hospital of delivery by the client's 35th week of pregnancy. The record must be made available to the client if the client transfers care to another institution. Records completed by licensed professional clinic staff under the direction of a physician must be signed by the supervising physician.

7.4 Claims Filing and Reimbursement

MSC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

MSCs are reimbursed in accordance with 1 TAC §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

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.*

8 Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)

For other APRNs, see Section 4, "Certified Registered Nurse Anesthetist (CRNA)" in this handbook for information regarding CRNAs, and Section 3, "Certified Nurse Midwife (CNM)" in this handbook for information about certified nurse midwives (CNMs).

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8.1 Enrollment

To enroll in Texas Medicaid, an NP or CNS must be licensed as a registered nurse and as an APRN by the Texas BON. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 3, "Certified Nurse Midwife (CNM)" in this handbook for more information on CNM enrollment.

Section 4, "Certified Registered Nurse Anesthetist (CRNA)" in this handbook for more information on CRNA enrollment.

APRNs may be included as primary care providers in the provider network for Medicaid and CHIP programs (both fee-for-service and managed care), regardless of whether the physician supervising the APRN is enrolled in Medicaid or in the provider network.

8.1.1 Enrollment in Texas Health Steps (THSteps)

APRNs, including NPs, and CNSs, who are recognized by the Texas BON can enroll as THSteps providers and provide checkup services within their scope of practice. Specific information is found in the Children's Services Handbook.

Refer to: Subsection 4.2.1, "THSteps Medical Provider Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on enrollment procedures.

8.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by NPs and CNSs are benefits if the services meet the following criteria:

- Are within the scope of practice for NPs and CNSs, as defined by Texas state law.
- Are consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO).
- Are reasonable and medically necessary as determined by HHSC or its designee.

NPs and CNSs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician's own NPI for services provided by an NP or CNS must submit modifier SA on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

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Benefit limitation information for services can be found in Section 9, "Physician" in this handbook, the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*), and the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Payment for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 9, "Physician" in this handbook.

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on THSteps services.

Subsection 9.3, "Collaborative Care Model (CoCM)" in this handbook for information about CoCM services.

8.2.1 Prior Authorization

Services performed by an NP or CNS are subject to the same prior authorization guidelines as services performed by other provider types.

8.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including NP and CNS services. NP and CNS services are subject to retrospective review and recoupment if documentation does not support the service billed.

8.4 Claims Filing and Reimbursement

8.4.1 Claims Information

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

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

8.4.2 Reimbursement

According to 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. When NPs or CNSs bill Medicaid directly for services they performed, they must use their individual NPI. If the services are performed by the NP or CNS but billed by a physician or physician group, the billing provider is the physician or physician group. Physicians may be reimbursed 92 percent of the established reimbursement rate for services

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provided by an NP or CNS if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, and injections provided by an NP or CNS.

Note: *NP and CNS providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps NPI as the billing provider.*

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

9 Physician

9.1 Enrollment

9.1.1 Physicians and Doctors

To enroll in Texas Medicaid to provide medical services, physicians (MD or DO), doctors of dental surgery [DDS], and doctors of podiatric medicine (DPM) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

Important: *The Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.*

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

9.2 Services, Benefits, Limitations, and Prior Authorization

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided, based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of services as described in CPT. Reimbursement may be recouped when the medical record documents a different level of service from what is submitted on the claim. The level of service provided and documented must be medically necessary, based on the clinical situation and needs of the client.

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To receive reimbursement, providers must document the following information in the client's medical record:

- The service
- The date rendered
- Pertinent information about the client's condition supporting the need for the service
- The care given

Physician services include those reasonable and medically necessary services ordered and performed by physicians or under physician supervision that are within the scope of practice of their profession as defined by state law.

9.2.1 Electronic Signatures in Prior Authorizations

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

9.2.2 Teaching Physician and Resident Physician

The roles of the teaching physician and resident physician occur in the context of an accredited graduate medical education (GME) training program.

The teaching physician is the Medicaid-enrolled physician who is professionally responsible for the particular services that were provided and are being submitted for reimbursement; the physician must be affiliated and in good standing with an accredited GME program and must possess all appropriate licensure.

Physician services must be performed personally by the teaching physician or by the person to whom the physician has delegated the responsibility. The level of supervision required may be direct or personal.

In all cases, the client's medical record must clearly document that the teaching physician provided identifiable supervision of the resident. As defined below, the supervision must be direct or personal depending on the setting and the clinical circumstances:

- Direct supervision means that the teaching physician must be in the same office, building, or facility when and where the service is provided and must be immediately available to furnish assistance and direction.
- *Personal supervision* means that the teaching physician must be physically present in the room when and where the service is being provided.

Personal supervision by the teaching physician is required during the key portions of all major surgeries and the key portions of all other physician services billed to Texas Medicaid if the immediate supervision, participation, or intervention of the supervising physician is medically prudent in order to assure the health and safety of the client. Physician services that require personal supervision may include invasive procedures and evaluation and management services that require complex medical decision making. Situations that require personal supervision include those in which:

- The clinical condition of the client is unstable or will likely become unstable during, or as a result of, the planned medical intervention.

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- The planned medical intervention, even under optimal conditions will result in a medically reasonable risk for significant morbidity or death following the procedure.
- Deviation from the expected technique at the time the procedure or service is performed presents a medically reasonable, causally-related, foreseeable risk to the patient's life or health.

This criterion applies regardless of the place of service.

The teaching physician must provide medically appropriate, identifiable direct supervision for all other services that do not require personal supervision.

The following prerequisites apply when the teaching physician submits claims for services performed, in whole or in part, by the resident physician in the inpatient hospital setting, the outpatient hospital setting, and surgical services and procedures.

Note: *When requesting services for prior authorization at patient discharge, the signature of the resident on the actual prescription is permitted as long as the Medicaid enrolled attending/supervising physician's signature appears on the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form and on any letters or documentation provided to support medical necessity. The resident's order and the Title XIX Form signed by the attending/supervising physician must be for the same service.*

9.2.2.1 Teaching Physician Prerequisites

Services provided in an outpatient setting.

All requirements for personal or direct supervision in the outpatient setting must be met for the services to qualify for reimbursement. The following tasks must be performed by the teaching physician and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement:

- Review the patient's history and physical examination.
- Confirm or revise the patient's diagnosis.
- Determine the course of treatment to be followed.
- Assure that any necessary supervision of interns or residents was provided.
- Confirm that documentation in the medical record supports the level of service provided.

Exception: *Exception for E/M services furnished in certain primary care centers. Teaching physicians that meet the primary care exception under Medicare are allowed to bill for low-level and mid-level E/M services furnished by residents in the absence of a teaching physician. Facilities that meet the primary care exception under Medicare may bill Texas Medicaid, Family Planning, or the Children with Special Health Care Needs (CSHCN) Services Program for new patient services (procedure codes 99202 and 99203) and established patient services (procedure codes 99211, 99212, and 99213).*

Note: *All services provided in an outpatient setting that do not qualify for the exception above require that the teaching physician examine the patient.*

Services provided in an inpatient setting.

For services provided in an inpatient setting, the teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient's history, review the resident's physical examination, and examine the patient no later than 36 hours after the patient's admission and before the patient's discharge.

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- Confirm or revise the patient's diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.
- Confirm that documentation in the medical record supports the level of service provided.
- A face-to-face encounter with the client on the same day as any services provided by the resident physician.

Surgical services and procedures.

The teaching surgeon is responsible for the patient's preoperative, operative, and postoperative care. The teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient's history, review the resident's physical examination, and examine the patient within a reasonable period of time after the patient's admission and before the patient's discharge.
- Confirm or revise the client's diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.

Important: *Reimbursement may be reduced, denied, or recouped if the prerequisites are not documented in the medical record. The documentation must be made in the same manner as required by federal regulations under Medicare.*

9.2.3 Substitute Physician

Physicians may bill for the service of a substitute physician who sees clients in the billing physician's practice under either a reciprocal or locum tenens arrangement.

A reciprocal arrangement is one in which a substitute physician covers for the billing physician on an occasional basis when the billing physician is unavailable to provide services. Reciprocal arrangements are limited to a continuous period no longer than 14 days and do not have to be in writing.

A locum tenens arrangement is one in which a substitute physician assumes the practice of a billing physician for a temporary period no longer than 90 days when the billing physician is absent for reasons such as illness, pregnancy, vacation, continuing medical education, or active duty in the armed forces. The locum tenens arrangement may be extended for a continuous period of longer than 90 days if the billing physician's absence is due to being called or ordered to active duty as a member of a reserve component of the armed forces. Locum tenens arrangements must be in writing.

The substitute physician must be enrolled in Texas Medicaid and must not be on the Texas Medicaid or HHSC Family Planning Program provider exclusion list. The billing provider's name, address, and NPI must appear in Block 33 of the claim form. The name and office or mailing address of the substitute physician must be documented on the claim in Block 19, *not* Block 33.

When a physician bills for a substitute physician, modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q5 modifier is used to indicate a reciprocal arrangement and the Q6 modifier is used to indicate a locum tenens arrangement.

When physicians in a group practice bill substitute physician services, the performing NPI of the physician for whom the substitute provided services must be in Block 24J.

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Physicians must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation as detailed above will be subject to recoupment.

9.2.4 Aerosol Treatment

Nebulized aerosol treatments (procedure codes 94640, 94644, and 94645) with short-acting beta-agonists are a benefit of Texas Medicaid and considered medically necessary when breathing is compromised by certain acute medical conditions. Documentation to support an aerosol treatment for the worsening of an acute or chronic condition must be maintained in the client's medical record and is subject to retrospective review.

Procedure code 94645 is only a benefit in the outpatient setting, specifically in a hospital emergency department or an urgent care clinic.

Pulse oximetry and evaluation of the client's use of an aerosol generator, nebulizer, or metered-dose inhaler are considered part of an evaluation and management (E/M) visit and will not be reimbursed separately.

Hypertonic saline used in aerosol therapy will be denied if billed separately.

Refer to: Subsection 4.2.20.1, "Aerosol Treatment" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.4.1 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement (procedure code 95012) is a benefit for Texas Medicaid.

FeNO measurement provided in the physician's office is considered medically necessary as an adjunct to the established clinical and laboratory assessments for diagnosing and assessing asthma, predicting exacerbations, and evaluating the response of a client who has asthma to anti-inflammatory therapy. FeNO measurement may be reimbursed by Texas Medicaid when the test is used as follows:

- To assist in assessing the etiology of respiratory symptoms.
- To help identify the eosinophilic asthma phenotype.
- To assess potential response or failure to respond to anti-inflammatory agents, particularly inhaled corticosteroids (ICS).
- To establish a baseline FeNO during non-exacerbations for subsequent monitoring of chronic persistent asthma.
- To guide changes in dosing of anti-inflammatory medications, i.e., step-down dosing, step-up dosing, or discontinuation of anti-inflammatory medications.
- To assist in the evaluation of adherence to anti-inflammatory medications.
- To assess whether airway inflammation is contributing to respiratory symptoms.

The technical and interpretation components of procedure code 95012 will not be reimbursed separately, as the instrument produces an exhaled nitric oxide (NO) measurement that requires little interpretation. Procedure code 95012 will be limited to once per day and must be submitted with procedure code 94010 or 94060.

If FeNO is measured during an office visit where additional E/M components are fulfilled, a separate E/M procedure code may be reimbursed if it is submitted with modifier 25.

9.2.5 Allergy Services

Texas Medicaid uses the following guidelines for reimbursement of allergy services.

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9.2.5.1 * Allergy Immunotherapy

Allergen immunotherapy consists of the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.

Preparation of the allergy vial or extracts is a benefit of Texas Medicaid when preparations are made in accordance with the American Academy of Allergy, Asthma, and Immunology. Claims for preparations should be submitted using the following procedure codes:

Procedure Codes for Preparation of Allergy Vial or Extract									
95145	95146	95147	95148	95149	95165	95170			

Administration of the allergy extract may be reimbursed using procedure codes 95115 and 95117.

Rapid desensitization may be reimbursed using procedure code 95180 when submitted with one of the following diagnosis codes:

Diagnosis Codes							
Z516	Z880	Z881	Z882	Z883	Z884	Z885	Z886
Z887	Z888	Z889	Z91010	Z910110	Z910111	Z910112	Z910120
Z910121	Z910122	Z91013	Z91018	Z9102	Z91030	Z91038	Z91040
Z91041	Z91048	Z9109					

Allergen immunotherapy is a benefit for clients who have allergy conditions when the following criteria are met:

- A diagnosed hypersensitivity to an allergen can be indicated by one of the valid diagnosis codes listed below.
- Hypersensitivity cannot be managed by avoidance or pharmacologic therapy to control allergic symptoms, or the client has unacceptable side effects with pharmacologic therapy.
- The pharmacologic treatment is refused by the client or leads to significant side effects.
- The allergen content is based on appropriate skin testing, and the allergens are prepared for the client individually.

The preparation of the allergy vial or extract and the administration of an injection may be reimbursed for the following diagnosis codes:

[Revised] Diagnosis Codes							
B4481	B552	D690	G43009	G43019	G43109	G43119	G43409
G43419	G43509	G43519	G43609	G43619	G43709	G43719	G43809
G43819	G43829	G43839	G43909	G43919	G43A0	G43A1	G43B0
G43B1	G43C0	G43C1	G43D0	G43D1	G43E01	G43E09	G43E11
G43E19	H01111	H01112	H01113	H01114	H01115	H01116	H01119
H10011	H10012	H10013	H10019	H10021	H10022	H10023	H10029
H1010	H1011	H1012	H1013	H10231	H10232	H10233	H10239
H1030	H1031	H1032	H1033	H10401	H10402	H10403	H10409
H10411	H10412	H10413	H10419	H10421	H10422	H10423	H10429
H10431	H10432	H10433	H1044	H1045	H10501	H10502	H10503
H10509	H10511	H10512	H10513	H10519	H10521	H10522	H10523

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[Revised] Diagnosis Codes							
H10529	H10531	H10532	H10533	H10539	H1089	H109	H11421
H11422	H11423	H11429	H16261	H16262	H16263	H16269	H6500
H6501	H6502	H6503	H6504	H6505	H6506	H6507	H65111
H65112	H65113	H65114	H65115	H65116	H65117	H65119	H65191
H65192	H65193	H65194	H65195	H65196	H65197	H65199	H6520
H6521	H6522	H6523	H6530	H6531	H6532	H6533	H65411
H65412	H65413	H65419	H65491	H65492	H65493	H65499	H6590
H6591	H6592	H6593	H68001	H68002	H68003	H68009	H68011
H68012	H68013	H68019	H68021	H68022	H68023	H68029	H6981
H6982	H6983	J200	J201	J202	J203	J204	J205
J206	J207	J208	J209	J210	J211	J218	J219
J300	J301	J302	J305	J3081	J3089	J309	J310
J320	J321	J322	J323	J324	J328	J393	J440
J441	J4481	J4489	J449	J4520	J4521	J4522	J4530
J4531	J4532	J4540	J4541	J4542	J4550	J4551	J4552
J45901	J45902	J45909	J45990	J45991	J45998	J670	J671
J672	J673	J674	J675	J676	J677	J678	J679
J8281	J8283	J8289	K0855	L200	L2081	L2082	L2084
L2089	L209	L230	L231	L232	L233	L234	L235
L236	L237	L2381	L2389	L239	L240	L241	L242
L243	L244	L245	L246	L247	L2481	L2489	L249
L250	L251	L252	L253	L254	L255	L258	L259
L272	L279	L2989	L299	L300	L301	L302	L303
L304	L305	L308	L309	L500	L508	L509	L550
L551	L552	L559	L560	L561	L562	L563	L564
L565	L568	L570	L571	L572	L573	L574	L575
L578	L579	L580	L581	L589	L719	M041	M042
M043	M048	M049	R21	T50995A	T531X4A	T531X4D	T531X4S
T532X4A	T532X4D	T532X4S	T533X4A	T533X4D	T533X4S	T534X4A	T534X4D
T534X4S	T536X4A	T536X4D	T536X4S	T59812A	T59812D	T59812S	T63001A
T63001D	T63001S	T63002A	T63002D	T63002S	T63003A	T63003D	T63003S
T63004A	T63004D	T63004S	T63011A	T63011D	T63011S	T63012A	T63012D
T63012S	T63013A	T63013D	T63013S	T63014A	T63014D	T63014S	T63021A
T63021D	T63021S	T63022A	T63022D	T63022S	T63023A	T63023D	T63023S
T63024A	T63024D	T63024S	T63031A	T63031D	T63031S	T63032A	T63032D
T63032S	T63033A	T63033D	T63033S	T63034A	T63034D	T63034S	T63041A
T63041D	T63041S	T63042A	T63042D	T63042S	T63043A	T63043D	T63043S
T63044A	T63044D	T63044S	T63061A	T63061D	T63061S	T63062A	T63062D
T63062S	T63063A	T63063D	T63063S	T63064A	T63064D	T63064S	T63071A
T63071D	T63071S	T63072A	T63072D	T63072S	T63073A	T63073D	T63073S

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[Revised] Diagnosis Codes							
T63074A	T63074D	T63074S	T63081A	T63081D	T63081S	T63082A	T63082D
T63082S	T63083A	T63083D	T63083S	T63084A	T63084D	T63084S	T63091A
T63091D	T63091S	T63092A	T63092D	T63092S	T63093A	T63093D	T63093S
T63094A	T63094D	T63094S	T63111A	T63111D	T63111S	T63112A	T63112D
T63112S	T63113A	T63113D	T63113S	T63114A	T63114D	T63114S	T63121A
T63121D	T63121S	T63122A	T63122D	T63122S	T63123A	T63123D	T63123S
T63124A	T63124D	T63124S	T63191A	T63191D	T63191S	T63192A	T63192D
T63192S	T63193A	T63193D	T63193S	T63194A	T63194D	T63194S	T632X1A
T632X1D	T632X1S	T632X2A	T632X2D	T632X2S	T632X3A	T632X3D	T632X3S
T632X4A	T632X4D	T632X4S	T63301A	T63301D	T63301S	T63302A	T63302D
T63302S	T63303A	T63303D	T63303S	T63304A	T63304D	T63304S	T63311A
T63311D	T63311S	T63312A	T63312D	T63312S	T63313A	T63313D	T63313S
T63314A	T63314D	T63314S	T63321A	T63321D	T63321S	T63322A	T63322D
T63322S	T63323A	T63323D	T63323S	T63324A	T63324D	T63324S	T63331A
T63331D	T63331S	T63332A	T63332D	T63332S	T63333A	T63333D	T63333S
T63334A	T63334D	T63334S	T63391A	T63391D	T63391S	T63392A	T63392D
T63392S	T63393A	T63393D	T63393S	T63394A	T63394D	T63394S	T63411A
T63411D	T63411S	T63412A	T63412D	T63412S	T63413A	T63413D	T63413S
T63414A	T63414D	T63414S	T63421A	T63421D	T63421S	T63422A	T63422D
T63422S	T63423A	T63423D	T63423S	T63424A	T63424D	T63424S	T63431A
T63431D	T63431S	T63432A	T63432D	T63432S	T63433A	T63433D	T63433S
T63434A	T63434D	T63434S	T63441A	T63441D	T63441S	T63442A	T63442D
T63442S	T63443A	T63443D	T63443S	T63444A	T63444D	T63444S	T63451A
T63451D	T63451S	T63452A	T63452D	T63452S	T63453A	T63453D	T63453S
T63454A	T63454D	T63454S	T63461A	T63461D	T63461S	T63462A	T63462D
T63462S	T63463A	T63463D	T63463S	T63464A	T63464D	T63464S	T63481A
T63481D	T63481S	T63482A	T63482D	T63482S	T63483A	T63483D	T63483S
T63484A	T63484D	T63484S	T63511A	T63511D	T63511S	T63512A	T63512D
T63512S	T63513A	T63513D	T63513S	T63514A	T63514D	T63514S	T63591A
T63591D	T63591S	T63592A	T63592D	T63592S	T63593A	T63593D	T63593S
T63594A	T63594D	T63594S	T63611A	T63611D	T63611S	T63612A	T63612D
T63612S	T63613A	T63613D	T63613S	T63614A	T63614D	T63614S	T63621A
T63621D	T63621S	T63622A	T63622D	T63622S	T63623A	T63623D	T63623S
T63624A	T63624D	T63624S	T63631A	T63631D	T63631S	T63632A	T63632D
T63632S	T63633A	T63633D	T63633S	T63634A	T63634D	T63634S	T63691A
T63691D	T63691S	T63692A	T63692D	T63692S	T63693A	T63693D	T63693S
T63694A	T63694D	T63694S	T63711A	T63711D	T63711S	T63712A	T63712D
T63712S	T63713A	T63713D	T63713S	T63714A	T63714D	T63714S	T63791A
T63791D	T63791S	T63792A	T63792D	T63792S	T63793A	T63793D	T63793S
T63794A	T63794D	T63794S	T63811A	T63811D	T63811S	T63812A	T63812D

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[Revised] Diagnosis Codes							
T63812S	T63813A	T63813D	T63813S	T63814A	T63814D	T63814S	T63821A
T63821D	T63821S	T63822A	T63822D	T63822S	T63823A	T63823D	T63823S
T63824A	T63824D	T63824S	T63831A	T63831D	T63831S	T63832A	T63832D
T63832S	T63833A	T63833D	T63833S	T63834A	T63834D	T63834S	T63891A
T63891D	T63891S	T63892A	T63892D	T63892S	T63893A	T63893D	T63893S
T63894A	T63894D	T63894S	T6391XA	T6391XD	T6391XS	T6392XA	T6392XD
T6392XS	T6393XA	T6393XD	T6393XS	T6394XA	T6394XD	T6394XS	T65824A
T65824D	T65824S	T7801XA	T7801XD	T7801XS	T78070A	T78070D	T78070S
T78071A	T78071D	T78071S	T78079A	T78079D	T78079S	T78080A	T78080D
T78080S	T78081A	T78081D	T78081S	T78089A	T78089D	T78089S	T78110A
T78110D	T78110S	T78111A	T78111D	T78111S	T78119A	T78119D	T78119S
T78120A	T78120D	T78120S	T78121A	T78121D	T78121S	T78129A	T78129D
T78129S	T7819XA	T7819XD	T7819XS	T782XXA	T782XXD	T782XXS	T783XXA
T783XXD	T783XXS	T7840XA	T7840XD	T7840XS	T7849XA	T7849XD	T7849XS
T8062XD	T8062XS	T8069XD	T8069XS	T886XXA	T886XXD	T886XXS	

9.2.5.1.1 Prior Authorization for Allergy Immunotherapy

Authorization is not required for immunotherapy services; however, requests for services beyond the established limits of 160 doses per one-year period for procedure code 95165 may be considered for prior authorization with documentation of medical necessity. Documentation must be submitted to the Special Medical Prior Authorization Department and include the following information:

- Copy of the allergen testing results
- Severity and periodicity of symptoms
- Physical limitations created by the symptoms
- Concurrent drug treatment
- Explanation of how efficacy has not been achieved with prior treatment and the objectives of the new anticipated treatment program

9.2.5.1.2 Limitations of Allergy Immunotherapy

The quantity billed for the allergy extract preparation procedure must represent the total number of doses to be administered from the vial. If the number of doses is not stated on the claim, a quantity of one is allowed.

> ***Note:*** *A "dose" is defined as the amount of antigen(s) administered in a single injection from a multidose vial.*

Procedure code 95165 is limited to a total of 160 doses per one-year period, which begins the date the immunotherapy is initiated. Additional doses may be considered for reimbursement through prior authorization with documentation of medical necessity. Procedure code 95165 is limited to no more than ten doses per vial.

When an injection is given from a vial, providers should use an administration-only procedure code (95115 or 95117). Reimbursement for the administration is limited to one per day.

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An office visit, clinic visit, or treatment visit is not considered for reimbursement in addition to the fee for the preparation or the administration of the allergy vial or extract unless the additional visit results in a non-allergy-related diagnosis or a re-evaluation of the client's condition. The following E/M procedure codes may be submitted with modifier 25:

Procedure Codes									
99202	99203	99204	99205	99211	99212	99213	99214	99215	

Allergen immunotherapy that is considered experimental, investigational, or unproven is not a benefit of Texas Medicaid.

Single dose vials are not a benefit of Texas Medicaid.

Refer to: Subsection 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about outpatient hospital revenue codes for clinic visits, treatment rooms, and observation services.

9.2.5.2 Allergy Testing

Texas Medicaid benefits include allergy testing for clients with clinically significant allergic symptoms. Allergy testing is focused on determining the allergens that cause a particular reaction and the degree of the reaction. Allergy testing also provides justification for recommendations of particular medicines, of immunotherapy, or of specific avoidance measures in the environment.

Evaluation and management (E/M) procedure codes will not be reimbursed in addition to allergy testing on the same day by the same provider, unless they are submitted with modifier 25.

Modifier 25 must be present for both to be reimbursed. Modifier 25 indicates that a significant, separately identifiable E/M service was performed by the same provider on the same date of service as the allergy testing. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

If modifier 25 is not submitted with documentation of a significant, separately identifiable service the allergy testing will be reimbursed, and the E/M procedure code will be denied as part of another procedure on the same day.

The following allergy tests are benefits of Texas Medicaid:

- Percutaneous and intracutaneous skin test. The skin test for IgE-mediated disease with allergenic extracts is used in the assessment of allergy-prone clients. The test involves the introduction of small quantities of test allergens below the epidermis. Procedure codes 95004, 95017, 95018, 95024, 95027, and/or 95028 should be used to submit skin tests for consideration of reimbursement.
- *Patch or application tests*. Patch testing (procedure code 95044) is used for diagnosing contact allergic dermatitis.
- *Photo or photo patch skin test*. Procedure codes 95052 and 95056 may be used for diagnosing contact allergic dermatitis.
- *Ophthalmic mucous membrane or direct nasal mucous membrane tests*. Direct nasal or ophthalmic mucous membrane tests (procedure codes 95060 and 95065) are used for the diagnosis of either food or inhalant allergies and involve the direct administration of the allergen to the mucosa.
- *Inhalation bronchial challenge testing (not including necessary pulmonary function tests)*. Bronchial challenge testing with methacholine, histamine, or allergens (procedure code 95070) is used for defining asthma or airway hyperactivity when skin testing results are not consistent with the client's medical history. Results of these tests are evaluated by objective measures of pulmonary function.

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The number of allergy tests performed must be indicated on the claim. When the number of tests is not specified, a quantity of one is allowed.

9.2.5.2.1 Allergy Blood Tests

Allergy blood testing procedure codes 86001, 86003, 86005, and 86008 are a benefit when the test is performed for a reason that includes, but is not limited to, the following:

- The client is unable to discontinue medications
- An allergy skin test is inappropriate for the client for the following reasons:
  - The client is pediatric
  - The client is disabled
  - The client suffers from a skin condition such as dermatitis

Radioallergosorbent tests (RAST) and multiple allergosorbent tests (MAST) are benefits of Texas Medicaid. RAST testing is used to detect specific allergens. RAST testing is usually performed by an independent lab; however, there are physicians who have the capability of performing these tests in their offices. Physicians who submit RAST/MAST tests performed in the office setting must use modifier SU to be considered for reimbursement. Without the use of the SU modifier, RAST/MAST testing submitted with POS 1 (office) is denied with the message, "Lab performed outside of office must be billed by the performing facility."

RAST/MAST tests must be submitted using procedure codes 86003, 86005, and 86008.

Procedure code 86001 is limited to 20 allergens per rolling year, any provider.

Procedure code 86003 and 86008 are limited to 30 allergens per rolling year, any provider.

Procedure code 86005 is limited to 4 multiallergen tests per rolling year, same provider.

9.2.5.2.2 Collagen Skin Test

Collagen skin tests are a benefit of Texas Medicaid using procedure code Q3031. Collagen skin tests are administered to detect a hypersensitivity to bovine collagen. This skin test is given four weeks prior to any type of surgical procedure that utilizes collagen.

Collagen injections that are used for cosmetic surgery are not considered medically necessary and are not a benefit of Texas Medicaid.

9.2.5.2.3 Prior Authorization

Prior authorization is required for collagen skin test procedure code Q3031.

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department.

Prior authorization is required for procedure codes 86001, 86003, and 86005 only if the limits are exceeded. The following medical documentation must be submitted to the SMPA Department with the prior authorization request for additional procedures:

- Results of any previous treatment
- Documentation that explains why the client's treatment could not be completed within the policy limits for the requested procedures
- Client diagnosis and conditions that support the medical necessity for the additional procedures requested
- Client outcomes that the requested procedures will achieve

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Procedure code 95199 may be used for an unlisted allergy or clinical immunologic service or procedure if there is not a specific procedure code that describes the service performed. Prior authorization is required for unlisted procedure codes. Every effort must be used to bill with the appropriate CPT code that describes the procedure being performed. If a code does not exist to describe the service performed, prior authorization may be requested using unlisted procedure code 95199 and must be submitted with documentation to assist in determining coverage.

The documentation submitted must include all of the following:

- The client's diagnosis
- Medical records indicating prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A CPT or HCPCS procedure code that is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- Place of service (POS) the procedure is to be performed
- The physician's intended fee for this procedure

9.2.5.2.4 Ingestion Challenge Test

Ingestion challenge tests are a benefit of Texas Medicaid using procedure codes 95076 and 95079.

Procedure code 95076 is limited to one service per day, any provider.

Procedure code 95079 is limited to twice per day, any provider.

Add-on procedure code 95079 must be billed with primary procedure code 95076.

9.2.6 Ambulance Transport Services - Nonemergency

Nonemergency ambulance services require prior authorization in circumstances not involving an emergency. Facilities and other providers must request and obtain prior authorization before contacting the ambulance provider for nonemergency ambulance services.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

Subsection 2.2.3, "Nonemergency Ambulance Transport Services" in the *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about ambulance services.

Subsection 5.1.8, "Prior Authorization for Nonemergency Ambulance Transport" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about nonemergency ambulance transport prior authorization.

9.2.7 Anesthesia

Anesthesia services are a benefit of Texas Medicaid with specific benefits and limitations to reimbursement.

Medicaid may reimburse anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs) for administering anesthesia as defined within their individual scope of practice.

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9.2.7.1 Medical Direction by an Anesthesiologist

Medical direction by an anesthesiologist of an anesthesia practitioner (CRNA, AA, or other qualified professional) is a benefit of Texas Medicaid if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.
- The anesthesiologist is physically present in the operating suite.

Exception: *Anesthesiologists may be considered for reimbursement when they medically direct more than four anesthesia services or simultaneously supervise a combination of more than four CRNAs, AAs, or other qualified professionals under emergency circumstances only.*

Medical direction provided by an anesthesiologist is a benefit of Texas Medicaid if the following criteria are met:

- The anesthesiologist performs a preanesthetic examination and evaluation.
- The anesthesiologist prescribes the anesthesia plan.
- The anesthesiologist personally participates in the critical portions of the anesthesia plan, including induction and emergence.
- The anesthesiologist ensures that a qualified professional can perform the procedures in the anesthesia plan that the anesthesiologist does not perform personally.
- The anesthesiologist monitors the course of anesthesia administration at intervals.
- The anesthesiologist provides direct supervision when medically directing an anesthesia procedure. Direct supervision means the anesthesiologist must be immediately available to furnish assistance and direction.
- The anesthesiologist provides postanesthesia care.

The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist who directs the administration of no more than four anesthesia procedures may provide the following without affecting the eligibility of the medical direction services:

- Address an emergency of short duration in the immediate area
- Administer an epidural or caudal anesthetic to ease labor pain
- Provide periodic, rather than continuous, monitoring of an obstetrical patient
- Receive clients entering the operating suite for the next surgery
- Check or discharge clients in the recovery room
- Handle scheduling matters

As noted above, an anesthesiologist may concurrently medically direct up to four anesthesia procedures. Concurrency is defined as the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicaid client. For example, if three procedures are medically directed but only two involve Medicaid clients, the Medicaid claims must be billed as concurrent medical direction of three procedures.

For medical direction, the anesthesiologist must document in the client's medical record that he or she did the following:

- Performed the pre-anesthetic exam and evaluation.
- Provided indicated post-anesthesia care.
- Was present during the critical and key portions of the anesthesia procedure, including, if applicable, induction and emergence.

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- Was present during the anesthesia procedure to monitor the client's status.

The following information must be available to state agencies upon request and is subject to retrospective review:

- The name of each CRNA, AA, or other qualified professional that was concurrently medically directed or supervised and a description of the procedure that was performed must be documented and maintained.
- Signatures of the anesthesiologist, CRNA, AA, or other qualified professional involved in administering anesthesia services must be documented in the client's medical record.

9.2.7.2 Anesthesia for Sterilization

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for the complete list of family planning diagnosis codes.

Subsection 2.2.8, "Sterilization and Sterilization-Related Procedures" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about FQHCs and billing the annual family planning examination for Title XIX clients.

9.2.7.3 Anesthesia for Labor and Delivery

Providers must bill the most appropriate procedure code for the service provided. Other time-based procedure codes cannot be submitted if either 01960 or 01967 is the most appropriate procedure code.

The following procedure codes must be used for obstetrical anesthesia:

Procedure Codes									
01960	01961	01963	01967	01968	01969				

Procedure codes 01960 and 01967 are limited to once every 210 days when billed by any provider and are reimbursed a flat fee. The time reported must be in minutes. Providers should refer to the definition of time in the CPT manual in the "Anesthesia Guidelines—Time Reporting" section.

Procedure code 01968 or 01969 may be considered for reimbursement when submitted with procedure code 01967. For a Cesarean delivery following a planned vaginal delivery, the anesthesia administered during labor must be billed with procedure code 01967 and must indicate the time in minutes that represents the time between the start and stop times for the procedure. The additional anesthesia services administered during the operative session for a Cesarean delivery must be submitted using procedure code 01968 or 01969 and must indicate the time spent administering the epidural and the actual face-to-face time spent with the client. The insertion and injection of the epidural are not considered separately for reimbursement.

All time must be documented in block 24D of the claim form or the appropriate field of the chosen electronic format.

For continuous epidural analgesia procedure codes, Texas Medicaid reimburses providers for the time when the physician is physically present and monitors the continuous epidural. Reimbursable time refers to the period between the catheter insertion and when the delivery commences.

9.2.7.4 Anesthesia Provided by the Surgeon (Other Than Labor and Delivery)

Local, regional, or general anesthesia provided by the operating surgeon is not reimbursed separately from the surgery. A surgeon billing for a surgery will not be reimbursed for the anesthesia when billing for the surgery, even when using the CPT modifier 47. The anesthesia service is included in the global surgical fee.

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9.2.7.5 Complicated Anesthesia

The following procedure codes may be reimbursed in addition to an anesthesia procedure or service: 99100, 99116, 99135, and 99140. Documentation supporting the medical necessity for use of the procedure codes may be subject to retrospective review.

Procedure code 99140 is not reimbursed for diagnosis code O80 or O82 when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the complicating condition. An emergency is defined as existing when delay in treatment of the client would lead to a significant increase in the threat to life or body part.

9.2.7.6 Multiple Procedures

When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items.

When billing for multiple anesthesia services performed on the same day or during the same operative session, use the procedure code with the higher RVU. For accurate reimbursement, apply the total minutes and dollars for all anesthesia services rendered on the higher RVU code. Multiple services reimbursement guidelines apply.

9.2.7.7 Monitored Anesthesia Care

Monitored anesthesia care may include any of the following:

- Intraoperative monitoring by an anesthesiologist or qualified professional under the medical direction of an anesthesiologist
- Monitoring of the client's vital physiological signs in anticipation of the need for general anesthesia
- Monitoring of the client's development of an adverse physiological reaction to a surgical procedure

Anesthesiologists, CRNAs, AAs, or other qualified professionals may use modifier QS to report monitored anesthesia care.

The QS modifier is an informational modifier.

9.2.7.8 Reimbursement Methodology

There are two types of reimbursement for anesthesia procedure codes.

- Flat fee
- Time-based fees, which require documentation of the exact amount of face-to-face time with the client

Anesthesiologists directing one or multiple CRNAs and/or AAs during medical procedures will be reimbursed at 50 percent of the established reimbursement rate.

An AA under the supervision of an anesthesiologist is reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

If multiple CRNAs, anesthesiologists, or anesthesiologist assistants under anesthesiologist supervision are providing anesthesia services for a client, only one CRNA or AA and one anesthesiologist may be reimbursed.

Both the flat-fee and time-based-fee procedure codes must be submitted with modifiers and are subject to medical direction/supervision reimbursement adjustments.

Flat Fees

Both OB related anesthesia procedure codes 01960 and 01967 are considered for reimbursement with a flat-fee rate.

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- Flat fees are subject to medically-directed modifier combination adjustments based on the modifier submitted with the anesthesia procedure code.
- The time-based add-on procedure code 01968 must be billed in addition to the flat fee when anesthesia for Cesarean delivery following neuraxial labor analgesia/anesthesia has occurred.

For flat-fee anesthesiology codes, anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance, that is, when the client may be safely placed under postoperative supervision.

Time-Based Fees

For time-based anesthesiology procedure codes, anesthesia time is the time during which an anesthesia practitioner is present with the client. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance (e.g., when the client may be safely placed under postoperative supervision).

For time-based anesthesiology codes, anesthesia practitioners must document interruptions in anesthesia time in the client's medical record.

The documented time must be the same in the records or claims of the anesthesiologist and other anesthesia practitioners who were medically directed by the anesthesiologist.

One time unit is equal to 15 minutes of anesthesia. Providers must submit the total anesthesia time in minutes on the claim. The claims administrator will convert total minutes to time units.

Reimbursement of time-based anesthesia services is derived by adding the RVUs (e.g., base units) for the procedures performed (when multiple procedures are performed use the procedure with the highest RVUs) to the total face-to-face anesthesia time in minutes divided by 15 minutes, multiplied by the appropriate conversion factor:

[RVUs + (Minutes / 15] x Conversion Factor = Anesthesia Reimbursement

Provider Type Description - Physician Pricing Example				
Time: 120 minutes	=	120/15	=	8 (quantity billed)
Procedure code: 00851	=	(6 RVUs) 6.00 + 8	=	14.00
Conversion factor: $19.58	=	14.00 x 19.58	=	$274.12 (physician reimbursement)

Conversion Factor

A conversion factor is the multiplier that transforms relative values into payment amounts. There is a standard conversion factor for anesthesia services.

9.2.7.9 Anesthesia Modifiers

Each anesthesia procedure code must be submitted with the appropriate anesthesia modifier combination whether billing as the sole provider or for the medical direction of CRNAs, AAs, or other qualified professionals.

When an anesthesia procedure is billed without the appropriate reimbursement modifiers or is billed with modifier combinations other than those listed below in the Modifier Combinations section, the claim will be denied.

A procedure billed with a modifier indicating that the anesthesia was personally performed by an anesthesiologist (modifier AA) will be denied if another claim has been paid indicating the service was personally performed by, and reimbursed to, a CRNA (modifier QZ) for the same client, date of service,

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and procedure code. The opposite is also true—a CRNA-administered procedure will be denied if a previous claim was paid to an anesthesiologist for the same client, date of service, and procedure code. Denied claims may be appealed with supporting documentation of any unusual circumstances.

9.2.7.9.1 State-Defined Modifiers

Modifiers U1 (indicating one Medicaid claim billed by an anesthesia practitioner) and U2 (indicating two Medicaid claims) are state-defined modifiers that must be billed by an anesthesiologist, CRNA, AA, or other qualified professional.

Modifier U1, indicating that only one Medicaid claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two Medicaid claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

Anesthesia providers must submit modifier U1 or U2 in combination with an appropriate pricing modifier (AA, GC, QY, QK, AD, QZ, QX) when billing for any payable anesthesia procedure codes.

9.2.7.9.2 Modifier Combinations

When a single claim per client is billed by the anesthesiologist for personally performing the anesthesia service, the AA and U1 modifier combination must be billed together.

Anesthesiologists may be reimbursed for medical direction of CRNAs, AAs, or other qualified professional by using one of the following modifier combinations:

Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
Anesthesiologist Directing Other Qualified Professionals		
QY and U1	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one CRNA, AA, or other qualified professional, the QY + U1 modifier combination must be billed together when the CRNA, AA, or qualified professional are a part of a clinic/group.	Only the anesthesiologist
AA, U1, and GC	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one resident physician. ***Note:*** *For procedure code 01967 medical supervision of resident physicians rather than medical direction is required, however, modifiers AA-U1-GC must still be noted on the claim.*	Only the anesthesiologist
QK and U1	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals.	Only the anesthesiologist

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Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
AD and U1 (Emergency circumstances only)	When a single claim per client is billed by the anesthesiologist for medical supervision of anesthesia services for more than four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.	Only the anesthesiologist
Anesthesiologist Directing CRNAs or AAs		
QY and U2	When two claims per client are billed, one by the medically directing anesthesiologist and one by the CRNA, AA, or other qualified professional.	Both the anesthesiologist and CRNA, AA, or other qualified professional
QK and U2	When two claims per client are billed for medically directed anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals.	Both the anesthesiologist and CRNA, AA, or other qualified professional
AD and U2 (Emergency circumstances only)	When two claims per client are billed for the medical supervision of more than four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.	Both the anesthesiologist and CRNA, AA, or other qualified professional

9.2.7.9.3 CRNA, AA, and Other Qualified Professional Services

Modifiers QZ and U1 must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the physician.

Modifiers QX and U2 must be submitted by a CRNA, AA, or other qualified professional who provided services under the medical direction of an anesthesiologist.

9.2.7.10 Prior Authorization for Anesthesia

9.2.7.10.1 Anesthesia for Medical Services

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

9.2.7.11 Claims Filing

Texas Medicaid reimburses anesthesiologists based on the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 paper claim form).
- Person (physician, CRNA, or AA) administering anesthesia (modifiers must be used to designate this provider type).

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- Time in minutes.
- Any other appropriate modifier (refer to subsection 6.3.5, "Modifiers" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for a list of the most common modifiers).

9.2.7.12 Anesthesia (General) for THSteps Dental

Refer to: Section 3, "Texas Health Steps (THSteps) Dental" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information.

9.2.8 Bariatric Surgery

Bariatric surgery is considered medically necessary when used as a means to treat covered medical conditions that are caused or significantly worsened by the client's obesity in cases where those comorbid conditions cannot be adequately treated by standard measures unless significant weight reduction takes place. The pathophysiology of the covered comorbid conditions must be sufficiently severe that the expected benefits of weight loss subsequent to this surgery significantly outweigh the risks associated with bariatric surgery.

The following procedure codes may be reimbursed for medically necessary bariatric surgery services with prior authorization: 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, and 43888.

Bariatric surgery is not a benefit when the primary purpose of the surgery is any of the following:

- For weight loss for its own sake
- For cosmetic purposes
- For reasons of psychological dissatisfaction with personal body image
- For the client's or provider's convenience or preference

9.2.8.1 Prior Authorization for Bariatric Surgery

All clients must meet the criteria outlined below.

The same contraindications exist for bariatric surgery as for any other elective abdominal surgery. Documentation provided for prior authorization must attest that none of the following additional contraindications exist:

- Endocrine cause for obesity, inflammatory bowel disease, chronic pancreatitis, cirrhosis, portal hypertension, or abnormalities of the gastrointestinal tract
- Chronic, long-term steroid treatment
- Pregnant, or plans to become pregnant within 18 months
- Noncompliance with medical treatment
- Significant psychological disorders that would be exacerbated or interfere with the long-term management of the client after the operation
- Active malignancy

All clients must undergo preoperative psychological evaluation by a behavioral health provider and have clearance for surgery if any of the following conditions exist:

- They have a history of psychiatric or psychological disorders.
- They are currently under the care of a psychologist or psychiatrist.
- They are on psychotropic medications.

The client's medical record must include documentation of the evaluation.

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Clients without a history of psychiatric or psychological disorder must also undergo a preoperative psychological evaluation by a behavioral health provider and have clearance for surgery. The client's medical record must include documentation that the client is psychologically mature and able to cope with the postsurgical changes of the surgery.

Documentation must be submitted with the prior authorization request that is signed by the surgeon and attests that the services are provided by a facility in Texas that is one of the following:

- Accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
- A children's hospital that has a bariatric surgery program and provides access to an experienced surgeon who employs a team that is capable of long-term follow-up of the metabolic and psychosocial needs of the client and family.

Bariatric surgery for clients who are 20 years of age and younger may be prior authorized when the client meets all of the following criteria:

- The client has reached a Tanner Scale stage IV or V plus 95 percent of adult height based on bone age.
- The client has a body mass index (BMI) of greater than or equal to 40 kg/m2.
- The client has one or more comorbid conditions that are exacerbated by or attributable to obesity.
- Female clients must be at least 13 years of age and menstruating.
- Male clients must be at least 15 years of age.

Bariatric surgery for clients who are 21 years of age and older may be prior authorized when the client meets all of the following criteria:

- The client has a BMI of greater than or equal to 35 kg/m2.
- The client has one or more of the following comorbid conditions that are exacerbated by or attributable to obesity:
  - Obesity-associated hypoventilation
  - Moderate to severe sleep apnea (defined as apnea/hypoapnea index of 16 or more events per hour)
  - Congestive heart failure
  - Obesity-induced cardiomyopathy
  - Refractory hypertension resistant to pharmacotherapy (defined as blood pressure greater than 140mmHg systolic or greater than 90mmHg diastolic, despite maximally tolerated doses of at least three different classes of antihypertensive medications)
  - Pseudotumor cerebri (documented idiopathic intracerebral hypertension)
  - Adult onset (Type II) diabetes (with or without complications) with Hgb A1c greater than 9 percent, regardless of therapy, or 7 to 9 percent on maximal medical therapy (defined as taking insulin or maximally tolerated doses of at least two different classes of oral hypoglycemic medications)
  - Cardiovascular or peripheral vascular disease
  - Refractory hyperlipidemia (defined as triglycerides greater than 250 mg/dl, cholesterol greater than 220/mg/dl, HDL less than 35 mg/dl, or LDL greater than 200 mg/dl, despite maximally tolerated doses of at least two different classes of lipid-lowering medications)
  - Recurrent or chronic skin ulcerations with infection

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- Pulmonary hypertension
- Chronic joint disease, deterioration of the joint cartilage, and the formation of new bone (bone spurs) at the margins of the joints, with symptoms that severely affect work or leisure activities, on maximal medical therapy (defined as maximally tolerated dose of a non-steroidal anti-inflammatory drug (NSAID) or COX-II inhibitor or acetaminophen and the completion of at least one physical-therapist-supervised exercise program)
- Hepatic steatosis without evidence of active inflammation

Documentation must include a summary of the treatment provided for the client's comorbid conditions, including descriptions of how the client's response to standard treatment measures are unsatisfactory and why the bariatric surgery is medically necessary in the context of current treatment and medically-reasonable alternatives that are available.

Referral for bariatric surgery to the bariatric surgeon is required from the practitioner who is treating the comorbid condition(s). The bariatric surgeon will determine the client's eligibility for bariatric surgery. Documentation of the referral must be submitted with the prior authorization request.

The client must have had previous unsuccessful medical treatment for obesity, as documented in the medical record. All of the following minimal requirements must be met:

- The client has made a diligent effort to achieve healthy body weight with such efforts described in the medical record and certified by the operating surgeon.
- The client has failed to maintain a healthy weight despite a minimum of 6 months documented regular participation in a structured dietary program overseen by a physician (M.D. or D.O.) within 12 months of the request date.

Documentation that is submitted for prior authorization must also include all of the following:

- The process by which the client will receive postoperative surgical, nutritional, and psychological services.
- Affirmation that the client and the parent/guardian (if applicable) understand and will support the changes in eating habits that must accompany the surgery and the extensive postoperative follow-up.

Repeat bariatric surgery may be considered medically necessary in either of the following circumstances:

- To correct complications from bariatric surgery such as band malfunction, obstruction, or stricture
- To convert to a Roux-en-Y gastroenterostomy or to correct pouch failure in an otherwise compliant client when the initial bariatric surgery met medical necessity criteria

Note: *Conversion to a Roux-en-Y gastroenterostomy may be considered medically necessary for clients who have not had adequate success (defined as a loss of more than 50 percent of excess body weight) two years following the primary bariatric surgery procedure, and the client has been compliant with a prescribed nutrition and exercise program following the procedure.*

All documentation required for prior authorization is to be maintained in the client's medical record and is subject to retrospective review. This includes medical records from both the practitioner treating the comorbid condition(s) and the bariatric surgeon.

Providers may fax or mail prior authorization requests for bariatric surgery services for clients who are 20 years of age and younger to the TMHP Comprehensive Care Program (CCP) Prior Authorization Department. Prior authorization requests for clients who are 21 years of age and older may be faxed or mailed to the TMHP Special Medical Prior Authorization Department.

Clients may be eligible under Texas Medicaid or CCP for separate reimbursement for nutritional and psychological assessment and counseling associated with bariatric surgery.

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Behavioral health services provided as part of the preoperative or postoperative phase of bariatric surgery are subject to behavioral health guidelines, and are not considered part of the bariatric surgery.

Refer to: Subsection 8, "Inpatient Psychiatric Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for information about behavioral health services.

9.2.9 Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer

Live BCG for intravesical (procedure code 90586) or transvesical (procedure code J9030) are benefits of Texas Medicaid for the following diagnosis codes:

Diagnosis Codes							
C670	C671	C672	C673	C674	C675	C676	C677
C678	C679	C7911	D090				

Procedure code 90585 is a benefit of Texas Medicaid and restricted to diagnosis code Z201. Procedure code 90585 is limited to one service per day, same procedure, any provider. Authorization is not required for the BCG vaccine.

Bladder instillation of anticarcinogenic agent (procedure code 51720) may be reimbursed separately when billed with BCG instillation (procedure code 90586 or J9030).

9.2.10 Behavioral Health Services

Refer to: The *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.11 Biopsy

A biopsy refers to the surgical excision of tissue for pathological examination.

If a surgeon bills separate charges for a surgical procedure and a biopsy on the same organ or structure on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

9.2.12 Biofeedback Services

Biofeedback services are a benefit of Texas Medicaid for clients who are 4 years of age and older with the following conditions:

- Urinary incontinence
- Fecal incontinence
- Migraine and tension headache

Biofeedback services may be reimbursed using procedure codes 90901, 90912, and 90913.

Biofeedback services are limited to a maximum of 18 sessions rendered by any provider for the lifetime of each client for each condition.

Biofeedback services that are not a benefit of Texas Medicaid are the following:

- Biofeedback performed in the home setting
- Neurofeedback (such as, but not limited to, electroencephalography [EEG])
- Treatment for muscle tension, except tension headache
- Psychological, psychophysiological, and behavioral health therapy and psychosomatic conditions
- Investigational or experimental biofeedback services and procedures

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Procedure codes 90901, 90912, and 90913 are limited to one service per day. The reimbursement for procedure codes 90901, 90912, and 90913 include all modalities of the biofeedback training performed on the same day, regardless of the time increments or the number of modalities performed.

Any device used during a biofeedback session is considered part of the procedure and will not be reimbursed separately.

9.2.12.1 Biofeedback Certification

A staff member who is certified by Biofeedback Certification International Alliance (BCIA) must perform biofeedback services.

The certification types accepted by Texas Medicaid are the following:

- General biofeedback certification (BCB)
- Pelvic muscle dysfunction biofeedback certification (BCB-PMD)

Providers must maintain documentation in the client's medical record to support the medical necessity of the biofeedback service provided. Documentation must include the name of the staff person who provided the biofeedback and the prescribing physician must maintain in the office a record of the current certification of the staff member(s) who perform biofeedback. Documentation is subject to retrospective review.

9.2.12.2 Prior Authorization for Biofeedback Services

Prior authorization is required for biofeedback services.

- Any combination of procedure codes 90901, 90912, and 90913 are a benefit for biofeedback sessions for urinary or fecal incontinence conditions in clients who are 4 years of age and older.
- Procedure code 90901 is a benefit for biofeedback sessions for migraine or tension headache conditions.

The initial request may include up to 12 visits and not exceed a total duration of 12 weeks. Documentation of the following must be submitted for consideration of prior authorization:

- Conventional treatments that were given but were not successful, including, but not limited to, pharmacotherapy, exercise, rest, and heating and cooling modalities.
- Statements from the prescribing physician that the client is capable of understanding the requirements and agrees actively to participate in the biofeedback sessions.
- Name and certification information for the person performing the training.

In addition, documentation must be submitted to support the specific type of biofeedback requested.

Urinary and Fecal Incontinence

- Diagnosis of fecal or urinary stress, urge, overflow, or a mix of stress and urge incontinence in a client who is 4 years of age or older.
- Exclusion by the physician of any underlying medical conditions that could be causing the problem.
- Failed pelvic floor muscle exercise (PME) training for clients who are 21 years of age and older.

Note: *Failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of PME exercises.*

Migraine and tension headache

- A diagnosis of migraine, tension headache, or mixed migraine and tension headache.
- Symptoms that occur with a duration of at least 4 hours for at least 15 days a month over at least 3 months.

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- Failure of first-line approaches, including avoidance of precipitating stimuli and pharmacological prophylaxis.

Prior authorization requests must be submitted by the physician to the Special Medical Prior Authorization (SMPA) Department. The request must be submitted with documentation that supports medical necessity. Providers may submit prior authorization requests online through the TMHP website at www.tmhp.com, by fax to 1-512-514-4213, or by mail to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418

After the client completes the initial biofeedback treatment course, prior authorization may be considered for a total of six follow-up sessions not to exceed three sessions per week and total duration not to exceed eight weeks. Providers must submit prior authorization documentation for the same condition as the original request, and must include each original symptom and how it has objectively improved. Documentation may include, but is not limited to, the following:

- For treatment of urinary incontinence, improvement in continence scores, vitality, health, a decrease in high-grade stress incontinence, nocturnal enuresis, and urine loss with activity. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.
- For treatment of fecal incontinence, improvement in continence scores, squeeze and anal pressures, squeeze duration, vitality, and health. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.
- For migraine and tension headaches, diminished intensity, frequency, and duration of the headache activity.

9.2.13 Blepharoplasty Procedures

Procedure codes 15820, 15821, 67911, 67961, 67966, 67971, 67973, 67974, and 67975 are not diagnosis-restricted.

Procedure codes 67901, 67902, 67903, 67904, 67906, 67908, and 67909 may be reimbursed for clients who are 20 years of age and younger without prior authorization when performed for one of the following diagnosis codes:

Diagnosis Codes							
Q100	Q101	Q102	Q103				

Procedure codes 67901, 67902, 67903, 67904, 67906, and 67908 do not require prior authorization for clients who are 21 years of age and older when billed for the following diagnosis codes:

Diagnosis Codes							
H0231	H0232	H0234	H0235	H02411	H02412	H02413	H02421
H02422	H02423	H02431	H02432	H02433			

Blepharoplasty for clients who are 21 years of age and older requires mandatory prior authorization. The following information from the physician is required at the time of the request for blepharoplasty for procedure codes 15820, 15821, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911:

- A brief history and physical evaluation
- Photographs of the eyelid problem

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- Visual field measurements
- Diagnosis code

The following blepharoplasty and eyelid repair procedures do not require prior authorization:

Procedure Codes									
67916	67917	67923	67924	67961	67966	67971	67973	67974	67975

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

Retroactive authorization may be granted on an appeal basis when submitted with the appropriate documentation.

9.2.14 Bone Growth Stimulation

Professional services for bone growth stimulation (procedure codes 20974, 20975, and 20979) are a benefit of Texas Medicaid.

Prior authorization is required for a bone growth stimulator device (procedure codes E0747, E0748, E0749, and E0760).

Refer to: Subsection 2.2.8, "Bone Growth Stimulators" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for prior authorization criteria.

9.2.14.1 Invasive Bone Growth Stimulation

Invasive bone growth stimulation (procedure code 20975) is indicated for the following conditions:

- Nonunion of long bone fractures (i.e., clavicle, humerus, radius, ulna, femur, tibia, fibula, and metacarpal, metatarsal, carpal, and tarsal bones). Nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for three or more months prior to starting treatment with the bone growth stimulator. Serial radiographs must include a minimum of 2 sets of radiographs separated by a minimum of 90 days. Each set of radiographs must include multiple views of the fracture site.
- Failed fusion of a joint other than the spine when a minimum of three months has elapsed since the joint fusion was performed.
- Congenital pseudoarthrosis.
- An adjunct to spinal fusion surgery for patients at high-risk for pseudoarthrosis due to previously failed spinal fusion at the same site.
- An adjunct to multiple-level fusion, which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

9.2.14.2 Non-invasive Bone Growth Stimulation

Non-invasive bone growth stimulation (procedure code 20974) is indicated for the following conditions:

- Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three or more months despite appropriate fracture care.
- Delayed unions of fractures of failed arthrodesis at high-risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures).

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Documentation must also indicate all of the following:

- Serial radiographs have confirmed that no progressive signs of healing have occurred.
- The fractured gap is 1 cm or less.
- The individual can be adequately immobilized and is likely to comply with non-weight-bearing restrictions.

Non-invasive bone growth stimulation for spinal application is indicated for the following conditions:

- One or more failed fusions.
- Grade II or worse spondylolisthesis.
- A multiple-level fusion with extensive bone grafting is required.
- Other risk factors for fusion failure are present, including gross obesity, degenerative osteoarthritis, severe spondylolisthesis, current smoking, previous fusion surgery, previous disc surgery, or gross instability.

9.2.14.3 Ultrasound Bone Growth Stimulation

Ultrasound bone growth stimulation (procedure code 20979) is indicated for nonunion of a fracture, other than the skull or vertebrae, in a skeletally mature person, which is documented by a minimum of two sets of radiographs that were:

- Obtained prior to starting treatment with the osteogenesis stimulator.
- Separated by a minimum of 90 days.
- Taken with multiple views of the fracture site.
- Accompanied by a written interpretation by a physician who states that there has been no clinically significant evidence of fracture healing between the two set of radiographs.

Documentation must also indicate evidence of all of the following:

- The fracture is not tumor related.
- The fracture is not fresh (less than 7 days), closed or grade I open, tibial diaphyseal fractures, or closed fractures of the distal radius (Colles fracture).

9.2.14.4 Reimbursement

Professional claims that are submitted for bone growth stimulation (procedure codes 20974, 20975, and 20979) may be reimbursed if the claim includes documentation of one of the following:

- Documentation of medical necessity as outlined for each type of bone growth stimulation.
- The corresponding bone growth stimulator device was submitted within 95 days of the date the bone growth stimulation procedure was performed.

The appropriate evaluation and management (E/M) procedure code must be billed for monitoring the effectiveness of bone growth stimulation treatment.

Procedure codes 20974, 20975, and 20979 are limited to one per six months. During the six-month limitation period, a subsequent fracture that meets the criteria for a bone growth stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

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9.2.15 Cancer Screening and Testing

9.2.15.1 BRCA Testing

Refer to: Subsection 3.5, "Breast Cancer Gene 1 and 2 (BRCA) Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.15.1.1 Colorectal Cancer Screening

Colorectal cancer screening is a benefit of Texas Medicaid. Fecal occult blood tests, multi-targeted stool DNA (mt-sDNA) tests, screening colonoscopies, and sigmoidoscopies are evidenced based methods of colorectal cancer screening. Screening refers to the testing of asymptomatic persons to assess their risk for the development of colorectal cancer. Screening has been shown to decrease mortality due to this cancer by detecting cancers at earlier stages and allowing the removal of adenomas, thus preventing the subsequent development of cancer.

The American Cancer Society (ACS) recommends screening people at average risk for colorectal cancer beginning at 45 years of age by any of the following methods:

- A fecal occult blood test (FOBT)* or fecal immunochemical test (FIT) every year, or
- A multi-targeted stool DNA test (mt-sDNA) every three years, or
- Flexible sigmoidoscopy every five years, or
- A Flexible sigmoidoscopy every ten years, in addition to annual FIT screening, or
- Colonoscopy every ten years

Note: *For FOBT, the take-home multiple sample method with three samples should be used.*

The U.S. Preventative Services Task Force (USPSTF) guidelines indicate that the net benefit of colorectal cancer screening in adults who are 76 years of age and older who have been previously screened is small. The risks should be considered on an individual basis, as screening in this age group is most appropriate for those healthy enough to undergo treatment.

The ACS and USPSTF recommends screening for people at high-risk for colorectal cancer once every two years.

Indications/characteristics of a high-risk individual may include one or more of the following:

- A close relative (sibling, parent or child) has had colorectal cancer or an adenomatous polyp.
- There is a family history of familial adenomatous polyposis.
- There is a family history of hereditary nonpolyposis colorectal cancer.
- There is a personal history of adenomatous polyps.
- There is a personal history of colorectal cancer.
- There is a personal history of colonic polyps.
- There is a personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Note: *"Relative" means close blood relatives including first degree male or female relatives (parents, siblings, or children), second-degree relatives (aunts, uncles, grandparents, nieces, nephews), and third-degree relatives (first cousins, great-grandparents) who are on the same side of the family as the clients.*

Colorectal screening services are considered for reimbursement when submitted using procedure codes G0328 (with modifier QW), G0104, G0105, and G0121, by associated risk category based on the ACS and USPSTF frequency recommendations. Reimbursement for these procedure codes is considered when medical necessity is documented in the client's record.

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Fecal Occult Blood Tests

Procedure code G0328 (with modifier QW) and 82270 may be reimbursed once per rolling year for clients who are 45 years of age and older.

MT-sDNA Test

Procedure code 81528 is considered for reimbursement once every three years for clients who are 45 years of age and older.

Sigmoidoscopies

Procedure code G0104 is considered for reimbursement once every five years for clients who are 45 years of age or older when submitted with one of the following diagnosis codes, as recommended by the ACS and USPSTF:

Diagnosis Codes							
Z0000	Z0001	Z1210	Z1211	Z1213	Z859	Z86002	Z86003
Z86004	Z86006	Z86007	Z860100	Z860102	Z860109		

Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.

If a lesion or growth is detected that results in a biopsy or removal of the growth during a screening flexible sigmoidoscopy, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal must be reported.

Colonoscopies: Average Risk

Procedure code G0121 is considered for reimbursement once every ten rolling years for clients who are 45 years of age and older when submitted with diagnosis code Z0000, Z0001, Z1210, Z1211, or Z1213. Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.

Colonoscopies: High-Risk

Procedure code G0105 is considered for reimbursement once every two years for clients who meet the definition of high-risk. Procedure code G0105 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5120	K51211	K51212	K51213	K51214	K51218	K5130
K51311	K51312	K51313	K51314	K51318	K5180	K51811	K51812
K51813	K51814	K51818	K5190	K51911	K51912	K51913	K51914
K51918	K51919	K523	K5281	K5282	K52831	K52832	K52838
K52839	K5289	K529	Z800	Z83710	Z83711	Z83718	Z83719
Z8372	Z85038	Z85048	Z859	Z86002	Z86003	Z86004	Z86006
Z86007	Z860101						

9.2.15.1.2 Prior Authorization for Colorectal Cancer Screening

Prior authorization is not required for colorectal screening.

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9.2.15.1.3 Exclusions

Barium enemas for colorectal cancer screening are not a benefit of Texas Medicaid.

9.2.15.2 Genetic Testing for Colorectal Cancer

Genetic testing for colorectal cancer may be considered for reimbursement to independent laboratories with prior authorization.

Genetic testing may be provided to clients who have a known predisposition (i.e., having a first- or second-degree relative) for colorectal cancer. Results of the testing may indicate whether the client has an increased risk of developing colorectal cancer. A first-degree relative is defined as a sibling, parent, or offspring. A second-degree relative is defined as an uncle, aunt, grandparent, nephew, niece, or half-sibling.

Genetic test results, when informative, may influence clinical management decisions. Documentation in the medical record must reflect that the client or family members have been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions before the genetic testing.

Genetic testing for colorectal cancer may be considered for reimbursement with the following procedure codes:

Procedure Codes									
81201	81202	81203	81210	81233	81237	81275	81288	81292	81293
81294	81295	81296	81297	81298	81299	81300	81301	81317	81318
81319	81327								

Diagnosis code Z800 is acceptable as a diagnosis for the procedure codes in the table above. Prior authorization is still required and must be obtained for these services. Interpretation of gene mutation analysis results is not reimbursed separately. Interpretation is part of the physician E/M service.

The genetic testing for colorectal testing procedure codes in the table above are limited to once per lifetime for any procedure code by any provider. Testing is limited to once per lifetime for any procedure code by any provider, regardless of whether additional services are authorized.

Providers must maintain the following documentation in the client's medical record for genetic testing for colorectal cancer:

- Documentation of formal pre-test counseling, including assessment of the client's ability to understand the risks and limitations of the test.
- The client's informed choice to proceed with the genetic testing for colorectal cancer.

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results.

The medical record is subject to retrospective review.

9.2.15.2.1 Testing for Familial Adenomatous Polyposis

Testing for familial adenomatous polyposis (procedure codes 81201, 81202, and 81203) may be offered to clients who have well-defined hereditary cancer syndromes and for whom a positive or negative result will change medical care. Testing for familial adenomatous polyposis may be considered for reimbursement with documentation of at least one of the following:

- The client has more than 20 polyps.
- The client has a first-degree relative with familial adenomatous polyposis and a documented mutation.

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- For clients who are 7 years of age and younger, testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client's medical record.

9.2.15.2.2 Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

Testing for HNPCC (procedure codes 81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, and 81319) is used to determine whether a client has an increased risk of colorectal cancer or other HNPCC-associated cancers, including Lynch Syndrome. Results of the test may influence clinical management decisions. Testing for HNPCC may be considered for reimbursement with documentation of at least one of the following:

- The client has three or more family members, one of whom is a first-degree relative, with colorectal cancer; two successive generations are affected; one or more of the colorectal cancers was diagnosed before the family member was 50 years of age; and familial adenomatous polyposis has been ruled out for the client.
- The client has had two previous HNPCCs.
- The client has colorectal cancer and a first-degree relative who has one of the following:
  - Colorectal cancer or HNPCC extracolonic cancer at 50 years of age and younger
  - Colorectal adenoma at 40 years of age and younger
- The client has had colorectal cancer or endometrial cancer at 50 years of age and younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern of histology at 50 years of age and younger.
- The client has had signet-cell type colorectal cancer at 50 years of age and younger.
- The client has had a colorectal adenoma at 40 years of age and younger.
- The client is asymptomatic and has a first- or second-degree relative who has a documented HPNCC mutation.
- The client has a family history of malignant neoplasm in the gastrointestinal tract.
- For clients who are 20 years of age and younger, testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client's medical record.

9.2.15.2.3 Prior Authorization for Genetic Testing for Colorectal Cancer

Prior authorization is required for genetic testing for colorectal cancer. A completed Special Medical Authorization Request Form must be signed, dated, and submitted by the ordering provider rendering direct care. Requests from laboratories will not be processed. The provider should then share the authorization number with the laboratory submitting the claim.

A provider's signature, including the prescribing provider's, on a submitted document indicates that the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete.

Medical documentation that is submitted by the physician must verify the client's diagnosis or family history. Requisition forms from the laboratory are not sufficient for verification of the personal and family history.

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To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity. The form may be faxed to 1-512-514-4213 or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12365-A Riata Trace Parkway
Austin, TX 78727-6418

A request for retroactive authorization must be submitted no later than 7 calendar days after the lab draw is performed. To facilitate a determination of medical necessity and avoid unnecessary denials, the ordering physician rendering care must provide correct and complete information, including the accurate medical necessity of the services requested.

9.2.15.3 Mammography (Screening and Diagnostic Studies of the Breast)

The following breast imaging studies are benefits of Texas Medicaid:

- Screening mammogram
- Diagnostic mammogram
- Diagnostic breast ultrasound

The American Cancer Society recommends that women discuss when to start breast cancer screening mammography with their provider beginning at 40 years of age.

By the age of 45 all women should begin annual breast cancer mammography screening.

By the age of 55 women may transition to screening with mammography every other year, or in some cases may continue annual screenings in consultation with their healthcare provider.

Digital breast tomosynthesis (DBT), also known as three-dimensional (3D) mammography, provides 3D images and is a modification of conventional mammography. Screening DBT is used, along with conventional screening mammography, to detect breast changes in women who have no signs or symptoms of breast cancer.

Diagnostic DBT is used, along with conventional diagnostic mammography, to diagnose breast disease in women or men who have breast symptoms or findings on physical examination or screening mammogram.

A screening mammogram may be billed using procedure code 77067.

Procedure code 77063 must be billed with primary procedure code 77067. Reimbursement may be considered for procedure code 77063 when performed on the same date of service, by any provider, as procedure code 77067.

Procedure codes 77063 and 77067 are limited to one per rolling year, any provider.

A diagnostic mammogram may be billed using procedure code 77065 or 77066.

Procedure code 77065 will be denied if it is submitted for the same date of service as procedure code 77066 by any provider.

Procedure code G0279 must be billed with primary procedure code 77065 or 77066. Reimbursement may be considered for procedure code G0279 when performed on the same date of service, by any provider, as procedure code 77065 or 77066.

Reimbursement may be considered for a screening mammogram (procedure code 77063 or 77067) performed on the same patient on the same date of service as a diagnostic mammogram (procedure code 77065, 77066, or G0279), by submitting the diagnostic mammography with the modifier GG.

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A mammogram may be indicated for a male client based on medical necessity due to existing signs and symptoms. In such rare circumstances, procedure codes 77065, 77066, and G0279 may be considered for reimbursement.

Other breast diagnostic radiology procedures may be medically necessary based on existing signs and symptoms. When indicated, such procedures may be considered for reimbursement using procedure code 76098, 77053, or 77054. Procedure code 77053 will be denied if it is submitted for the same date of service as procedure code 77054 by any provider. Procedure code 76098 may be reimbursed for both male and female clients.

Breast ultrasound may be considered for reimbursement using procedure code 76641 or 76642.

Authorization is not required for these services.

The prescribing physician must maintain documentation of medical necessity in the client's medical record.

The radiologist or interpreting physician at the testing facility may determine and document that, because of the abnormal result of the diagnostic test performed, additional studies are medically necessary. The radiologist or interpreting physician ordering the additional studies must provide documentation to the prescribing physician.

9.2.15.4 Prognostic Breast and Gynecological Cancer Studies

Prognostic breast and gynecological cancer studies are benefits of Texas Medicaid when ordered by a physician for the purpose of determining the best course of treatment for a patient with breast/gynecological cancers.

Prognostic breast and gynecological cancer studies are divided into three categories: Receptor assays, Her-2/neu, and gene expression profiling.

- Receptor Assays (procedure codes 84233 and 84234) - The estrogen receptor assay (ERA) and the progesterone receptor assay (PRA) are tests in which a tissue sample is exposed to radioactively tagged estrogen or progesterone. The presence of these receptors can have prognostic significance in breast and endometrial cancer.
- Her-2/neu (procedure codes 83950, 88237, 88239, 88271, 88274, 88291, 88341, 88342, 88344, 88360, 88361, 88364, 88365, 88366, 88367, 88368, 88369, 88373, 88374, and 88377) - Human epidermal growth factor receptor 2 (Her-2/neu) is responsible for the production of a protein that signals cell growth. The overexpression of Her-2/neu in breast cancer is associated with decreased overall survival and response to some therapies. Each procedure used in the analysis should be coded separately.
- Gene expression profiling (procedure code 81518, 81519, and 81520) - Gene expression profiling analyzes the expression of a panel of genes to predict the likelihood of breast cancer recurrence in clients with newly diagnosed early-stage invasive breast cancer.

Reimbursement for procedure codes 88360 and 88361 is limited to claims with a diagnosis of breast or uterine cancer as listed in the following table:

Diagnosis Codes							
C50011	C50012	C50021	C50022	C50111	C50112	C50121	C50122
C50211	C50212	C50221	C50222	C50311	C50312	C50321	C50322
C50411	C50412	C50421	C50422	C50511	C50512	C50521	C50522
C50611	C50612	C50621	C50622	C50811	C50812	C50821	C50822
C50921	C50922	C50A0	C50A1	C50A2	C540	C541	C542
C543	C548	C792	C7981	D0501	D0502	D0511	D0512

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Diagnosis Codes							
D0581	D0582						

Testing for other diagnoses will be denied.

Interpretation of receptor assays, and Her-2/neu results is not considered separately for reimbursement. Interpretation is part of the physician's E/M service.

Gene expression profiling (procedure code 81518, 81519, and 81520) is a benefit when all of the following criteria are met:

- The test is ordered by an oncologist.
- The client has newly diagnosed breast cancer. ("Newly diagnosed" means that not more than six months have elapsed since the initial diagnosis.)
- There is no evidence of metastatic breast cancer.

Procedure code 81519 is a benefit when all the following additional criteria are met:

- The clinical stage of the breast cancer is I, II, or IIIa, and the cancer has not spread to more than three lymph nodes.
- The primary tumor is estrogen receptor positive and Her-2/neu receptor negative, or the primary tumor is Her-2/neu receptor positive and less than 1 cm in diameter.
- The client is a candidate for adjuvant chemotherapy.
- The outcome of the test will guide decision-making regarding adjuvant chemotherapy.

Procedure code 81520 is a benefit when all the following additional criteria are met:

- The clinical stage of the breast cancer is I or II, and the cancer has not spread to more than three lymph nodes.
- The primary tumor is hormone receptor positive.
- The client is female and post-menopausal.

Procedure code 81518 is a benefit when all the following additional criteria are met:

- The clinical stage of breast cancer is I, II, or IIIa in cases where the cancer has not spread to more than three lymph nodes.
- The primary tumor is estrogen receptor or progesterone receptor positive.
- The cancer cells are Her-2/neu receptor negative.
- Adjuvant therapy is not precluded due to any other factor (e.g., advanced age or significant comorbidities).
- Before Breast Cancer Index (BCI) testing, the client and provider have discussed the potential results of the test and agree to use the results to guide therapy.

Procedure code 81518 may be reimbursed once per lifetime, any procedure, any provider, when submitted with one of the following diagnosis codes:

Diagnosis Codes							
C50011	C50012	C50111	C50112	C50211	C50212	C50311	C50312
C50411	C50412	C50511	C50512	C50611	C50612	C50811	C50812
C50911	C50912	C50A0	C50A1	C50A2	D0501	D0502	D0511
D0512	D0581	D0582	Z170	Z1721	Z1731	Z1732	Z17410

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Diagnosis Codes							
Z17411							

Procedure code 81519 may be reimbursed once per lifetime, any procedure, any provider, when submitted with one of the following diagnosis codes:

Diagnosis Codes							
C50011	C50012	C50021	C50022	C50111	C50112	C50121	C50122
C50211	C50212	C50221	C50222	C50311	C50312	C50321	C50322
C50411	C50412	C50421	C50422	C50511	C50512	C50521	C50522
C50611	C50612	C50621	C50622	C50811	C50812	C50821	C50822
C50911	C50912	C50921	C50922	D0501	D0502	D0511	D0512
D0581	D0582	Z170	Z1721	Z1731	Z1732	Z17410	Z17411

Procedure code 81520 may be reimbursed once per lifetime, any procedure, any provider, when submitted with one of the following diagnosis codes:

Diagnosis Codes							
C50011	C50012	C50111	C50112	C50211	C50212	C50311	C50312
C50411	C50412	C50511	C50512	C50611	C50612	C50811	C50812
C50911	C50912	D0501	D0502	D0511	D0512	D0581	D0582
Z170							

Gene expression profiling is limited to once per lifetime, but may be considered for reimbursement more than once per lifetime for the same client on appeal. The provider must submit documentation that demonstrates that the client has a new, second, primary breast cancer diagnosis that meets the criteria described above.

The provider must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service.

Gene expression profiling is not covered for repeat testing or testing of multiple tumor sites in the same client.

9.2.16 Capsulotomy

A capsulotomy is a benefit when not performed with a joint surgery.

9.2.17 Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment. Cardiac rehabilitation programs must include all of the following:

- Physician-prescribed exercise for each day on which cardiac rehabilitation items and services are furnished
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to a client's individual needs
- Psychosocial assessment
- Outcomes assessment

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- An individual treatment plan that specifies how components are used for a client and that is reviewed and signed by the prescribing physician every 30 days

Cardiac rehabilitation procedure codes 93797 and 93798 are benefits of Texas Medicaid.

The appropriate procedure code must be billed with one of the following diagnosis codes:

Diagnosis Codes							
I110	I160	I161	I169	I201	I202	I2081	I2089
I209	I2101	I2102	I2109	I2111	I2119	I2121	I2129
I213	I214	I219	I21A1	I21A9	I21B	I220	I221
I222	I228	I229	I2720	I2721	I2722	I2723	I2724
I2729	I2783	I501	I5020	I5021	I5022	I5023	I5030
I5031	I5032	I5033	I5040	I5041	I5042	I5043	I50810
I50811	I50812	I50813	I50814	I5082	I5083	I5084	I5089
I509	I5A	Z941	Z943	Z951	Z952	Z953	Z954
Z955	Z9861	Z98890					

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for clients for whom there is documentation of any of the following conditions within the 12 months immediately preceding the beginning of the program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

Note: *A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms (ECGs) to a remote site is not a benefit of Texas Medicaid.*

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use.

Cardiac rehabilitation is limited to 2 one-hour sessions per day for 18 weeks per rolling year and can not exceed 36 sessions.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the client has another documented cardiac event or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. To confirm that a continuation of cardiac rehabilitation is at the request of or is coordinated with the prescribing physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and the prescribing physician. If the physician responsible for such follow-up is the medical director, then the physician's notes must be evident in each client's chart.

Additional cardiac rehabilitation sessions must be prior authorized and must not exceed a total of 36 sessions for 52 weeks from the date of authorization of additional sessions.

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If no clinically-significant arrhythmia is documented during the first three weeks of the program, the physician may give the order for the client to complete the remaining portion of the cardiac rehabilitation without telemetry monitoring.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program that is conducted by personnel who are not physicians but are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease and who provide the services under the direct supervision of a physician.

Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs.

9.2.17.1 Prior Authorization for Cardiac Rehabilitation

Prior authorization is not required for the initial 36 sessions of cardiac rehabilitation.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions in the following circumstances:

- The medical record must support the client has had another cardiac event; or
- The prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Documentation must include the following:
  - Progress made from the beginning of cardiac rehabilitation period to the current service request date, including progress towards previous goals.
  - Information that supports the client's capability of continued measurable progress.
  - A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs.

Requests for prior authorization for additional sessions that exceed a total of 36 sessions in 52 weeks will not be granted. Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department.

9.2.17.2 Reimbursement

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be billed with modifier 25 appended to the E/M code when a separately identifiable E/M service was provided on the same day by the provider that rendered cardiac rehabilitation. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Physical and occupational therapy will not be reimbursed when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition that requires such therapy, e.g., a client who is recuperating from an acute phase of heart disease and may have had a stroke that requires physical and/or occupational therapy.

Client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity, that help a client adjust living habits because of the cardiac condition; will not be separately reimbursed when the services are provided as part of the cardiac rehabilitation program.

9.2.18 Casting, Splinting, and Strapping

Casting, splinting, and strapping are subject to global surgery fee guidelines. The following procedure codes for casting, splinting, and strapping are a benefit of Texas Medicaid:

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Procedure Codes									
29000	29010	29015	29035	29040	29044	29046	29049	29055	29058
29065	29075	29085	29086	29105	29125	29126	29130	29131	29200
29240	29260	29280	29305	29325	29345	29355	29358	29365	29405
29425	29435	29440	29445	29450	29505	29515	29520	29530	29540
29550	29580	29799							

The following procedure codes for cast removal, windowing, wedging, or repair may be reimbursed to a provider other than the provider who applied the initial cast, splint, or strap:

Procedure Codes									
29700	29705	29710	29720	29730	29740	29750	29799		

Authorization is not required for casting, splinting, or strapping services.

9.2.19 Cardiopulmonary Resuscitation (CPR)

CPR (procedure code 92950) is a benefit of Texas Medicaid and may be reimbursed when medical necessity is documented in the client's medical record. Only the primary provider performing CPR may be reimbursed for procedure code 92950. CPR billed as an ambulance service by an ambulance provider will be denied.

CPR may be billed with the same date of service as critical care when reported as a separately identifiable procedure. The time spent performing CPR must not be included in the time reported as critical care.

9.2.20 Circumcisions

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54161. Circumcisions performed on clients who are 1 year of age and older must be documented with medical necessity.

Refer to: Subsection 9.2.47.1, "Circumcisions for Newborns" in this handbook for additional benefit information.

9.2.21 Closure of Wounds

The repair of wounds is defined as simple, intermediate, or complex. Simple repair involves the dermis and subcutaneous tissue and requires a one-layer closure. Intermediate repair requires some layered closure of deeper layers of subcutaneous tissue and superficial fascia. Complex repair involves more layered closure, debridement, extensive undermining, stints, or retention sutures.

Wound closures may use sutures, staples, or tissue adhesives. Wounds closed with adhesive strips must not be reported using wound closure procedure codes. When adhesive strips are the only wound closure material used, providers must report the most appropriate E/M visit procedure code on their claim.

Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is considered inclusive to the wound closure and will not be reimbursed separately.

The lengths of multiple closures of wounds must be added together and billed as one procedure code if they meet at least one of the following criteria:

- The closures have the same CPT classification (see "Repair [Closure]" in the CPT manual).
- The closures are in anatomic sites that are grouped together in the same procedure code descriptor.

Providers must submit the procedure code that represents the total length of the repairs. Lengths of repairs from different CPT classifications or groupings of anatomic sites must be billed as separate procedure codes.

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Wound closures must be billed using the following procedure codes:

Procedure Codes									
Repair Simple									
12001	12002	12004	12005	12006	12007	12011	12013	12014	12015
12016	12017	12018	12020	12021					
Repair Intermediate									
12031	12032	12034	12035	12036	12037	12041	12042	12044	12045
12046	12047	12051	12052	12053	12054	12055	12056	12057	
Repair Complex									
13100	13101	13102	13120	13121	13122	13131	13132	13133	13151
13152	13153	13160							

Multiple wounds on the same day will be paid the full allowed amount for the major (largest total length of the repair at the same anatomic site) wound and one-half the allowed amount for each additional laceration (total length of the repair at the same anatomic site).

No separate payment will be made for incision closures billed in addition to a surgical procedure when the closure is part of that surgical procedure.

No separate payment will be made for supplies in the office.

When the debridement is carried out separately without immediate primary closure, when gross contamination requires prolonged cleansing, or when large amounts of devitalized or contaminated tissue are removed, debridement may be reimbursed separately. Debridement rendered during the same surgical session as wound closure is considered inclusive to the closure and is not reimbursed separately.

Refer to: Subsection 9.2.74.11, "Supplies, Trays, and Drugs" in this handbook for the hospital-based emergency department.

Wound suture and wound closure are considered part of any surgical procedure performed on the same area, except for excision of benign or malignant lesion procedure codes that require more than simple closure. Providers may be reimbursed for the appropriate intermediate or complex closure procedure code. Multiple surgery guidelines apply.

The exceptions listed above apply to the following excision and closure procedure codes:

Excision of Benign Lesion Procedure Code									
11400	11401	11402	11403	11404	11406	11420	11421	11422	11423
11424	11426	11440	11441	11442	11443	11444	11446		

Excision of Malignant Lesion Procedure Codes									
11600	11601	11602	11603	11604	11606	11620	11621	11622	11623
11624	11626	11640	11641	11642	11643	11644	11646		

Intermediate Closure Procedure Codes									
12031	12032	12034	12035	12036	12037	12041	12042	12044	12045
12046	12047	12051	12052	12053	12054	12055	12056	12057	

Complex Closure Procedure Codes									
13100	13101	13102	13120	13121	13122	13131	13132	13133	13151

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Complex Closure Procedure Codes									
13152	13153	13160							

9.2.22 Cochlear Implants

Cochlear implants, when medically indicated, are benefits of Texas Medicaid with prior authorization. A cochlear implant device (procedure code 69930) is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn externally to capture and amplify sound. These devices are available in single and multichannel models. Cochlear implants are used to provide awareness and identification of sound and to facilitate communication for persons who are profoundly hearing impaired.

Refer to: Subsection 3.2.1, "Cochlear Implants" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on benefit and authorization requirements for cochlear implants.

9.2.23 Colon Capsule Endoscopy

Colon capsule endoscopy (procedure code 91113) is a benefit of Texas Medicaid and limited to the following diagnosis codes:

Diagnosis Codes					
K635	K921	K922	R195	Z5309	Z538

9.2.24 Continuous Glucose Monitoring (CGM)

CGM (procedure codes 95250 and 95251) is a benefit of Texas Medicaid with prior authorization.

Procedure codes 95250 and 95251 are limited to once per 12 calendar months by any provider.

The rental or purchase of a continuous glucose monitoring system (CGMS) is considered part of the CGM and is not reimbursed separately.

9.2.24.1 Prior Authorization for Continuous Glucose Monitoring

CGM requires prior authorization and must be prescribed by the client's treating practitioner performing the glucose monitoring.

Prior authorization will be considered for clients who have diabetes mellitus. The client must be compliant with his or her current medical regimen, use multiple daily insulin administrations or be on an insulin pump, have documentation of medical necessity, and have a provider statement in the medical record that they have a history of performing daily self blood glucose monitoring. For all diabetic clients who are not using insulin, at least one or more of the following conditions must be present:

- Frequent problematic hypoglycemic episodes
- Unexplained large fluctuations in daily, preprandial blood glucose
- Episodes of ketoacidosis or hospitalization for uncontrolled glucose

Additional CGM services may be considered with documentation of medical necessity that indicates the client meets the criteria above and has a change in condition that would warrant a second procedure within 12 calendar months.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested services. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the use of CGM.

Note: *The submission of daily blood glucose logs is not required for prior authorization.*

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9.2.25 Developmental Screening and Testing and Aphasia Assessment

The following types of developmental screening and testing and aphasia assessment are benefits of Texas Medicaid when medically necessary:

- Developmental screening when performed outside of a Texas Health Steps (THSteps) medical checkup (procedure code 96110)
- Developmental testing (procedure codes 96112 and 96113 [add-on procedure code must be submitted with primary procedure code 96112])
- Assessment of aphasia (procedure code 96105)

Re-evaluations are a benefit of Texas Medicaid only to address a clinical need, to provide the documentation needed to measure a client's status over time, and to direct the plan of care.

Procedure codes 96105, 96110, 96112, and 96113 are used to report medically necessary aphasia assessment, developmental screening, and testing.

Prior authorization is not required for developmental screening, developmental testing, and aphasia assessment.

9.2.25.1 Developmental Screening

Developmental screening requiring the use of a standardized, validated screening tool (procedure code 96110) is a benefit of Texas Medicaid for clients who are birth through 6 years of age.

Developmental screening is limited to once per rolling year, any provider, outside of a THSteps medical checkup when medically necessary. This screening should only be completed for a diagnosis of suspected developmental delay or to evaluate a change in the client's developmental status outside of a THSteps medical checkup.

Developmental screening should be used to identify clients who are birth through 6 years of age and who may need a more comprehensive evaluation. Results of developmental screening may guide or identify the need for further testing. Clients with abnormal screening results must be referred to an appropriate provider for further testing. Clients who are birth through 35 months of age who have suspected developmental delay must be referred to Texas Early Childhood Intervention (ECI) within 7 days after the child has been identified.

Refer to: Subsection 2.9, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on the Texas ECI program.

Subsection 4.3.12.1.2, "Developmental Surveillance or Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on developmental screening for THSteps checkups.

9.2.25.2 Developmental Testing

Developmental testing (procedure codes 96112 and 96113) is a benefit of Texas Medicaid for clients who are birth through 20 years of age.

Developmental testing consists of an extended evaluation and requires the use of a standardized norm-referenced tool. Developmental testing is medically necessary when there is suspected developmental delay supported by clinical evidence. Developmental testing is only medically indicated when clinical evidence suggests the following:

- Suspected developmental delay or atypical development when the diagnosis cannot be clearly identified through clinical interview or standardized screening tool alone.
- Retesting of a client to evaluate a change in developmental status that results in a change of treatment plan.

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Procedure codes 96112 and 96113 are limited to two services per rolling year, any provider.

Developmental testing performed when a development delay or a change in the client's developmental status is not suspected is not a benefit of Texas Medicaid.

Developmental testing is not a benefit when completed for the purposes of entering day care, Head Start, or a school setting.

Providers cannot bill the client for developmental testing that better fits the description of developmental screening.

The physician must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service. The following information is required at least every six months to establish medical necessity:

- The physician's prescription that includes a description of the specific service being prescribed
- The treatment plan that includes a copy of the current evaluation and documented age of the child at the time of the evaluation

9.2.25.3 Assessment of Aphasia

Aphasia assessment (procedure code 96105) is a benefit of Texas Medicaid when medically necessary and is limited to the following diagnosis codes:

Diagnosis codes				
R4701	R4702	R471	R4781	R4789

Procedure code 96105 is limited to two services per rolling year, any provider.

9.2.25.4 12-Hour Limitation for Procedure Codes 96110, 96112, and 96113

APRNs, PAs, and psychologists are limited to a maximum, combined total of 12 hours per day for developmental screening and testing, and inpatient and outpatient mental health services.

Because physicians (M.D. and D.O.) can delegate and may submit claims for services in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

Developmental screening and testing are included in the 12-hour per day, per provider, system limitation. The following table lists the procedure codes that are included in the 12-hour per day system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

Procedure Code	Time Applied by System
96110	30 Minutes
96112	60 Minutes
96113	30 minutes

Refer to: Subsection 4.5, "Twelve Hour System Limitation" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about procedure codes included in the 12-hour system limitation.

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All providers, including physicians and all providers to whom they delegate services, are subject to retrospective review. HHSC and TMHP routinely perform retrospective reviews of all providers. All providers are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day. Retrospective review may include:

- All E/M procedure codes, including those listed in the Evaluation and Management Section of the *CPT Manual,* billed with a diagnosis listed in the diagnosis table above under Neurobehavioral Testing
- All developmental screening and testing procedure codes included in the 12-hour system limitation

Note: *Developmental screening and testing procedure codes and mental health procedure codes are included in the review. If a provider provides developmental and neurological assessment and testing at more than one location, any of these services may be retrospectively reviewed.*

9.2.26 Diagnostic Tests

9.2.26.1 Blood Pressure Monitoring

Blood pressure monitoring by either self-measured blood pressure monitoring or ambulatory blood pressure monitoring is a benefit of Texas Medicaid when used as a diagnostic tool to assist a physician in diagnosing hypertension in individuals whose blood pressure is either elevated, or inconclusive when evaluated in the office alone.

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring may also be used for the following:

- Clients who are under treatment for established hypertension
- Evaluating refractory or treatment-resistant blood pressure
- Evaluating symptoms such as light-headedness corresponding with blood pressure changes
- Evaluating nighttime blood pressure
- Examining diurnal patterns of blood pressure

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are indicated for the evaluation of one of the following conditions:

- White coat hypertension, which is defined as the following:
  - Blood pressure measurements taken in the clinic or office are greater than 140/90 mm Hg on at least three separate visits, with two separate measurements made at each visit.
  - At least two separately documented blood pressure measurements taken outside of the clinic or office that are less than 140/90 mm Hg.
  - There is no evidence of end-organ damage.
- Resistant hypertension
- Hypotensive symptoms as a response to hypertension medications
- Nocturnal angina
- Episodic hypertension
- Syncope

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are indicated for initial diagnosis of hypertension and should not be used for maintenance monitoring.

Self-measured blood pressure monitoring may also be indicated for re-evaluation of clients previously diagnosed with hypertension.

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Providers must document that the self-measured blood pressure monitoring was performed for at least 24 hours.

Procedure code 99473 is limited to one service per year, any provider. Procedure code 99473 may be considered for reimbursement more than once per year when the following documentation of medical necessity is submitted with the claim:

- Documentation of erroneous blood pressure readings-excessively high or low blood pressure, blood pressure readings excessively inconsistent with those measured professionally
- Documentation of erroneous blood pressure logs-day of the week, time of day, setting or location, or timing of medication administration inconsistent with prior professional instruction
- Documentation of poor health literacy, developmental, or intellectual challenges that may require repeated client education
- Client purchase or receipt of new blood pressure device

Procedure code 99474 is limited to four services per year, any provider, and may be reimbursed only if a claim for procedure code 99473 has been submitted within 12 rolling months.

Only one method of blood pressure monitoring (self-measured or ambulatory) may be reimbursed within a rolling 12-month period. Self-measured blood pressure monitoring submitted within the same rolling 12-month period as ambulatory blood pressure monitoring will be denied.

Use procedure codes 93784, 93786, 93788, and/or 93790 to bill in 24-hour increments for ambulatory blood pressure monitoring. Ambulatory blood pressure monitoring is limited to two services per lifetime, any provider. Ambulatory blood pressure monitoring performed more than twice per lifetime may be considered when documentation of medical necessity is submitted with the claim.

9.2.26.2 Ambulatory and Long-Term Electroencephalogram (Ambulatory EEG)

Ambulatory EEG monitoring is a covered benefit for clients in whom a seizure diathesis is suspected but not defined by history, physical, and resting EEG.

The EEG technical component procedure codes are limited to 3 studies for each physician for the same client per 6 months when medically necessary.

The following procedure codes should be submitted when billing for the EEG technical component:

Procedure Codes									
95705	95706	95707	95708	95709	95710	95711	95712	95713	95714
95715	95716								

Procedure code 95700 will be limited to three units per six months for each physician for the same client.

Professional component procedure codes are limited to three studies per six months for each physician for the same client, when medically necessary.

Technical component procedure codes are limited to three studies per six months for each physician for the same client, when medically necessary.

Note: A study includes one unit of procedure code 95700 (set-up, education, and takedown) and any appropriate combination of the corresponding technical and professional procedure codes.

The following procedure codes should be submitted when billing for the EEG professional component:

Procedure Codes									
95717	95718	95719	95720	95721	95722	95723	95724	95725	95726

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The procedure codes in the tables above may be reimbursed when they are submitted with the following diagnosis codes:

Diagnosis Codes							
F05	F060	F068	G253	G3101	G3109	G3183	G40001
G40009	G40011	G40019	G40101	G40109	G40111	G40119	G40201
G40209	G40211	G40219	G40301	G40309	G40311	G40319	G40401
G40409	G40411	G40419	G40501	G40509	G40801	G40802	G40803
G40804	G40811	G40812	G40813	G40814	G40841	G40842	G40843
G40844	G4089	G40901	G40909	G40911	G40919	G40A11	G40A19
G40B01	G40B09	G40B11	G40B19	G40C01	G40C09	G40C11	G40C19
G912	O99351	O99352	O99353	O99354	O99355	P90	P912
R410	R4182	R5601	R561	R569	S060X1A	S060X1D	S060X1S
S060XAA	S060XAD	S060XAS	Z052				

Other diagnosis codes may be considered on appeal with supporting medical documentation to the TMHP Medical Director.

9.2.26.3 Bone Marrow Aspiration, Biopsy

Physicians may bill procedure code 85097 if interpretation is for smear interpretation, or procedure code 88305 if interpretation is for preparation and interpretation of cell block. If both procedure codes 85097 and 88305 are billed, procedure code 88305 is paid and procedure code 85097 is denied.

Physicians may bill procedure code 85097 or 88305 for preparation and interpretation of the specimen.

9.2.26.4 Cytopathology Studies—Other Than Gynecological

Procurement and handling of the specimen for cytopathology of sites other than vaginal, cervical, or uterine is considered part of the client's E/M and will not be reimbursed separately.

Procedure codes 88160, 88161, and 88162 are reimbursed according to the POS where the cytopathology smear is interpreted.

Procedure code 88177 is limited to three services per day by the same provider.

9.2.26.5 Echoencephalography

Echoencephalography (procedure code 76506) is medically indicated for the following conditions or diagnosis codes:

Diagnosis Codes							
A066	A170	A171	A1781	A1782	A1789	C410	C6961
C6962	C700	C710	C711	C712	C713	C714	C715
C716	C717	C718	C719	C7221	C7222	C7231	C7232
C7241	C7242	C7259	C729	C751	C752	C768	C7931
C7932	C7940	C7949	C7951	C7952	C7989	D075	D098
D164	D3161	D3162	D320	D329	D330	D331	D332
D333	D3500	D3501	D3502	D420	D421	D429	D432
D433	D434	D438	D439	D47Z1	D47Z2	D480	D487
D492	D496	D497	F0390	F03911	F03918	F0392	F0393
F0394	G060	G062	G07	G08	G132	G138	G232

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Diagnosis Codes							
G233	G300	G301	G308	G309	G3101	G3109	G311
G312	G3180	G3183	G3184	G3185	G3186	G3187	G3189
G319	G910	G911	G912	G930	G932	G9340	G9341
G9342	G9343	G9344	G9345	G9349	G935	G936	G937
G9381	G9389	G939	G94	G988	G998	H35361	H4600
H4601	H4602	H4603	H4610	H4611	H4612	H4613	H462
H463	H468	H469	H47011	H47012	H47013	H47019	H47021
H47022	H47023	H47029	H47031	H47032	H47033	H47039	H47091
H47092	H47093	H47099	H4710	H4711	H4712	H4713	H47141
H47142	H47143	H47149	H4720	H47211	H47212	H47213	H47219
H4722	H47231	H47232	H47233	H47239	H47291	H47292	H47293
H47299	H47311	H47312	H47313	H47319	H47321	H47322	H47323
H47329	H47331	H47332	H47333	H47339	H47391	H47392	H47393
H47399	H4741	H4742	H4743	H4749	H47511	H47512	H47519
H47521	H47522	H47529	H47531	H47532	H47539	H47611	H47612
H47619	H47621	H47622	H47629	H47631	H47632	H47639	H47641
H47642	H47649	I6000	I6001	I6002	I6010	I6011	I6012
I602	I6030	I6031	I6032	I604	I6050	I6051	I6052
I606	I607	I608	I609	I610	I611	I612	I613
I614	I615	I616	I618	I619	I6200	I6201	I6202
I6203	I621	I629	I6330	I63311	I63312	I63319	I63321
I63322	I63323	I63333	I63329	I63331	I63332	I63339	I6339
I6340	I63411	I63412	I63419	I63421	I63422	I63429	I63431
I63432	I63439	I6349	I6350	I63511	I63512	I63513	I63519
I63521	I63522	I63523	I63529	I63531	I63532	I63533	I63539
I63543	I6381	I6389	I6601	I6602	I6603	I6609	I6611
I6612	I6613	I6619	I6621	I6622	I6623	I6629	I668
I669	I671	I6781	I6782	I6783	I67850	I67858	I6789
I680	I69098	I6921	I69210	I69211	I69212	I69213	I69214
I69215	I69218	I69219	I69220	I69221	I69222	I69223	I69269
I69290	I69291	I69292	I69293	I69298	O99411	O99412	O99413
O99419	O9942	O9943	P0082	P0700	P0701	P0702	P0703
P0710	P0714	P0715	P0716	P0717	P100	P101	P102
P103	P104	P108	P109	P112	P119	P120	P121
P122	P123	P124	P1281	P1289	P129	P150	P151
P152	P153	P154	P155	P156	P158	P352	P370
P371	P372	P373	P374	P378	P520	P521	P5221
P5222	P523	P524	P525	P526	P528	P529	P90
P912	P91811	P91819	P91821	P91822	P91823	P91829	P9188
Q010	Q011	Q012	Q018	Q02	Q030	Q031	Q038

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Diagnosis Codes							
Q040	Q041	Q042	Q045	Q046	Q048	Q050	Q051
Q052	Q054	Q0701	Q0702	Q0703	Q282	Q283	R220
R221	R5600	R569	S0190XA	S0190XD	S0190XS	S060X0A	S060X0D
S060X0S	S060X1A	S060X1D	S060X1S	S060X9A	S060X9D	S060X9S	S060XAA
S060XAD	S060XAS	S061X0A	S061X0D	S061X0S	S061X1A	S061X1D	S061X1S
S061X2A	S061X2D	S061X2S	S061X3A	S061X3D	S061X3S	S061X4A	S061X4D
S061X4S	S061X5A	S061X5D	S061X5S	S061X6A	S061X6D	S061X6S	S061X7A
S061X8A	S061X9A	S061X9D	S061X9S	S061XAA	S061XAD	S061XAS	S06305A
S06305D	S06305S	S06306A	S06306D	S06306S	S06307A	S06308A	S0630AA
S0630AD	S0630AS	S06310A	S06310D	S06310S	S06311A	S06311D	S06311S
S06312A	S06312D	S06312S	S06313A	S06313D	S06313S	S06314A	S06314D
S06314S	S06315A	S06315D	S06315S	S06316A	S06316D	S06316S	S06317A
S06318A	S06319A	S06319D	S06319S	S0631AA	S0631AD	S0631AS	S06320A
S06320D	S06320S	S06321A	S06321D	S06321S	S06322A	S06322D	S06322S
S06323A	S06323D	S06323S	S06324A	S06324D	S06324S	S06325A	S06325D
S06325S	S06326A	S06326D	S06326S	S06327A	S06328A	S06329A	S06329D
S06329S	S0632AA	S0632AD	S0632AS	S06330A	S06330D	S06330S	S06331A
S06331D	S06331S	S06332A	S06332D	S06332S	S06333A	S06333D	S06333S
S06334A	S06334D	S06334S	S06335A	S06335D	S06335S	S06336A	S06336D
S06336S	S06337A	S06338A	S06339A	S06339D	S06339S	S0633AA	S0633AD
S0633AS	S06340A	S06340D	S06340S	S06341A	S06341D	S06341S	S06342A
S06342D	S06342S	S06343A	S06343D	S06343S	S06344A	S06344D	S06344S
S06345A	S06345D	S06345S	S06346A	S06346D	S06346S	S06347A	S06348A
S06349A	S06349D	S06349S	S0634AA	S0634AD	S0634AS	S06350A	S06350D
S06350S	S06351A	S06351D	S06351S	S06352A	S06352D	S06352S	S06353A
S06353D	S06353S	S06354A	S06354D	S06354S	S06355A	S06355D	S06355S
S06356A	S06356D	S06356S	S06357A	S06358A	S06359A	S06359D	S06359S
S0635AA	S0635AD	S0635AS	S06360A	S06360D	S06360S	S06361A	S06361D
S06361S	S06362A	S06362D	S06362S	S06363A	S06363D	S06363S	S06364A
S06364D	S06364S	S06365A	S06365D	S06365S	S06366A	S06366D	S06366S
S06367A	S06368A	S06369A	S06369D	S06369S	S0636AA	S0636AD	S0636AS
S06370A	S06370D	S06370S	S06371A	S06371D	S06371S	S06372A	S06372D
S06372S	S06373A	S06373D	S06373S	S06374A	S06374D	S06374S	S06375A
S06375D	S06375S	S06376A	S06376D	S06376S	S06377A	S06378A	S06379A
S06379D	S06379S	S0637AA	S0637AD	S0637AS	S06380A	S06380D	S06380S
S06381A	S06381D	S06381S	S06382A	S06382D	S06382S	S06383A	S06383D
S06383S	S06384A	S06384D	S06384S	S06385A	S06385D	S06385S	S06386A
S06386D	S06386S	S06387A	S06388A	S06389A	S06389D	S06389S	S0638AA
S0638AD	S0638AS	S064X0A	S064X0D	S064X0S	S064X1A	S064X1D	S064X1S
S064X2A	S064X2D	S064X2S	S064X3A	S064X3D	S064X3S	S064X4A	S064X4D

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Diagnosis Codes							
S064X4S	S064X5A	S064X5D	S064X5S	S064X6A	S064X6D	S064X6S	S064X7A
S064X8A	S064X9A	S064X9D	S064X9S	S064XAA	S064XAD	S064XAS	S065X0A
S065X0D	S065X0S	S065X1A	S065X1D	S065X1S	S065X2A	S065X2D	S065X2S
S065X3A	S065X3D	S065X3S	S065X4A	S065X4D	S065X4S	S065X5A	S065X5D
S065X5S	S065X6A	S065X6D	S065X6S	S065X7A	S065X8A	S065X9A	S065X9D
S065X9S	S065XAA	S065XAD	S065XAS	S066X0A	S066X0D	S066X0S	S066X1A
S066X1D	S066X1S	S066X2A	S066X2D	S066X2S	S066X3A	S066X3D	S066X3S
S066X4A	S066X4D	S066X4S	S066X5A	S066X5D	S066X5S	S066X6A	S066X6D
S066X6S	S066X7A	S066X8A	S066X9A	S066X9D	S066X9S	S066XAA	S066XAD
S066XAS	S06890A	S06890D	S06890S	S06891A	S06891D	S06891S	S06892A
S06892D	S06892S	S06893A	S06893S	S06894A	S06894D	S06894S	S06895A
S06895D	S06895S	S06896A	S06896D	S06896S	S06897A	S06898A	S06899A
S06899D	S06899S	S0689AA	S0689AD	S0689AS	S069X0A	S069X0D	S069X0S
S069X1A	S069X1D	S069X1S	S069X2A	S069X2D	S069X2S	S069X3A	S069X3D
S069X3S	S069X4A	S069X4D	S069X4S	S069X5A	S069X5D	S069X5S	S069X6A
S069X6D	S069X6S	S069X7A	S069X8A	S069X9A	S069X9D	S069X9S	S069XAA
S069XAD	S069XAS	S06A0XA	S06A0XD	S06A0XS	S06A1XA	S06A1XD	S06A1XS
S0990xA	S0990xD	S0990xS					

9.2.26.6 Electrocardiogram (ECG)

Electrocardiograms (ECG) are a benefit of Texas Medicaid when used for the evaluation and management (E/M) of a confirmed or suspected primary disease of the heart, pericardium, and coronary arteries or when necessary for management of diseases that are not primarily cardiac, but can affect the heart directly or indirectly.

ECGs are limited to six treatments for each client, by any provider per benefit period.

For ECGs, a benefit period is defined as 12 consecutive months, beginning with the month the client receives the first ECG.

The following procedure codes may be reimbursed for ECGs: 93000, 93005, 93010, 93040, 93041, and 93042.

Claims that are denied for exceeding the six-ECG limitation may be appealed with documentation supporting medical necessity. The documentation must include the following:

- Diagnosis
- Treatment history
- Documentation of why additional ECGs are needed

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The report of the professional component (the interpretation) for the ECG must be a complete written report that includes relevant findings and appropriate comparisons.

The interpretation may appear on the actual tracing.

When the ECG is performed in conjunction with the performance of an evaluation and management (E/M) service, the interpretation may appear with a progress note or other report of the E/M service; however, if the ECG is billed as a separate service from the E/M service, the interpretation should contain the same information as a report made upon the tracing itself.

A simple notation of "ECG/EKG normal" without an accompanying tracing will not suffice as documentation of a separately payable interpretation.

Appropriate documentation, which includes a copy of the ECG tracing, must be kept in the client's medical record. Documentation must support the medical necessity of the ECG. Documentation may appear on the actual tracing or with a progress note or report. Documentation is subject to retrospective review.

Only an ECG interpretation that directly contributes to the diagnosis and treatment of a client may be considered for reimbursement. Services, such as routine admission ECGs performed without medical indications, that do not directly contribute to the diagnosis and treatment of an individual client are not considered medically necessary.

9.2.26.6.1 Prior Authorization for ECG

Prior authorization is not required for ECGs performed in the emergency room or inpatient hospital setting.

Prior authorization is required for more than six ECGs in a rolling 12-month period.

Requests for additional ECGs must be submitted on the Special Medical Prior Authorization (SMPA) Request Form along with documentation of medical necessity.

Providers may request a prior authorization up to 12 months in advance. When requesting retroactive authorization, a provider must submit the request no later than 14 calendar days after the ECG is completed.

Before submitting a prior authorization request for an ECG, a provider must have a completed SMPA Request Form that has been signed and dated by a physician who is familiar with the client. The completed SMPA Request Form must include the procedure codes and numerical quantities for the services requested. The completed SMPA Request Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

The SMPA Request Form must include all of the following information, which is related to medical necessity:

- Procedure requested (CPT)
- Diagnosis
- Treatment history
- Treatment plan

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Prior authorization requests submitted by paper, must be faxed or mailed with the completed SMPA Request Form to the SMPA department and a copy of the signed and dated form must be retained in the client's medical record at the provider's place of business. Requests may be faxed or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

9.2.26.7 Esophageal pH Probe Monitoring

Esophageal pH monitoring uses an indwelling pH microelectrode positioned just above the esophageal sphincter. The pH electrode and skin reference electrode are connected to a battery-powered pH meter and transmitter worn as a shoulder harness. The esophageal pH is monitored continuously and a strip chart is used to record the pH determinations. The patient is usually monitored for a 24-hour period. Esophageal pH monitoring is a medically appropriate adjunct procedure to help establish the presence or absence of gastroesophageal reflux.

Esophageal pH probe monitoring should be coded with procedure codes 91034, 91035, and 78262.

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) are limited to two services per rolling year, same procedure, any provider.

Claims that are denied for exceeding two services per rolling year may be considered on appeal with documentation of one of the following:

- The client is new and the provider has been unsuccessful in obtaining the client's previous records from a different provider.
- The provider is not aware that the client received previous esophageal testing.

Only one appeal will be considered per client, for the same provider. Providers must request prior authorization for any additional esophageal testing performed after the appealed service.

9.2.26.7.1 Prior Authorization

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) require prior authorization for services that exceed two per rolling year.

Requests for additional testing may be considered when submitted with documentation of medical necessity that supports, but is not limited to, the following:

- Adult's unintentional weight loss is more than 5 percent of their normal body weight in a span of 12 months or less
- Child's weight loss is 3 to 5 percent of their body mass in less than 30 days
- Symptoms of gastroesophageal reflux disease (GERD) that include heartburn and regurgitation that do not respond to treatment with medication
- Atypical symptoms of GERD, such as chest pain, coughing, wheezing, hoarseness, and sore throat

Prior authorization requests must be submitted to the Special Medical Prior Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. The completed prior authorization request form must be maintained by the requesting provider and the prescribing physician. The original, signed copy must be kept by the physician in the client's medical record.

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9.2.26.8 Helicobacter Pylori (H. pylori)

Initial testing for H. pylori may be performed using the following tests:

- Serology testing (procedure codes 83009 and 86677)
- Stool testing (procedure code 87338 with modifier QW)
- Breath testing (procedure codes 78267, 78268, 83013, and 83014)
- Amplified probe technique (procedure code 87513)

Serology testing for H. pylori is a noninvasive diagnostic procedure that is preferred for initial diagnosis but is not indicated after a diagnosis has been made. Serology testing is not indicated or covered for monitoring a response to therapy.

Procedure codes 83009 and 86677 are allowed once per lifetime when submitted by any provider. A second test may be considered on appeal with documentation that indicates the original test result was negative for H. pylori.

Procedure code 87513 is limited to two services per 28 days, any provider.

Urea breath tests (UBTs) and fecal antigen tests provide reliable means of identifying active H. pylori infection before antibiotic therapy. UBTs are the most reliable non-endoscopic test to document eradication of H. pylori infection.

H. pylori is accepted as an etiologic factor in duodenal ulcers, peptic ulcer disease, gastric carcinoma, and primary B cell gastric lymphoma. H. pylori testing may be indicated for symptomatic clients who have a documented history of chronic/recurrent duodenal ulcer, gastric ulcer, or chronic gastritis. The history must delineate the failed conservative treatment for the condition.

H. pylori testing is not indicated or covered for any of the following:

- New onset uncomplicated dyspepsia.
- New onset dyspepsia responsive to conservative treatment (e.g., withdrawal of nonsteroidal anti-inflammatory drugs [NSAID] and/or use of antisecretory agents). If the treatment does not prove successful in eliminating the symptoms, further testing may be indicated to determine the presence of H. pylori.
- Screening for H. pylori in asymptomatic clients.
- Dyspeptic clients requiring endoscopy and biopsy.

H. pylori testing is not indicated under the following circumstances:

- There has been a negative endoscopy in the previous 90 days.
- An endoscopy is planned.
- H. pylori is of new onset and still being treated.

H. pylori testing will be denied if it is performed within 90 days of an upper gastrointestinal endoscopy. Procedure codes 87338 (with modifier QW), 78267, 78268, 83013, and 83014 may be reimbursed within the 90 days if the provider submits documentation that indicates the client was tested for eradication after treatment.

If a follow-up breath or stool test is used to document eradication of H. pylori, the medical record documentation must verify the history of the following previous complication(s):

- The client remains symptomatic after a treatment regimen for H. pylori.
- The client is asymptomatic after H. pylori eradication therapy but has a history of hemorrhage, perforation, or outlet obstruction from peptic ulcer disease.
- The client has a history of ulcer on chronic NSAID or anticoagulant therapy.

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Testing for H. pylori eradication after the completion of antibiotic therapy (procedure codes 87338 [with modifier QW], 78267, 78268, 83013, and 83014) will be denied if billed less than 35 days after the initial test.

Procedure code 87339 is not a benefit of Texas Medicaid.

9.2.26.9 Myocardial Perfusion Imaging

Refer to: Subsection 4.2.1, "Cardiac Nuclear Imaging" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.26.10 Pediatric Pneumogram

A pediatric pneumogram (procedure code 94772) is a 12-hour to 24-hour recording of breathing effort, heart rate, oxygen level, and airflow to the lungs during sleep. The study is useful in identifying abnormal breathing patterns, with or without bradycardia, especially in premature infants.

The following diagnosis codes may be reimbursed for a pediatric pneumogram in infants from birth through 11 months of age:

Diagnosis Codes							
K200	K2080	K2081	K2090	K2091	K2100	K2101	K219
K220	P0082	P220	P228	P270	P271	P278	P282
P2830	P2831	P2832	P2833	P2839	P2840	P2841	P2842
P2843	P2849	P285	P2881	P2889	P84	R0600	R0609
R0681	R0682	R0683	R0689	R6813			

A pediatric pneumogram is limited to two services per lifetime without prior authorization when submitted with one of the diagnosis codes listed above. Additional studies may be considered under CCP with documentation of medical necessity, and will require prior authorization.

Refer to: Section 2, "Medicaid Children's Services Comprehensive Care Program (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

EMGs, polysomnography, EEGs, and ECGs are denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms are reimbursed on the same day as an apnea monitor (rented monthly) if documentation supports the medical necessity.

Pneumogram supplies are considered part of the technical component and are denied if billed separately.

9.2.27 Diagnostic Doppler Sonography

Diagnostic Doppler sonography is a benefit of Texas Medicaid when treatment decisions depend on the results. Authorization is not required for diagnostic Doppler services.

Doppler sonography uses a transducer that transmits and receives the returned sound waves as vibrations. The transducer turns the vibrations into electrical pulses that travel to the ultrasonic scanner where they are processed and transformed into a digital image. It is used to study blood flow throughout the body.

A vascular diagnostic study may be personally performed by a physician or by a technologist. The accuracy of noninvasive vascular diagnostic studies depends on the knowledge, skill, and experience of the technologist and physician performing and interpreting the study. Consequently, the physician who performs and/or interprets the study must be able to document training through recent residency training or post-graduate continuing medical education and experience and must maintain that documentation for post-payment review.

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If noninvasive vascular diagnostic studies are performed by a technologist, the technologist must have demonstrated competency in ultrasound by receiving one of the following credentials in vascular ultrasound technology:

- Registered Vascular Specialist (RVS) provided by Cardiovascular Credentialing International (CCI)
- Registered Vascular Technologist (RVT) provided by the American Registry of Diagnostic Medical Sonographers (ARDMS)
- Vascular Sonographer (VS) provided by the American Registry of Radiologic Technologists (ARRT), Sonography

Alternately, such studies must be performed in a facility or vascular laboratory accredited by one of the following nationally recognized accreditation organizations. If a vascular laboratory or facility is accredited, the technologists performing noninvasive cerebrovascular arterial studies in that laboratory are considered to have demonstrated competency in cerebrovascular ultrasound:

- American College of Radiology (ACR) Vascular Ultrasound Accreditation Program
- Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)

9.2.27.1 Cerebrovascular Doppler Studies

Cerebrovascular Doppler sonography includes both extracranial and transcranial (intracranial) studies. This group of Doppler studies is used to investigate cerebral hemodynamics (e.g., blood flow, vasculitis, cerebral fluid collection/hydrocephalus, cerebral vascular disorders,). Cerebrovascular Doppler sonography should not be used when treatment decisions will not be affected by the findings.

Cerebrovascular Doppler studies for the diagnosis of migraine are considered experimental and are not a benefit of Texas Medicaid.

Extracranial arterial Doppler (procedure codes 93880 and 93882) are limited to the following diagnosis codes:

Diagnosis Codes							
D446	D447	D7821	D7822	G450	G451	G452	G453
G454	G458	G459	G460	G461	G462	G463	G464
G465	G466	G467	G468	G8101	G8102	G8103	G8104
G8111	G8112	G8113	G8114	G8191	G8192	G8193	G8194
G830	G8311	G8312	G8313	G8314	G8321	G8322	G8323
G8324	G8331	G8332	G8333	G8334	G9751	G9752	G9761
G9762	H3401	H3402	H3403	H3411	H3412	H3413	H34211
H34212	H34213	H34231	H34232	H34233	H3582	H5311	H53121
H53122	H53123	H53131	H53132	H53133	H59311	H59312	H59313
H59319	H59321	H59322	H59323	H59329	H59331	H59332	H59333
H59339	H59341	H59342	H59343	H59349	H9541	H9542	H9551
H9552	I2510	I340	I341	I342	I350	I351	I352
I610	I611	I612	I613	I614	I615	I616	I618
I619	I6300	I63011	I63012	I63013	I6302	I63031	I63032
I63033	I6309	I6310	I63111	I63112	I63113	I6312	I63131
I63132	I63133	I6319	I6320	I63211	I63212	I63213	I63219

*** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**
**** Use R221 to report pulsatile neck mass**
***** Use R0989 to report carotid bruit**

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Diagnosis Codes							
I6322	I63231	I63232	I63233	I6329	I63311	I63312	I63313
I63321	I63322	I63323	I63331	I63332	I63333	I63341	I63342
I63343	I6339	I63411	I63412	I63413	I63421	I63422	I63423
I63431	I63432	I63433	I63441	I63442	I63443	I6349	I63511
I63512	I63513	I63521	I63522	I63523	I63531	I63532	I63533
I63541	I63542	I63543	I6359	I636	I6501	I6502	I6503
I651	I6521	I6522	I6523	I658	I6601	I6602	I6603
I6611	I6612	I6613	I6621	I6622	I6623	I663	I668
I671	I672	I676	I6781	I6782	I67841	I67848	I67850
I67858	I6789	I680	I69031	I69032	I69033	I69034	I69041
I69042	I69043	I69044	I69051	I69052	I69053	I69054	I69131
I69132	I69133	I69134	I69141	I69142	I69143	I69144	I69151
I69152	I69153	I69154	I69231	I69232	I69233	I69234	I69241
I69242	I69243	I69244	I69251	I69252	I69253	I69254	I69331
I69332	I69333	I69334	I69341	I69342	I69343	I69344	I69351
I69352	I69353	I69354	I69831	I69832	I69833	I69834	I69841
I69842	I69843	I69844	I69851	I69852	I69853	I69854	I69931
I69932	I69933	I69934	I69941	I69942	I69943	I69944	I69951
I69952	I69953	I69954	I720	I749	I76	I771	I772
I773	I776	I7771	I7789	I97610	I97611	I97618	I97620
I97621	I97630	I97631	I97638	J95830	J95831	J95860	J95861
K9161	K91840	K91841	K91870	K91871	L7621	L7622	L7631
L7632	M96830	M96831	M96840	M96841	N99820	N99821	N99840
N99841	R0989***	R221**	R260	R261	R295	R29810	R4701
R4702	R471	R4781	R4789	R55*	S15011A	S15011D	S15011S
S15012A	S15012D	S15012S	S15021A	S15021D	S15021S	S15022A	S15022D
S15022S	S15091A	S15091D	S15091S	S15092A	S15092D	S15092S	S15111A
S15111D	S15111S	S15112A	S15112D	S15112S	S15121A	S15121D	S15121S
S15122A	S15122D	S15122S	S15191A	S15191D	S15191S	S15192A	S15192D
S15192S	S25111A	S25111D	S25111S	S25112A	S25112D	S25112S	S25121A
S25121D	S25121S	S25122A	S25122D	S25122S	S25191A	S25191D	S25191S
S25192A	S25192D	S25192S	T82817A	T82817D	T82817S	T82818A	T82818D
T82818S	T82827A	T82827D	T82827S	T82828A	T82828D	T82828S	T82837A
T82837D	T82837S	T82838A	T82838D	T82838S	T82847A	T82847D	T82847S
T82848A	T82848D	T82848S	T82857A	T82857D	T82857S	T82858A	T82858D
T82858S	T82867A	T82867D	T82867S	T82868A	T82868D	T82868S	T8381XA
T8381XD	T8381XS	T8382XA	T8382XD	T8382XS	T8383XA	T8383XD	T8383XS
T8384XA	T8384XD	T8384XS	T8385XA	T8385XD	T8385XS	T8386XA	T8386XD

*** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**
**** Use R221 to report pulsatile neck mass**
***** Use R0989 to report carotid bruit**

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Diagnosis Codes							
T8386XS	T85818A	T85818D	T85818S	T85828A	T85828D	T85828S	T85838A
T85838D	T85838S	T85848A	T85848D	T85848S	T85858A	T85858D	T85858S
T85868A	T85868D	T85868S	T85898A	T85898D	T85898S	Z09	Z98890

*** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**
**** Use R221 to report pulsatile neck mass**
***** Use R0989 to report carotid bruit**

Transcranial Doppler (procedure codes 93886, 93888, 93892, 93893, 93896, 93897, and 93898) are limited to the following diagnosis codes:

Diagnosis Codes							
D7821	D7822	G450	G452	G453	G454	G458	G459
G460	G461	G462	G9382	G9389*	G9731	G9732	G9748
G9749	G9751	G9752	G9761	G9762	H59311	H59312	H59313
H59319	H59321	H59322	H59323	H59329	H59331	H59332	H59333
H59339	H59341	H59342	H59343	H59349	H9541	H9542	H9551
H9552	I6011	I6012	I602	I6031	I6032	I604	I6051
I6052	I606	I608	I610	I611	I613	I614	I615
I616	I618	I63011	I63012	I63013	I6302	I63031	I63032
I63033	I6309	I63111	I63112	I63113	I6312	I63131	I63132
I63133	I6319	I63211	I63212	I63213	I6322	I63231	I63232
I63233	I6329	I63311	I63312	I63313	I63321	I63322	I63323
I63331	I63332	I63333	I63341	I63342	I63343	I6339	I63411
I63412	I63413	I63421	I63422	I63423	I63431	I63432	I63433
I63441	I63442	I63443	I6349	I63511	I63512	I63513	I63521
I63522	I63523	I63531	I63532	I63533	I63541	I63542	I63543
I6359	I636	I6381	I6389	I639	I6501	I6502	I6503
I651	I6521	I6522	I6523	I658	I6601	I6602	I6603
I6611	I6612	I6613	I6621	I6622	I6623	I663	I668
I671	I672	I677	I6781	I6782	I67841	I67848	I67850
I67858	I6789	I679	I726	I749**	I76	I97610	I97611
I97618	I97620	I97621	I97630	I97631	I97638	J95830	J95831
J95860	J95861	K9161	K91840	K91841	K91870	K91871	L7621
L7622	L7631	L7632	M96830	M96831	M96840	M96841	N99820
N99821	N99840	N99841	Q282	Q283	R260	R261	R2681
R2689	R295	R29810	R4701	R4702	R471	R4781	R4789
R55***	S090XXA	S090XXD	S090XXS	S15111A	S15111D	S15111S	S15112A
S15112D	S15112S	S15121A	S15121D	S15121S	S15122A	S15122D	S15122S
S15191A	S15191D	S15191S	S15192A	S15192D	S15192S	T82818A	T82818D
T82818S	T82828A	T82828D	T82828S	T82838A	T82838D	T82838S	T82848A

*** Use G9389 to identify assessment of suspected brain death**
**** Use I749 to report paradoxical cerebral embolism**
***** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**

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Diagnosis Codes							
T82848D	T82848S	T82858A	T82858D	T82858S	T82868A	T82868D	T82868S
Z09							
*** Use G9389 to identify assessment of suspected brain death** **** Use I749 to report paradoxical cerebral embolism** ***** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**							

In addition to the diagnosis codes listed in the table above, procedure codes 93886, 93888, 93896, 93897, and 93898 are benefits for clients who are 2 through 16 years of age with sickle cell disease to evaluate the risk of stroke when submitted with the following diagnosis codes:

Diagnosis Codes							
D5700	D5702	D571	D5720	D57212	D57219	D5780	D57812
D57819							

9.2.27.2 Peripheral Doppler Studies

Peripheral Doppler sonography is used to determine vascular impedance and evaluate peripheral masses and peripheral nerve continuity.

9.2.27.3 Peripheral Arterial Doppler Studies

Noninvasive peripheral arterial examinations that are performed to establish the level and degree of arterial occlusive disease are reasonable and necessary if significant signs or symptoms of possible limbischemia are present, and the client is a candidate for invasive therapeutic procedures.

Peripheral arterial Doppler (procedure codes 93922, 93923, 93924, 93925, 93926, 93930, and 93931) are limited to the following diagnosis codes (unless otherwise indicated):

Diagnosis Codes							
E0851	E0852	E0859	E0951	E0952	E0959	E1051	E1052
E1059	E1151	E1152	E1159	E1351	E1352	E1359	G9751
G9752	I2583	I670	I700	I70218	I70228	I7025	I70268
I70298	I70418	I70428	I7045	I70468	I70498	I70518	I70528
I7055	I70568	I70598	I70618	I70628	I7065	I70668	I70698
I70718	I70728	I7075	I70768	I70798	I7092	I7102	I7103
I723	I728	I7300	I7301	I731	I7389	I739	I7401
I7409	I7411	I7419	I745	I748	I770	I771	I772
I773	I775	I7771	I7772	I7773	I7774	I7779	I77810
I77811	I77812	I7789	I790	I791	I798	I96	I97410
I97411	I97418	I9742	I9751	I9752	I97610	I97611	I97618
J9561	J9562	J9571	J9572	J95830	J95831	K9161	K9162
K9171	K9172	K91840	K91841	L7601	L7602	L7611	L7612
L7621	L7622	L89112	L89113	L89114	L89116	L89122	L89123
L89124	L89126	L89132	L89133	L89134	L89136	L89142	L89143
L89144	L89146	L89152	L89153	L89154	L89156	L89216	L89226
L89316	L89326	L8946	L89812	L89813	L89814	L89892	L89893
L89894	L89896	L98421	L98422	L98423	L98424	L98425	L98426
L98428	L98429	M314	M315	M316	M318	M79609	M96810

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Diagnosis Codes							
M96811	M96820	M96821	M96830	M96831	N184	N185	N186
N9961	N9962	N9971	N9972	N99820	N99821	R0989	R1901
R1902	R1903	R1904	R1905	R1906	R1907	R1909	R200
R201	R202	R203	T801XXA	T801XXD	T801XXS	T8131XA	T8131XD
T8131XS	T81320A	T81320D	T81320S	T81321A	T81321D	T81321S	T81328A
T81328D	T81328S	T81329A	T81329D	T81329S	T81718A	T81718D	T81718S
T8172XA	T8172XD	T8172XS	T8189XA	T8189XD	T8189XS	T82310A	T82310D
T82310S	T82311A	T82311D	T82311S	T82312A	T82312D	T82312S	T82318A
T82318D	T82318S	T82320A	T82320D	T82320S	T82321A	T82321D	T82321S
T82322A	T82322D	T82322S	T82328A	T82328D	T82328S	T82330A	T82330D
T82330S	T82331A	T82331D	T82331S	T82332A	T82332D	T82332S	T82338A
T82338D	T82338S	T82390A	T82390D	T82390S	T82391A	T82391D	T82391S
T82392A	T82392D	T82392S	T82398A	T82398D	T82398S	T8241XA	T8241XD
T8241XS	T8242XA	T8242XD	T8242XS	T8243XA	T8243XD	T8243XS	T8249XA
T8249XD	T8249XS	T82510A	T82510D	T82510S	T82511A	T82511D	T82511S
T82513A	T82513D	T82513S	T82514A	T82514D	T82514S	T82515A	T82515D
T82515S	T82518A	T82518D	T82518S	T82520A	T82520D	T82520S	T82521A
T82521D	T82521S	T82523A	T82523D	T82523S	T82524A	T82524D	T82524S
T82525A	T82525D	T82525S	T82528A	T82528D	T82528S	T82530A	T82530D
T82530S	T82531A	T82531D	T82531S	T82533A	T82533D	T82533S	T82534A
T82534D	T82534S	T82535A	T82535D	T82535S	T82538A	T82538D	T82538S
T82590A	T82590D	T82590S	T82591A	T82591D	T82591S	T82593A	T82593D
T82593S	T82594A	T82594D	T82594S	T82595A	T82595D	T82595S	T82598A
T82598D	T82598S	T827XXA	T827XXD	T827XXS	T82817A	T82817D	T82817S
T82818A	T82818D	T82818S	T82827A	T82827D	T82827S	T82828A	T82828D
T82828S	T82837A	T82837D	T82837S	T82838A	T82838D	T82838S	T82847A
T82847D	T82847S	T82848A	T82848D	T82848S	T82856A	T82856D	T82856S
T82857A	T82857D	T82857S	T82858A	T82858D	T82858S	T82867A	T82867D
T82867S	T82868A	T82868D	T82868S	T82897A	T82897D	T82897S	T82898A
T82898D	T82898S	T8381XA	T8381XD	T8381XS	T8382XA	T8382XD	T8382XS
T8383XA	T8383XD	T8383XS	T8384XA	T8384XD	T8384XS	T8385XA	T8385XD
T8385XS	T8386XA	T8386XD	T8386XS	T8389XA	T8389XD	T8389XS	T8481XA
T8481XD	T8481XS	T8482XA	T8482XD	T8482XS	T8483XA	T8483XD	T8483XS
T8484XA	T8484XD	T8484XS	T8485XA	T8485XD	T8485XS	T8486XA	T8486XD
T8486XS	T8489XA	T8489XD	T8489XS	T85810A	T85810D	T85810S	T85818A
T85818D	T85818S	T85860A	T85860D	T85860S	T85868A	T85868D	T85868S
T8601	T8602	T8603	T8609	T8611	T8612	T8613	T8619
T8621	T8622	T8623	T86290	T86298	T8631	T8632	T8633
T8639	T8641	T8642	T8643	T8649	T86810	T86811	T86812
T86818	T86830	T86831	T86832	T86838	T86850	T86851	T86852

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Diagnosis Codes							
T86858	T86890	T86891	T86892	T86898	T872	T888XXA	Z09
Z4803	Z48812	Z4889	Z951	Z955	Z95820	Z95828	Z9861

Diagnosis Codes for Upper Extremity Conditions							
I721	I742	I75011	I75012	I75013	I7776	L89012	L89013
L89014	L89016	L89022	L89023	L89024	L89026	M79A11	M79A12
Q2731	S45011A	S45011D	S45011S	S45012A	S45012D	S45012S	S45091A
S45091D	S45091S	S45092A	S45092D	S45092S	S45111A	S45111D	S45111S
S45112A	S45112D	S45112S	S45191A	S45191D	S45191S	S45192A	S45192D
S45192S	S45211A	S45211D	S45211S	S45212A	S45212D	S45212S	S45219A
S45219D	S45219S	S45291A	S45291D	S45291S	S45292A	S45292D	S45292S
S45311A	S45311D	S45311S	S45312A	S45312D	S45312S	S45391A	S45391D
S45391S	S45392A	S45392D	S45392S	S45811A	S45811D	S45811S	S45812A
S45812D	S45812S	S45891A	S45891D	S45891S	S45892A	S45892D	S45892S
S55011A	S55011D	S55011S	S55012A	S55012D	S55012S	S55091A	S55091D
S55091S	S55092A	S55092D	S55092S	S55111A	S55111D	S55111S	S55112A
S55112D	S55112S	S55191A	S55191D	S55191S	S55192A	S55192D	S55192S
S55211A	S55211D	S55211S	S55212A	S55212D	S55212S	S55291A	S55291D
S55291S	S55292A	S55292D	S55292S	S55811A	S55811D	S55811S	S55812A
S55812D	S55812S	S55891A	S55891D	S55891S	S55892A	S55892D	S55892S
S65011A	S65011D	S65011S	S65012A	S65012D	S65012S	S65091A	S65091D
S65091S	S65092A	S65092D	S65092S	S65111A	S65111D	S65111S	S65112A
S65112D	S65112S	S65191A	S65191D	S65191S	S65192A	S65192D	S65192S
S65211A	S65211D	S65211S	S65212A	S65212D	S65212S	S65291A	S65291D
S65291S	S65292A	S65292D	S65292S	S65311A	S65311D	S65311S	S65312A
S65312D	S65312S	S65391A	S65391D	S65391S	S65392A	S65392D	S65392S
S65411A	S65411D	S65411S	S65412A	S65412D	S65412S	S65491A	S65491D
S65491S	S65492A	S65492D	S65492S	S65510A	S65510D	S65510S	S65511A
S65511D	S65511S	S65512A	S65512D	S65512S	S65513A	S65513D	S65513S
S65514A	S65514D	S65514S	S65515A	S65515D	S65515S	S65516A	S65516D
S65516S	S65517A	S65517D	S65517S	S65518A	S65518D	S65518S	S65590A
S65590D	S65590S	S65591A	S65591D	S65591S	S65592A	S65592D	S65592S
S65593A	S65593D	S65593S	S65594A	S65594D	S65594S	S65595A	S65595D
S65595S	S65596A	S65596D	S65596S	S65597A	S65597D	S65597S	S65598A
S65598D	S65598S	S65811A	S65811D	S65811S	S65812A	S65812D	S65812S
S65891A	S65891D	S65891S	S65892A	S65892D	S65892S	T870X1	T870X2

Diagnosis Codes for Lower Extremity Conditions							
I70211	I70212	I70213	I70221	I70222	I70223	I70231	I70232
I70233	I70234	I70235	I70238	I70241	I70242	I70243	I70244

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Diagnosis Codes for Lower Extremity Conditions							
I70245	I70248	I70261	I70262	I70263	I70291	I70292	I70293
I70411	I70412	I70413	I70421	I70422	I70423	I70431	I70432
I70433	I70434	I70435	I70438	I70441	I70442	I70443	I70444
I70445	I70448	I70461	I70462	I70463	I70491	I70492	I70493
I70511	I70512	I70513	I70521	I70522	I70523	I70531	I70532
I70533	I70534	I70535	I70538	I70541	I70542	I70543	I70544
I70545	I70548	I70561	I70562	I70563	I70591	I70592	I70593
I70611	I70612	I70613	I70621	I70622	I70623	I70631	I70632
I70633	I70634	I70635	I70638	I70641	I70642	I70643	I70644
I70645	I70648	I70661	I70662	I70663	I70691	I70692	I70693
I70711	I70712	I70713	I70721	I70722	I70723	I70731	I70732
I70733	I70734	I70735	I70738	I70741	I70742	I70743	I70744
I70745	I70748	I70761	I70762	I70763	I70791	I70792	I70793
I724	I743	I75021	I75022	I75023	I7777	I83011	I83012
I83013	I83014	I83015	I83018	I83021	I83022	I83023	I83024
I83025	I83028	L89212	L89213	L89214	L89222	L89223	L89224
L89312	L89313	L89314	L89322	L89323	L89324	L8942	L8943
L8944	L89512	L89513	L89514	L89516	L89522	L89523	L89524
L89526	L89612	L89613	L89614	L89616	L89622	L89623	L89624
L89626	L97111	L97112	L97113	L97114	L97115	L97116	L97118
L97119	L97121	L97122	L97123	L97124	L97125	L97126	L97128
L97129	L97205	L97206	L97208	L97209	L97211	L97212	L97213
L97214	L97215	L97216	L97218	L97219	L97221	L97222	L97223
L97224	L97305	L97306	L97308	L97309	L97311	L97312	L97313
L97314	L97315	L97316	L97318	L97319	L97321	L97322	L97323
L97324	L97325	L97326	L97328	L97329	L97411	L97412	L97413
L97414	L97415	L97416	L97418	L97419	L97421	L97422	L97423
L97424	L97425	L97426	L97428	L97429	L97511	L97512	L97513
L97514	L97521	L97522	L97523	L97524	L97811	L97812	L97813
L97814	L97816	L97818	L97819	L97821	L97822	L97823	L97824
L98411	L98412	L98413	L98414	L98415	L98416	L98418	L98419
M79A21	M79A22	Q2732	S75011A	S75011D	S75011S	S75012A	S75012D
S75012S	S75021A	S75021D	S75021S	S75022A	S75022D	S75022S	S75091A
S75091D	S75091S	S75092A	S75092D	S75092S	S75111A	S75111D	S75111S
S75112A	S75112D	S75112S	S75121A	S75121D	S75121S	S75122A	S75122D
S75122S	S75191A	S75191D	S75191S	S75192A	S75192D	S75192S	S75211A
S75211D	S75211S	S75212A	S75212D	S75212S	S75221A	S75221D	S75221S
S75222A	S75222D	S75222S	S75291A	S75291D	S75291S	S75292A	S75292D
S75292S	S75811A	S75811D	S75811S	S75812A	S75812D	S75812S	S75891A
S75891D	S75891S	S75892A	S75892D	S75892S	S85011A	S85011D	S85011S

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Diagnosis Codes for Lower Extremity Conditions							
S85012A	S85012D	S85012S	S85091A	S85091D	S85091S	S85092A	S85092D
S85092S	S85141A	S85141D	S85141S	S85142A	S85142D	S85142S	S85151A
S85151D	S85151S	S85152A	S85152D	S85152S	S85171A	S85171D	S85171S
S85172A	S85172D	S85172S	S85181A	S85181D	S85181S	S85182A	S85182D
S85182S	S85211A	S85211D	S85211S	S85212A	S85212D	S85212S	S85291A
S85291D	S85291S	S85292A	S85292D	S85292S	S85311A	S85311D	S85311S
S85312A	S85312D	S85312S	S85391A	S85391D	S85391S	S85392A	S85392D
S85392S	S85411A	S85411D	S85411S	S85412A	S85412D	S85412S	S85491A
S85491D	S85491S	S85492A	S85492D	S85492S	S85511A	S85511D	S85511S
S85512A	S85512D	S85512S	S85591A	S85591D	S85591S	S85592A	S85592D
S85592S	S85811A	S85811D	S85811S	S85812A	S85812D	S85812S	S85891A
S85891D	S85891S	S85892A	S85892D	S85892S	S95011A	S95011D	S95011S
S95012A	S95012D	S95012S	S95091A	S95091D	S95091S	S95092A	S95092D
S95092S	S95111A	S95111D	S95111S	S95112A	S95112D	S95112S	S95191A
S95191D	S95191S	S95192A	S95192D	S95192S	S95211A	S95211D	S95211S
S95212A	S95212D	S95212S	S95291A	S95291D	S95291S	S95292A	S95292D
S95292S	S95811A	S95811D	S95811S	S95812A	S95812D	S95812S	S95891A
S95891D	S95891S	S95892A	S95892D	S95892S	T871X1	T871X2	

9.2.27.4 Peripheral Venous Doppler Studies

Non-invasive vascular diagnostic studies utilize ultrasonic Doppler and physiologic principles to assess irregularities in blood flow in the venous system.

Peripheral venous Doppler (procedure codes 93970 and 93971) are limited to the following diagnosis codes:

Diagnosis Codes							
I2601	I2602	I2603	I2604	I2609	I2690	I2692	I2693
I2694	I2695	I2696	I2699	I749	I8001	I8002	I8003
I8011	I8012	I8013	I80211	I80212	I80213	I80221	I80222
I80223	I80231	I80232	I80233	I80241	I80242	I80243	I80251
I80252	I80253	I80291	I80292	I80293	I808	I821	I82220
I82411	I82412	I82413	I82421	I82422	I82423	I82431	I82432
I82433	I82441	I82442	I82443	I82451	I82452	I82453	I82461
I82462	I82463	I82491	I82492	I82493	I82511	I82512	I82513
I82521	I82522	I82523	I82531	I82532	I82533	I82541	I82542
I82543	I82551	I82552	I82553	I82561	I82562	I82563	I82591
I82592	I82593	I82611	I82612	I82613	I82621	I82622	I82623
I82711	I82712	I82713	I82721	I82722	I82723	I82A11	I82A12
I82A13	I82A21	I82A22	I82A23	I82C11	I82C12	I82C13	I82C21
I82C22	I82C23	I82811	I82812	I82813	I82890	I82891	I83011
I83012	I83013	I83014	I83015	I83018	I83021	I83022	I83023

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Diagnosis Codes							
I83024	I83025	I83028	I8311	I8312	I83211	I83212	I83213
I83214	I83215	I83218	I83221	I83222	I83223	I83224	I83225
I83228	I83811	I83812	I83813	I83891	I83892	I83893	I87001
I87002	I87003	I87011	I87012	I87013	I87021	I87022	I87023
I87031	I87032	I87033	I87091	I87092	I87093	I871	I872
I87311	I87312	I87313	I87321	I87322	I87323	I87331	I87332
I87333	I87391	I87392	I87393	I96	J80	J9600	J9601
J9602	J9690	L89016	L89026	L89116	L89126	L89136	L89146
L89156	L89216	L89226	L89316	L89326	L8946	L97111	L97112
L97113	L97114	L97115	L97116	L97118	L97119	L97121	L97122
L97123	L97124	L97125	L97126	L97128	L97129	L97211	L97212
L97213	L97214	L97215	L97216	L97218	L97219	L97221	L97222
L97223	L97224	L97225	L97226	L97228	L97229	L97311	L97312
L97313	L97314	L97315	L97316	L97318	L97319	L97321	L97322
L97323	L97324	L97325	L97326	L97328	L97329	L97411	L97412
L97413	L97414	L97415	L97416	L97418	L97419	L97421	L97422
L97423	L97424	L97425	L97426	L97428	L97429	L97511	L97512
L97513	L97514	L97515	L97516	L97518	L97519	L97521	L97522
L97523	L97524	L97525	L97526	L97528	L97529	L97811	L97812
L97813	L97814	L97815	L97816	L97818	L97819	L97821	L97822
L97823	L97824	L97825	L97826	L97828	L97829	M7121	M7122
M79601	M79602	M79604	M79605	M79621	M79622	M79631	M79632
M79641	M79642	M79644	M79645	M79651	M79652	M79661	M79662
M79671	M79672	M79674	M79675	O2221	O2222	O2223	O2231
O2232	O2233	O870	O871	O88211	O88212	O88213	O8822
O8823	Q2731	Q2732	Q278	R042	R0600	R0602	R0609
R0682	R071	R0781	R0782	R0789	R079	R2231	R2232
R2233	R2241	R2242	R2243	R600	R601	R609	T800XXA
T801XXA	T8172XA	T82817A	T82818A	T82827A	T82828A	T82837A	T82838A
T82847A	T82848A	T82857A	T82858A	T82867A	T82868A	T8381XA	T8382XA
T8383XA	T8384XA	T8385XA	T8386XA	T85818A	T85828A	T85838A	T85848A
T85858A	T85868A	T85898A					

In addition to the diagnosis codes listed in the table above, procedure code 93971 is also a benefit when submitted with diagnosis code Z01810, Z01818, or Z09.

Doppler echocardiography color flow velocity mapping (procedure code 93325) must be billed with one of the corresponding procedure codes in column B to be considered for reimbursement:

Column A Procedure Code	Column B Procedure Codes
93325	76825, 76826, 76827, 76828, 93303, 93304, 93308, 93312, 93314, 93315, 93317, 93350, or 93351

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9.2.27.5 Limitations for Diagnostic Doppler Sonography

Documentation of medical necessity for the diagnostic Doppler study must be maintained by the ordering provider in the client's medical record.

Procedure codes described as complete bilateral studies are inclusive codes, and right and left studies billed on the same day will be reimbursed at a quantity of one.

Diagnostic Doppler procedure codes are limited to one study per day, same provider.

When medically necessary, multiple Doppler procedures (e.g., studies of extracranial arteries and intracranial arteries) billed on the same day by the same provider will be reimbursed at full fee for the first study and one-half fee for each additional study, regardless of the number of services billed.

The use of transcranial Doppler studies performed for the assessment of stroke risk in clients who are 2 through 16 years of age who have sickle cell anemia should be limited to once every 6 months.

The use of a simple hand-held or other Doppler device that does not produce hard copy output or that does not permit analysis of bidirectional vascular flow is considered part of the physical examination of the vascular system and is not separately reported.

9.2.28 Evoked Response Tests and Neuromuscular Procedures

The following services are a benefit of Texas Medicaid:

- Autonomic function test (AFT)
- Electromyography (EMG)
- Nerve conduction studies (NCS)
- Evoked potential (EP) testing
- Motion analysis studies

9.2.28.1 Autonomic Function Tests

AFTs are a benefit of Texas Medicaid when submitted with procedure codes 95921, 95922, 95923, and 95924.

Prior authorization is not required for AFTs.

Procedure codes 95921, 95922, 95923, and 95924 are limited to once per date of service, by the same provider.

Autonomic disorders may be congenital or acquired (primary or secondary). Some of the conditions under which autonomic function testing may be appropriate include, but are not limited to, the following:

- Amyloid neuropathy
- Diabetic autonomic neuropathy
- Distal small fiber neuropathy
- Excessive sweating
- Gastrointestinal dysfunction
- Idiopathic neuropathy
- Irregular heart rate
- Multiple system atrophy
- Orthostatic symptoms
- Pure autonomic failure

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- Reflex sympathetic dystrophy or causalgia (sympathetically maintained pain)
- Sjögren's syndrome

9.2.28.1.1 Documentation Requirements for Autonomic Function Testing

The reason for the referral, the specific autonomic function being tested, and a clear diagnostic impression must be documented in the client's medical record for each AFT performed.

The client's medical records must clearly document the medical necessity for the AFT. The medical record documentation must reflect the actual results of specific tests.

Medical necessity for reevaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- Clinical benefit of additional studies.

The client's medical records are subject to retrospective review. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.28.2 Electromyography and Nerve Conduction Studies

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as electrodiagnostic (EDX) testing, must be medically indicated and may be reimbursed with the diagnosis codes listed below. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

Diagnosis Codes							
C701	C720	C721	D510	D511	D513	D518	D519
D538	E0842	E0942	E1041	E1042	E10610	E1141	E1142
E1144	E11610	E1342	E5111	E5112	E512	E518	E519
E52	E530	E531	E538	E550	E559	E560	E568
E610	E7281	E7289	E7841	E7849	E786	E851	E852
E853	E8581	E8582	E8589	E859	G120	G121	G1221
G1222	G1223	G1224	G1225	G1229	G128	G129	G130
G243	G2589	G26	G320	G360	G370	G375	G501
G510	G511	G512	G5131	G5132	G5133	G5139	G514
G518	G519	G522	G523	G527	G528	G540	G541
G542	G543	G544	G545	G548	G549	G5601	G5602
G5603	G5611	G5612	G5613	G5621	G5622	G5623	G5631
G5632	G5633	G5641	G5642	G5643	G5681	G5682	G5683
G5691	G5692	G5693	G5701	G5702	G5703	G5711	G5712

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Diagnosis Codes							
G5713	G5721	G5722	G5723	G5731	G5732	G5733	G5741
G5742	G5743	G5751	G5752	G5753	G5761	G5762	G5763
G5771	G5772	G5773	G5781	G5782	G5783	G5791	G5792
G5793	G587	G588	G589	G59	G600	G601	G602
G603	G608	G609	G610	G6181	G6182	G6189	G619
G620	G621	G622	G6281	G6282	G629	G63	G650
G651	G652	G7000	G7001	G701	G702	G7081	G7089
G709	G7100	G7101	G7102	G7109	G7111	G7112	G7113
G7114	G7119	G7120	G7121	G71220	G71228	G7129	G713
G718	G719	G721	G722	G723	G7241	G7249	G7281
G7289	G729	G731	G733	G737	G800	G801	G802
G803	G804	G808	G809	G8311	G8312	G8313	G8314
G8321	G8322	G8323	G8324	G834	G8381	G8382	G8383
G8384	G8389	G839	G9009	G902	G904	G9050	G90511
G90512	G90513	G90519	G90521	G90522	G90523	G90529	G9059
G909	G950	G9511	G9519	G9520	G9529	G9581	G9589
G959	G990	G992	I776	I951	J3800	J3801	J3802
K5902	K5903	K5904	K5909	K592	K594	K624	K6289
M05411	M05412	M05421	M05422	M05431	M05432	M05441	M05442
M05451	M05452	M05461	M05462	M05471	M05472	M0549	M05511
M05512	M05521	M05522	M05531	M05532	M05541	M05542	M05551
M05552	M05561	M05562	M05571	M05572	M0559	M05711	M05712
M05721	M05722	M05731	M05732	M05741	M05742	M05751	M05752
M05761	M05762	M05769	M05771	M05772	M05779	M0579	M057A
M05811	M05812	M05821	M05822	M05831	M05832	M05841	M05842
M05851	M05852	M05861	M05862	M05871	M05872	M0589	M058A
M05A	M06011	M06012	M06021	M06022	M06031	M06032	M06041
M06042	M06051	M06052	M06061	M06062	M06071	M06072	M0608
M0609	M060A	M06811	M06812	M06821	M06822	M06831	M06832
M06841	M06842	M06852	M06861	M06862	M06871	M06872	M0688
M0689	M068A	M069	M21271	M21272	M21331	M21332	M21511
M21512	M216X1	M216X2	M21831	M21832	M21931	M21932	M320
M3210	M3211	M3212	M3213	M3214	M3215	M3219	M328
M329	M3300	M3301	M3302	M3309	M3310	M3311	M3312
M3319	M3320	M3321	M3322	M3329	M3390	M3391	M3392
M3399	M340	M341	M342	M3481	M3482	M3483	M3489
M3500	M3501	M3502	M3503	M3504	M3505	M3506	M3507
M3508	M3509	M3581	M3589	M350A	M350B	M350C	M3581
M3589	M360	M4321	M4322	M4323	M4324	M4325	M4326
M4327	M4328	M436	M438X9	M4644	M4645	M4646	M4647

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Diagnosis Codes							
M4711	M4712	M4713	M4714	M4715	M4716	M4721	M4722
M4723	M4724	M4725	M4726	M4727	M4728	M47811	M47812
M47813	M47814	M47815	M47816	M47817	M47818	M47891	M47892
M47893	M47894	M47895	M47896	M47897	M47898	M4801	M4802
M4803	M4804	M4805	M48062	M4807	M4808	M5000	M5001
M50020	M50021	M50022	M50023	M5003	M5011	M50120	M50121
M50122	M50123	M5013	M5020	M5021	M50220	M50221	M50222
M50223	M5023	M5030	M5031	M50320	M50321	M50322	M50323
M5033	M5080	M5081	M50820	M50821	M50822	M50823	M5083
M5091	M50920	M50921	M50922	M50923	M5093	M5104	M5105
M5106	M5124	M5125	M5126	M5127	M5134	M5135	M51360
M51361	M51362	M51369	M51370	M51371	M51372	M51379	M5184
M5185	M5186	M5187	M5410	M5411	M5412	M5413	M5414
M5415	M5416	M5417	M5431	M5432	M5450	M5451	M5459
M546	M5489	M60011	M60012	M60021	M60022	M60031	M60032
M60041	M60042	M60044	M60051	M60052	M60061	M60062	M60070
M60071	M60073	M60074	M60076	M60077	M6008	M6009	M60111
M60112	M60121	M60122	M60131	M60132	M60141	M60142	M60151
M60152	M60161	M60162	M60171	M60172	M6018	M6019	M609
M6250	M62511	M62512	M62519	M62521	M62522	M62529	M62531
M62532	M62539	M62541	M62542	M62549	M62551	M62552	M62559
M62561	M62562	M62569	M62571	M62572	M62579	M6258	M6259
M625A0	M625A1	M625A2	M625A9	M6281	M6284	M6285	M629
M7910	M7911	M7912	M7918	M792	M79601	M79602	M79604
M79605	M79621	M79622	M79631	M79632	M79641	M79642	M79651
M79652	M79661	M79662	M79671	M79672	M797	M961	N393
N3941	N3942	N3943	N3944	N3945	N3946	N39490	N39491
N39492	N39498	N94819	R150	R151	R152	R159	R200
R201	R202	R203	R208	R209	R260	R261	R2681
R2689	R269	R290	R295	R29701	R29702	R29703	R29704
R29705	R29706	R29707	R29708	R29709	R29710	R29711	R29712
R29713	R29714	R29715	R29716	R29717	R29718	R29719	R29720
R29721	R29722	R29723	R29724	R29725	R29726	R29727	R29728
R29729	R29730	R29731	R29732	R29733	R29734	R29735	R29736
R29737	R29738	R29739	R29740	R29741	R29742	R32	R3914
R39191	R39192	R39198	R4702	R471	R4781	R4789	R498
R6884	R7681	S14101A	S14101D	S14101S	S14102A	S14102D	S14102S
S14103A	S14103D	S14103S	S14104A	S14104D	S14104S	S14105A	S14105D
S14105S	S14106A	S14106D	S14106S	S14107A	S14107D	S14107S	S14108A
S14108D	S14108S	S14109A	S14109D	S14109S	S14111A	S14111D	S14111S

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Diagnosis Codes							
S14112A	S14112D	S14112S	S14113A	S14113D	S14113S	S14114A	S14114D
S14114S	S14115A	S14115D	S14115S	S14116A	S14116D	S14116S	S14117A
S14117D	S14117S	S14118A	S14118D	S14118S	S14121A	S14121D	S14121S
S14122A	S14122D	S14122S	S14123A	S14123D	S14123S	S14124A	S14124D
S14124S	S14125A	S14125D	S14125S	S14126A	S14126D	S14126S	S14127A
S14127D	S14127S	S14128A	S14128D	S14128S	S14131A	S14131D	S14131S
S14132A	S14132D	S14132S	S14133A	S14133D	S14133S	S14134A	S14134D
S14134S	S14135A	S14135D	S14135S	S14136A	S14136D	S14136S	S14137A
S14137D	S14137S	S14138A	S14138D	S14138S	S14141A	S14141D	S14141S
S14142A	S14142D	S14142S	S14143A	S14143D	S14143S	S14144A	S14144D
S14144S	S14145A	S14145D	S14145S	S14146A	S14146D	S14146S	S14147A
S14147D	S14147S	S14148A	S14148D	S14148S	S14151A	S14151D	S14151S
S14152A	S14152D	S14152S	S14153A	S14153D	S14153S	S14154A	S14154D
S14154S	S14155A	S14155D	S14155S	S14156A	S14156D	S14156S	S14157A
S14157D	S14157S	S14158A	S14158D	S14158S	S142XXA	S142XXD	S142XXS
S143XXA	S143XXD	S143XXS	S144XXA	S144XXD	S144XXS	S145XXA	S145XXD
S145XXS	S148XXA	S148XXD	S148XXS	S149XXA	S149XXD	S149XXS	S24101A
S24101D	S24101S	S24102A	S24102D	S24102S	S24103A	S24103D	S24103S
S24104A	S24104D	S24104S	S24109A	S24109D	S24109S	S24111A	S24111D
S24111S	S24112A	S24112D	S24112S	S24113A	S24113D	S24113S	S24114A
S24114D	S24114S	S24131A	S24131D	S24131S	S24132A	S24132D	S24132S
S24133A	S24133D	S24133S	S24134A	S24134D	S24134S	S24141A	S24141D
S24141S	S24142A	S24142D	S24142S	S24143A	S24143D	S24143S	S24144A
S24144D	S24144S	S24151A	S24151D	S24151S	S24152A	S24152D	S24152S
S24153A	S24153D	S24153S	S24154A	S24154D	S24154S	S242XXA	S242XXD
S242XXS	S243XXA	S243XXD	S243XXS	S244XXA	S244XXD	S244XXS	S248XXA
S248XXD	S248XXS	S249XXA	S249XXD	S249XXS	S34109A	S34109D	S34109S
S34111A	S34111D	S34111S	S34112A	S34112D	S34112S	S34113A	S34113D
S34113S	S34114A	S34114D	S34114S	S34115A	S34115D	S34115S	S34121A
S34121D	S34121S	S34122A	S34122D	S34122S	S34123A	S34123D	S34123S
S34124A	S34124D	S34124S	S34125A	S34125D	S34125S	S34131A	S34131D
S34131S	S34132A	S34132D	S34132S	S34139A	S34139D	S34139S	S3421XA
S3421XD	S3421XS	S3422XA	S3422XD	S3422XS	S343XXA	S343XXD	S343XXS
S344XXA	S344XXD	S344XXS	S345XXA	S345XXD	S345XXS	S4400XA	S4400XD
S4400XS	S4401XA	S4401XD	S4401XS	S4402XA	S4402XD	S4402XS	S4410XA
S4410XD	S4410XS	S4411XA	S4411XD	S4411XS	S4412XA	S4412XD	S4412XS
S4420XA	S4420XD	S4420XS	S4421XA	S4421XD	S4421XS	S4422XA	S4422XD
S4422XS	S4430XA	S4430XD	S4430XS	S4431XA	S4431XD	S4431XS	S4432XA
S4432XD	S4432XS	S4440XA	S4440XD	S4440XS	S4441XA	S4441XD	S4441XS
S4442XA	S4442XD	S4442XS	S4450XA	S4450XD	S4450XS	S4451XA	S4451XD

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Diagnosis Codes							
S4451XS	S4452XA	S4452XD	S4452XS	S448X1A	S448X1D	S448X1S	S448X2A
S448X2D	S448X2S	S448X9A	S448X9D	S448X9S	S4490XA	S4490XD	S4490XS
S4491XA	S4491XD	S4491XS	S4492XA	S4492XD	S4492XS	S5400XA	S5400XD
S5400XS	S5401XA	S5401XD	S5401XS	S5402XA	S5402XD	S5402XS	S5410XA
S5410XD	S5410XS	S5411XA	S5411XD	S5411XS	S5412XA	S5412XD	S5412XS
S5420XA	S5420XD	S5420XS	S5421XA	S5421XD	S5421XS	S5422XA	S5422XD
S5422XS	S5430XA	S5430XD	S5430XS	S5431XA	S5431XD	S5431XS	S5432XA
S5432XD	S5432XS	S5490XA	S5490XD	S5490XS	S5491XA	S5491XD	S5491XS
S5492XA	S5492XD	S5492XS	S6400XA	S6400XD	S6400XS	S6401XA	S6401XD
S6401XS	S6402XA	S6402XD	S6402XS	S6410XA	S6410XD	S6410XS	S6411XA
S6411XD	S6411XS	S6412XA	S6412XD	S6412XS	S6420XA	S6420XD	S6420XS
S6421XA	S6421XD	S6421XS	S6422XA	S6422XD	S6422XS	S6430XA	S6430XD
S6430XS	S6431XA	S6431XD	S6431XS	S6432XA	S6432XD	S6432XS	S64490A
S64490D	S64490S	S64491A	S64491D	S64491S	S64492A	S64492D	S64492S
S64493A	S64493D	S64493S	S64494A	S64494D	S64494S	S64495A	S64495D
S64495S	S64496A	S64496D	S64496S	S64497A	S64497D	S64497S	S64498A
S64498D	S64498S	S648X1A	S648X1D	S648X1S	S648X2A	S648X2D	S648X2S
S648X9A	S648X9D	S648X9S	S6490XA	S6490XD	S6490XS	S6491XA	S6491XD
S6491XS	S6492XA	S6492XD	S6492XS	S7401XA	S7401XD	S7401XS	S7402XA
S7402XD	S7402XS	S7411XA	S7411XD	S7411XS	S7412XA	S7412XD	S7412XS
S7421XA	S7421XD	S7421XS	S7422XA	S7422XD	S7422XS	S748X1A	S748X1D
S748X1S	S748X2A	S748X2D	S748X2S	S7491XA	S7491XD	S7491XS	S7492XA
S7492XD	S7492XS	S8401XA	S8401XD	S8401XS	S8402XA	S8402XD	S8402XS
S8410XS	S8411XA	S8411XD	S8411XS	S8412XA	S8412XD	S8412XS	S8421XA
S8421XD	S8421XS	S8422XA	S8422XD	S8422XS	S84801A	S84801D	S84801S
S84802A	S84802D	S84802S	S8491XA	S8491XD	S8491XS	S8492XA	S8492XD
S8492XS	S9421XA	S9421XD	S9421XS	S9422XA	S9422XD	S9422XS	S9431XA
S9431XD	S9431XS	S9432XA	S9432XD	S9432XS	S948X1A	S948X1D	S948X1S
S948X2A	S948X2D	S948X2S	S948X9A	S948X9D	S948X9S	S9490XA	S9490XD
S9490XS	S9491XA	S9491XD	S9491XS	S9492XA	S9492XD	S9492XS	T85840A
T85840D	T85840S						

Any EDX testing procedures may be reimbursed up to four different dates of service per calendar year, same provider. Any E/M service will be denied as part of another service when billed for the same date of service as EMG or NCS service by the same provider.

Claims for nerve conduction studies that are denied for exceeding the maximum number of studies allowed per day, may be appealed with supporting medical record documentation.

9.2.28.2.1 Documentation Requirements for EMG and NCS

The reason for the referral, the specific site(s) tested, and a clear diagnostic impression must be documented in the client's medical record for each NCS or EMG study performed.

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The client's medical records must clearly document the medical necessity for the NCS and EMG testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis. Examples may include suspected:
  - Peripheral nerve entrapment syndromes
  - Other neuropathies (traumatic, metabolic, or demyelinating)
  - Neuromuscular junction disorders (myasthenia gravis, botulism)
  - Myopathies (dermatomyositis, congenital myopathies)
  - Unexplained symptoms suggestive of peripheral nerve, muscle or neuromuscular junction pathology, manifested by:
    - Muscle weakness
    - Muscle atrophy
    - Loss of dexterity
    - Spasticity
    - Sensory deficits
    - Swallowing dysfunction
    - Diplopia
    - Dysarthria
- The client's diagnosis could not be confirmed on previous studies, although suspected.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional electrodiagnostic studies.

The client's medical records are subject to retrospective review. NCS hard copies of the wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.28.2.2 EMG

The following EMG procedure codes may be reimbursed for one service per day, each procedure, by the same provider:

Procedure Codes									
51784	51785	95860	95861	95863	95864	95865	95866	95867	95868
95869	95999								

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Procedure codes 95872 and 95875 may be reimbursed up to two services per day, same provider. Procedure code 95870 may be reimbursed in multiple quantities if specific muscles are documented.

The needle EMG examination must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.

Prior authorization is not required for EMG.

9.2.28.2.3 NCS

NCS are reimbursed by Texas Medicaid with documentation of medical necessity using the following procedure codes:

Procedure Codes									
95885	95886	95887	95905	95907	95908	95909	95910	95911	95912
95913	95933	95937							

NCS must be performed by either one of the following:

- A physician
- A trained individual under the direct supervision of a physician. (Direct supervision means that the physician is in close physical proximity to the electrodiagnostic laboratory while testing is underway, immediately available to provide the trained individual with assistance and direction, and responsible for selecting the appropriate NCS to be performed.)

When the same studies are performed on unique sites by the same provider for the same date of service, studies for the first site must be billed without a modifier and studies for each additional site must be billed with modifier 59, indicating a distinct procedural service. Modifier 59 should be used when modifier XE, XP, XS, or XU is not appropriate.

Procedure codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 may be reimbursed only once when multiple sites on the same nerve are stimulated or recorded.

Prior authorization is required when the anticipated number of nerve conduction studies planned for an evaluation exceeds the following maximum number of studies:

Procedure Code	Limitation
95885, 95886	Reimbursed once per extremity up to 2 units, using any combination of procedure codes, per day, any provider.
95885, 95886, 95887	Must be billed with one of the primary procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913.
95937	Up to 3 studies per day, per procedure, same provider without prior authorization.

9.2.28.2.4 Prior Authorization for NCS

Requests for prior authorization with documentation supporting the medical necessity for the number of studies requested must be received on or within 90 days before the requested date(s) of service.

The Special Medical Prior Authorization (SMPA) Request Form must be signed by the requesting provider on or within 90 days prior to the requested start of service. All dates of service prior to the prescribing providers signature date will be denied.

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of evoked response tests and neuromuscular procedures on behalf of the client's physician when the physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number blocks are required.*

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Medical record documentation must establish medical necessity for the additional studies, including one or more of the following:

- Other diagnosis in the differential that require consideration should include provider notes about both of the following:
  - The additional diagnoses considered.
  - The clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.
- If multiple diagnoses have been established by nerve conduction studies and the recommendations in the table above for a single diagnostic category do not apply, then the provider should document all diagnoses established as a result of EDX testing.
- Testing of an asymptomatic contralateral limb to establish normative values for an individual client (particularly the elderly, diabetic, and clients with a history of ethyl alcohol [ETOH] usage).
- Comorbid clinical conditions are identified. The clinical condition must be one that may cause sensory or motor symptoms, for example:
  - Underlying metabolic disease (such as thyroid condition or diabetes mellitus)
  - Nutritional deficiency (alcoholism)
  - Malignant disease
  - Inflammatory disorder (including but not limited to lupus, sarcoidosis or Sjögren's syndrome)

9.2.28.3 Evoked Potential Testing

Evoked potential (EP) testing is a benefit of Texas Medicaid when medically necessary. Prior authorization is not required for EP testing. The most common EP tests are:

- Brainstem auditory evoked potentials (BAEPs)
- Intraoperative neurophysiology monitoring (IONM)
- Motor evoked potentials (MEPs)
- Somatosensory evoked potentials (SEPs)
- Vestibular evoked myogenic potentials (VEMP)
- Visual evoked potentials (VEPs)

Each EP test (procedure codes 92650, 92651, 92652, 92653, 95925, 95926, 95927, 95928, 95929, 95930, 95938, or 95939) is considered a bilateral procedure and is limited to once per date of service any provider regardless of modifiers that indicate multiple sites were tested.

EP tests may be reimbursed up to four services per rolling year, any combination of services by any provider. Claims that exceed the limitation of four services per rolling year may be considered for reimbursement on appeal with documentation that supports the medical necessity.

Intraoperative neurophysiology monitoring (procedure codes 95940 and 95941) is a benefit when performed in addition to each evoked potential test on the same day.

Procedure codes 95940 and 95941 are limited to a maximum of two hours per date of service, per client, same procedure, any provider.

Procedure codes 95940 and 95941 must be billed in conjunction with one of the following procedure codes or the service will be denied:

Procedure Codes									
92653	95822	95860	95861	95863	95864	95865	95866	95867	95868

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Procedure Codes									
95869	95870	95907	95908	95909	95910	95911	95912	95913	95925
95926	95927	95928	95929	95930	95933	95937	95938	95939	

Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

9.2.28.3.1 Documentation Requirements for Evoked Potential Testing

The reason for the referral, the specific nerve evoked potential being tested, and a clear diagnostic impression must be documented in the client's medical record for each EP study performed.

The client's medical records must clearly document the medical necessity for the EP testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional studies.

The client's medical records are subject to retrospective review. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

The documentation for the IONM (procedure codes 95940 and 95941) must include the time during which each test is performed.

9.2.28.3.2 Intraoperative Neurophysiology Monitoring (IONM)

IONM is a benefit of Texas Medicaid when performed in addition to each evoked potential test on the same day.

Prior authorization is not required for IONM.

9.2.28.3.3 Visual Evoked Potentials

Some of the conditions under which VEP testing (procedure code 95930) may be appropriate include, but are not limited to, the following:

- Identification of persons at increased risk for developing clinically definite multiple sclerosis.
- Diagnosing, monitoring, and assessing treatment response in multiple sclerosis.
- Localizing the cause of a visual field defect not explained by lesions seen on CT or MRI, or by metabolic disorders or infectious disease.
- Evaluating the signs and symptoms of visual loss in persons who are unable to communicate (e.g., unresponsive persons, non-verbal persons).
- Evaluating clients who experience double vision, blurred vision, loss of vision, eye injuries, head injuries, or weakness of the eyes, arms, or legs.

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9.2.28.4 Vestibular Evoked Myogenic Potentials (VEMP)

Vestibular Evoked Myogenic Potential (VEMP) is a benefit of Texas Medicaid when submitted with procedure codes 92517, 92518, and 92519.

VEMP testing must be medically indicated and may be reimbursed when submitted with one of the following diagnosis codes:

Diagnosis Codes							
H81311	H81312	H81313	H81319	H81391	H81392	H81393	H81399
H814	H818X1	H818X2	H818X3	H818X9	H8190	H8191	H8192
H8193	H821	H822	H823	H829	H8301	H8302	H8303
H8309	H8311	H8312	H8313	H8319	H832X1	H832X2	H832X3
H832X9	H833X1	H833X2	H833X3	H833X9	H838X1	H838X2	H838X3
H838X9	H8390	H8391	H8392	H8393	H9311	H9312	H9313
H9319	R110	R1110	R1111	R112	R42		

VEMP testing is not medically necessary for any other indications and will not be covered.

Some conditions under which VEMP testing (procedure codes 92517, 92518, and 92519) may be appropriate include:

- Evaluation of chronic symptoms of pressure, tinnitus, disorientation, or chronic vertigo after all other recommended vestibular tests are completed and is lacking a definitive diagnosis.
- Evaluation after a positive CT scan for Superior Semicircular Canal Dehiscence Syndrome (SCDS)

Documentation must include other differential diagnoses under consideration, and must include the following:

- The additional diagnoses considered.
- The clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.

All of the following criteria are documentation requirements for VEMP testing:

- For each VEMP test performed, the referral reason includes a clear diagnostic impression documented in the client's medical record
- Medical necessity for the VEMP test must be clearly documented in the medical record and reflect the actual results of specific tests (which could include latency and amplitude).
- Medical necessity for client reevaluation after the initial consultation and testing must be clearly documented in the medical record. Supporting documentation must include the following:
    - New symptoms unrelated to previously evaluated symptoms which may result in a new diagnosis.
    - Rapidly changing client condition documentation, supported by the following:
        - Diagnosis
        - Current clinical signs and symptoms
        - Prior clinical condition
        - Expected clinical disease course
        - Clinical benefit of additional studies

The client's medical records are subject to retrospective review.

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9.2.28.5 Motion Analysis Studies

Motion analysis studies (procedure codes 96000, 96001, and 96002) are a benefit of Texas Medicaid for clients who are 3 through 20 years of age.

The neuromuscular disorders evaluated include, but are not limited to, cerebral palsy, traumatic brain injury, myelomeningocele, or stroke.

Prior authorization is not required for motion analysis studies.

Procedure codes 96000, 96001, and 96002 are limited to one per date of service by the same provider and two per rolling year, any provider.

In the following table, the procedure codes in Column A will be denied when they are submitted on the same date of service by the same provider as the procedure codes in Column B:

Column A (Denied)	Column B
96000	96001
95860, 95861, 95863, 95864, 95865, 95866, 95869, 95870, 95872	96002

9.2.28.5.1 Documentation Requirements for Motion Analysis Studies

Documentation must include the following information that indicates the client meets all the requirements for motion analysis studies. The client must be:

- Ambulatory for a minimum of ten consecutive steps, with or without assistive devices.
- At least 3 through 20 years of age.
- Physically able to tolerate up to three hours of testing.

The reason for the referral and a clear diagnostic impression must be documented in the client's medical record for each motion analysis study performed.

The client's medical records must clearly document the medical necessity for the motion analysis study. The medical record documentation must reflect the actual results of specific tests.

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional studies.

The client's medical records are subject to retrospective review.

9.2.29 Extracorporeal Membrane Oxygenation (ECMO)

ECMO may be effective on a short-term basis for clients with life-threatening respiratory and/or cardiac insufficiency.

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ECMO may be reimbursed for clients who have the following clinical indications (this is not an all-inclusive list):

- Persistent pulmonary hypertension
- Meconium aspiration syndrome
- Respiratory distress syndrome
- Adult respiratory distress syndrome
- Congenital diaphragmatic hernia
- Sepsis
- Pneumonia
- Preoperative and postoperative congenital heart disease or heart transplantation
- Reversible causes of cardiac failure
- Cardiomyopathy
- Myocarditis
- Aspiration pneumonia
- Pulmonary contusion
- Pulmonary embolism

The following procedure codes may be used when billing ECMO:

Procedure Codes									
33946	33947	33948	33949	33951	33952	33953	33954	33955	33956
33957	33958	33959	33962	33963	33964	33965	33966	33969	33984
33985	33986	33987	33988	33989					

Terminal disease with expectation of short survival, advanced multiple organ failure syndrome, irreversible central nervous system injury and severe immunosuppression are contraindications to ECMO. Claims for ECMO services may be recouped if the services are provided in the presence of these conditions.

The initial 24 hours of veno-venous (VV) ECMO should be submitted using procedure code 33946. Procedure code 33948 should be used for each additional 24 hours. Procedure code 33946 is denied as part of procedure code 33948 if submitted with the same date of service. Procedure codes 33946 and 33948 are limited to one per day when billed by any provider.

The initial 24 hours of veno-arterial (VA) ECMO should be submitted using procedure code 33947. Procedure code 33949 should be used for each additional 24 hours. Procedure codes 33947 and 33949 are limited to one per day when billed by any provider.

If insertion of VV cannula (procedure codes 33951, 33952, 33953, 33954, 33955, and 33956) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33946 or 33948, the insertion of the cannula is denied, and the ECMO (procedure code 33946 or 33948) is considered for reimbursement.

If insertion of VA cannula (procedure codes 33951, 33952, 33953, 33954, 33955, and 33956) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33947 or 33949, the insertion of the cannula is denied, and the ECMO (procedure code 33947 and 33949) is considered for reimbursement.

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9.2.30 Family Planning

Physicians, PAs, NPs, CNSs, and CNMs are encouraged to provide family planning services to Texas Medicaid clients, especially pregnant and postpartum clients. No separate enrollment is required. Providers are reimbursed for family planning services through Texas Medicaid (Title XIX) or through the DSHS Family Planning Program.

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 2, "Healthy Texas Women (HTW) Program Overview" in the *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*).

The *Health and Human Services Commission Family Planning Program Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.31 Gynecological Health Services

Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

Refer to: Section 6, "Gynecological Health Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about contraception, sterilizations, and family planning annual examinations.

9.2.32 Hospital Visits

Refer to: Subsection 9.2.60, "Physician Evaluation and Management (E/M) Services" in this handbook.

9.2.33 Hyperbaric Oxygen Therapy (HBOT)

Physicians who bill for the professional component of HBOT must use procedure code 99183. Hospital providers who bill for the chamber time must use procedure code G0277 with revenue code 413.

Note: *Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, or other device, or applied topically is not considered hyperbaric treatment in itself.*

Texas Medicaid recognizes the following indications for HBOT, as approved by the Undersea and Hyperbaric Medical Society (UHMS):

- Air or gas embolism
- Carbon monoxide poisoning
- Central retinal artery occlusion
- Compromised skin grafts and flaps
- Crush injuries, compartment syndrome, and other acute traumatic ischemias
- Decompression sickness
- Delayed radiation injury (soft tissue and bony necrosis)
- Diabetic foot ulcer
- Severe anemia
- Clostridial myositis and myonecrosis (gas gangrene)
- Intracranial abscess
- Necrotizing soft tissue infections
- Refractory osteomyelitis

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- Acute thermal burn injuries

HBOT is not a replacement for other standard successful therapeutic measures.

Texas Medicaid considers HBOT experimental and investigational for any indications other than the ones approved by UHMS and outlined in this section. Non-covered indications include, but are not limited to, autism and traumatic brain injury.

Oxygen administered outside of a hyperbaric chamber, by any means, is not considered hyperbaric treatment.

The physician must be in constant attendance of hyperbaric oxygen therapy during compression and decompression of the chamber and may not delegate the rendering of the service. Both the facility's medical record and the client's medical record must contain documentation to support that there was a physician in attendance who provided direct supervision of the compression and decompression phases of the HBOT treatment. All documentation pertaining to HBOT is subject to retrospective review.

9.2.33.1 Prior Authorization for HBOT

HBOT procedure codes 99183 and G0277 require prior authorization. Prior authorization requests submitted for procedure code G0277 must also include revenue code 413. When requesting prior authorization, providers should use the Special Medical Prior Authorization (SMPA) Request Form on the TMHP website at www.tmhp.com.

Refer to: "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for detailed information about prior authorization requirements.

The prior authorization request must include documentation that supports medical necessity and is specific to each appropriate covered indication as listed in the following table:

Covered Indication	Total 30-Minute Intervals Allowed for Procedure Code G0277	Total Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Air or gas embolism	6	2	Evidence that gas bubbles are detectable by ultrasound, Doppler or other diagnostics
Carbon monoxide poisoning - initial authorization	15	5	Persistent neurological dysfunction secondary to carbon monoxide inhalation
Carbon monoxide poisoning - one subsequent authorization	9	3	Evidence of continuing improvement in cognitive functioning
Central retinal artery occlusion	36	6	Evidence of central retinal artery occlusion with treatment initiated within 24 hours of the occlusion
Compromised skin grafts and flaps - initial authorization	80	10	Evidence the flap or graft is failing because tissue is/has been compromised by irradiation or there is decreased perfusion or hypoxia
Compromised skin grafts and flaps - one subsequent authorization	40	5	Evidence of stabilization of graft or flap

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Covered Indication	Total 30-Minute Intervals Allowed for Procedure Code G0277	Total Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Crush injury, compartment syndrome and other acute traumatic ischemias	36	12	Adjunct to standard medical and surgical interventions
Decompression sickness	28	1	Diagnosis based on signs and/or symptoms of decompression sickness after a dive or altitude exposure
Diabetic foot ulcer - initial authorization	60	30	After at least 30 days of standard medical wound therapy, with a wound pO2 less than 40 mmHg AND wound classified as Wagner grade 3 or higher. *
Diabetic foot ulcer - two subsequent authorizations	60	20	Evidence of continuing healing and wound pO2 less than 40 mmHg
Severe anemia	50	10	Hgb less than 6.0 sustained secondary to hemorrhage, hemolysis, or aplasia, when the client is unable to be cross matched or refuses transfusion because of religious beliefs
Clostridial myositis and myonecrosis (gas gangrene)	39	13	Evidence of unsuccessful medical and/or surgical wound treatment and positive Gram-stained smear of the wound fluid
Necrotizing soft tissue infections - initial authorization	36	12	Evidence of unsatisfactory response to standard medical and surgical treatment and advancement of dying tissue
Necrotizing soft tissue infections - two subsequent authorizations	15	5	Evidence that advancement of dying tissue has slowed
Delayed radiation injury (soft tissue and bony necrosis) -initial authorization	40	10	Evidence of unsatisfactory clinical response to conventional treatment
Delayed radiation injury - one subsequent authorization	40	10	Evidence of improvement demonstrated by clinical response
Refractory osteomyelitis - initial authorization	40	10	Evidence of unsatisfactory clinical response to conventional multidisciplinary treatment
Refractory osteomyelitis - one subsequent authorization	15	5	Evidence of improvement demonstrated by clinical response
Acute thermal burn injury - initial authorization	45	15	Partial or full thickness burns covering greater than 20% of total body surface area OR with involvement of the hands, face, feet or perineum

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Covered Indication	Total 30-Minute Intervals Allowed for Procedure Code G0277	Total Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Acute thermal burn injury - three subsequent authorizations	30	10	Evidence of continuing improvement demonstrated by clinical response
Intracranial abscess - initial authorization	15	5	Adjunct to standard medical and surgical interventions when one or more of the following conditions exist: Multiple abscesses Abscesses in a deep or dominant location Compromised host Surgery contraindicated or client is a poor surgical risk
Intracranial abscess - one subsequent authorization	15	5	Evidence of improvement demonstrated by clinical response and radiological findings

The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:

- Grade 1: Superficial diabetic ulcer
- Grade 2: Ulcer extension—involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)
- Grade 3: Deep ulcer with abscess or osteomyelitis
- Grade 4: Gangrene to portion of forefoot
- Grade 5: Extensive gangrene of foot

Procedure code 99183 is authorized according to the number of professional sessions (total HBOT treatments), and procedure code G0277 is authorized according to the number of 30-minute intervals of chamber time. The units in the columns for procedure codes 99183 and G0277 represent the maximum number of sessions and intervals that are allowed for that procedure code per authorization.

Limitations beyond those listed in the table above are considered experimental and investigational.

In emergency situations, the prior authorization request must be submitted no later than three business days after the date the service is rendered. Providers must not submit a claim until the prior authorization request has been approved. If the request has not been approved, the claim will be denied.

9.2.34 Ilizarov Device and Procedure

Providers must use procedure codes 20692, 20693, 20694, and 20999 when submitting claims for the Ilizarov procedure. A global fee payment methodology is applied to the Ilizarov device procedure codes. Procedure codes 20692, 20693, 20694, and 20999 include the preconstruction, surgical application, adjustments to the device for up to 6 months, and the removal of the device.

Providers who bill for other external fixator devices, such as the Monticelli device, should continue to use procedure codes 20690 or 20692, where applicable, when billing for the surgical applications.

9.2.35 Immunization Guidelines and Administration

Texas Medicaid reimburses immunizations (vaccines and toxoids) that the Advisory Committee on Immunization Practices (ACIP) recommends as routine.

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Providers must follow the most current ACIP recommendations unless they conflict with guidelines from the Texas Vaccines for Children (TVFC) Program, in which case providers must follow TVFC guidelines. Providers must also provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC). VISs explain the benefits and risks of the vaccines and toxoids administered.

Note: *Administered vaccines and toxoids must be reported to DSHS. After obtaining consent, DSHS submits all reported vaccines and toxoids to a centralized repository of immunization histories. This lifespan registry is known in Texas as ImmTrac2.*

9.2.35.1 Administration Fee

An administration fee may be reimbursed for all covered vaccines and toxoids that are administered according to the ACIP. The following procedure codes may be reimbursed when billed for vaccine and toxoid administration:

Procedure Code									
90460	90461	90471	90472	90473	90474				

Procedure code 90461 is used to report the administration of additional components of a vaccine and is not reimbursable for providers when administering TVFC-eligible vaccines under the TVFC program.

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471, 90472, 90473, and 90474 are benefits when counseling is not provided for the immunization administered. Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed for services rendered to clients of any age.

The administration fee may be reimbursed when the procedure code for the vaccine or toxoid administered (regardless of the source of the vaccine or toxoid) and the administration fee procedure code are billed on the same claim with the same date of service. Only one administration fee may be reimbursed to any provider for each vaccine or toxoid administered per day.

The following vaccine procedure codes are a benefit of Texas Medicaid and distributed by TVFC (does not include COVID-19, influenza, and RSV vaccines):

Procedure Codes	Age Range	Number of Recognized Components
90619	2 years of age or older	1
90620	10 years of age or older	1
90621	10 years of age or older	1
90623	10 years through 23 years of age	1
90624	10 through 23 years of age	1
90632	18 years of age or older	1
90633	Birth through 18 years of age	2
90647	6 weeks through 18 years of age	1
90648	6 weeks of age or older	1
90651	9 years through 45 years of age	1
90670	2 months of age or older	1
90671	6 weeks of age or older	1
90677	2 months of age or older	1
90680	Birth through 8 months of age	1

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Procedure Codes	Age Range	Number of Recognized Components
90681	Birth through 8 months of age	1
90696	4 years through 6 years of age	4
90697	Birth through 4 years of age	6
90698	Birth through 5 years of age	5
90700	Birth through 6 years of age	3
90702	Birth through 6 years of age	2
90707	1 year of age or older	3
90710	1 year through 12 years of age	4
90713	2 months of age or older	1
90714	7 years of age or older	2
90715	7 years of age or older	3
90716	1 year of age or older	1
90723	6 weeks through 6 years of age	5
90732	2 years of age or older	1
90734	2 months of age through 55 years of age	1
90743	11 years through 17 years of age	1
90744	Birth through 17 years of age	1
90746	18 years of age or older	1
90750	50 years of age or older	1

Note: *A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

COVID-19 Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for COVID-19:

Procedure Codes	Age Range
91320	12 years of age or older
91322	12 years of age or older
91323	12 years of age or older

Because the ACIP frequently reviews the composition of COVID-19 vaccines and makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of COVID-19 vaccines that TVFC is distributing for clients who are birth through 18 years of age.

Procedure code 90480 must be used in conjunction with one of the vaccine procedure codes listed above for reimbursement of COVID-19 vaccine administration.

COVID-19 vaccine counseling (procedure code G0315) may be reimbursed for clients who are birth through 20 years of age.

Procedure code G0315 will be denied if billed on the same day by the same provider as procedure code 90480.

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Procedure code G0315 is limited to once per day, by the same provider, and three per rolling year by any provider.

Influenza Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for influenza:

Procedure Codes	Age Range
90653	65 years of age or older
90655	6 months through 35 months of age
90656	6 months of age or older
90657	6 months through 35 months of age
90658	6 months of age or older
90660	2 years through 49 years of age
90661	6 months of age or older
90662	65 years of age or older
90672	2 years through 49 years of age
90673	18 years of age or older
90674	6 months of age or older
90682	18 years of age or older
90685	6 months through 35 months of age
90686	6 months of age or older
90687	6 months through 35 months of age
90688	6 months of age or older
90694	65 years of age or older
90756	6 months of age or older

Because the ACIP reviews the composition of influenza vaccines annually and frequently makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the influenza vaccines that TVFC is distributing for clients who are birth through 18 years of age for the current flu season.

Peak influenza activity generally occurs from October of one year through February of the next year, although activity can last through May. This time period is commonly referred to as "flu season."

The first time a client who is 6 months through 8 years of age receives the influenza vaccine, he/she should receive a second dose of the vaccine during the same flu season at least 4 weeks after the first dose. If the client turns 9 years old between the first and second doses, he/she should still receive the second dose.

Excepting the scenario described in the previous line, clients who are 9 years of age or older should only receive one dose of the influenza vaccine per flu season, even if it is their first time receiving the influenza vaccine.

The following vaccine procedure codes are a benefit of Texas Medicaid and are not distributed by TVFC:

Procedure Codes	Age Range	Number of Recognized Components
90476	19 years through 50 years of age	1
90477	19 years through 50 years of age	1

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Procedure Codes	Age Range	Number of Recognized Components
90581	19 years through 65 years of age	1
90585	All ages	1
90586	All ages	1
90589	19 years of age or older	1
90593	12 years of age or older	1
90611	18 years of age or older	1
90625	19 years through 64 years of age	1
90626	19 years of age or older	1
90627	19 years of age or older	1
90636	19 years of age or older	2
90675	All ages	1
90679	50 years of age or older	1
90683	50 years of age or older	1
90684	19 years of age or older	1
90690	19 years of age or older	1
90691	19 years of age or older	1
90717	19 years of age or older	1
90736	60 years of age or older	1
90738	19 years of age or older	1
90739	18 years of age or older	1
90740	20 years of age or older	1
90747	20 years of age or older	1
90758	18 years of age or older	2
90759	18 years of age or older	1
J9030	All ages	1

Each vaccine and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable vaccine administration procedure code(s). All of the vaccine administration procedure codes that correspond to a single vaccine procedure code must be submitted on the same claim as the vaccine procedure code.

Each vaccine procedure code must be submitted with the appropriate "administration with counseling" procedure code(s) (procedure codes 90460 and 90461) or the most appropriate "administration without counseling" procedure code (procedure code 90471, 90472, 90473, or 90474). If an "administration with counseling" procedure code is submitted with an "administration without counseling" procedure code for the same vaccine, the second administration of the vaccine will be denied.

Procedure code 90480 is a benefit for clients who are 6 months of age or older. Procedure code 90480 includes counseling and may only be reported with a COVID-19 vaccine procedure code.

Procedure code M0201 is a benefit for clients of any age. Procedure code M0201 may be reported, in addition to the vaccine and vaccine administration procedure codes when a pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine is administered inside a client's home.

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Administration with Counseling

Providers must submit claims for immunization administration procedure codes 90460 or 90461 based on the number of components per vaccine. Providers must specify the number of components per vaccine by billing 90460 and 90461 as defined by the procedure code descriptions:

- Procedure code 90460 is submitted for the administration of the first component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client's medical record.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code with 1 component	1
90460 (1st component)	1
Vaccine or toxoid procedure code with 3 components	1
90460 (1st component)	1
90461 (2nd and 3rd components)	2

Note: *The term "components" refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

Administration without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route of administration.

The following is an example of how to submit claims for injection administration procedure codes when counseling is not provided:

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code	1
90471 (Injection administration)	1
Vaccine or toxoid procedure code	1
90472 (Injection administration)	1
Vaccine or toxoid procedure code	1
90472 (Injection administration)	1

9.2.35.2 Documentation

Providers must document the following information in the client's medical record, which is subject to retrospective review to determine appropriate utilization and reimbursement of this service:

- The vaccine or toxoid given
- The date of the vaccine or toxoid administration (day, month, year)
- The name of the vaccine or toxoid manufacturer and the vaccine or toxoid lot number
- The signature and title of the person administering the vaccine or toxoid
- The organization's name and address

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- The publication date of the VIS issued to the client, parent, or guardian
- The site at which the vaccine was given (recommended)

9.2.35.3 Vaccine Adverse Event Reporting System (VAERS)

VAERS encourages providers to report any adverse event that occurs after the administration of any vaccine in the United States, even if it's unclear whether a vaccine caused it. The *National Childhood Vaccine Injury Act* (NCVIA) requires health-care providers to report:

- Any adverse event listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the VAERS Reportable Events Table that occurs within the specified time period after vaccination.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Documentation of the injection site is recommended but not required.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from vaers.hhs.gov/docs/VAERS_Table_of_Reportable_Events_Following_Vaccination.pdf.

9.2.36 Immunizations for Clients Birth through 20 Years of Age

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of THSteps when provided as part of a THSteps medical checkup. A THSteps provider who bills vaccines and toxoids with diagnosis or age restrictions is subject to those restrictions. In addition to the age appropriate diagnosis for the THSteps preventive care medical checkup, providers must bill the claim with the diagnosis code that indicates the condition that necessitates the vaccine or toxoid.

If an immunization is administered as part of the preventive care medical checkup, diagnosis code Z23 may also be included on the claim, in addition to the age-appropriate diagnosis.

If an immunization is the only service provided during an office visit, providers may submit only diagnosis code Z23 on the claim.

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of CCP when the vaccine or toxoid is provided as part of an acute medical visit outside of a THSteps medical checkup.

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on THSteps age related diagnosis codes.

9.2.36.1 Vaccine Coverage Through the TVFC Program

Providers may refer to the TVFC web site at www.dshs.texas.gov/immunizations/health-departments/overview for information about the program and for a list of vaccines available through the program.

Note: *All vaccines and toxoids recommended by Advisory Committee on Immunization Practices (ACIP) are available from the TVFC Program to enrolled clinic sites. Clinics participating in the TVFC Program have agreed to administer all ACIP-recommended vaccines to the eligible populations that are served.*

When a single antigen vaccine or toxoid or a comparable antigen vaccine or toxoid is available through TVFC, but the provider chooses to use a different ACIP-recommended product, the administration fee will be reimbursed but the vaccine or toxoid will not be reimbursed.

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Although Texas Medicaid does not mandate that providers enroll in TVFC, Texas Medicaid will not reimburse providers when the vaccine is available through TVFC. Only the administration fee will be reimbursed through Texas Medicaid when the vaccine or toxoid procedure code is identified on the claim. Clients may not be billed for vaccines and toxoids that are available through TVFC.

If a vaccine or toxoid meets the definition of "not available" through TVFC, it may be separately reimbursed through CCP when billed with modifier U1. Modifier U1 may be used in the following situations:

- The TVFC, based on their federal resolution (distribution/guidelines), does not distribute an HHSC-approved vaccine or toxoid following the ACIP recommendation, and the provider purchases vaccine to administer to all ACIP-recommended ages or risk groups.
- A new vaccine or toxoid approved by the ACIP with established guidelines, but has not been negotiated or added to a TVFC contract
- Funding for new vaccine or toxoid has not been established by TVFC
- Insufficient vaccine and toxoid supply due to national supply or distribution issues, as reported to HHSC by TVFC

HHSC will notify providers if a vaccine or toxoid meets the definition of "not available" from TVFC and when the provider's privately purchased vaccine or toxoid may be billed with modifier U1. Modifier U1 must not be used due to a provider's failure to enroll in TVFC or to maintain sufficient TVFC vaccine or toxoid inventory.

Refer to: Subsection 4.5.1, "Texas Vaccines for Children (TVFC) Program" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about TVFC and immunizations for infants and children.

9.2.36.2 Vaccine and Toxoid Procedure Codes

The following vaccine and toxoid procedure codes may be reimbursed for Texas Medicaid clients who are birth through 20 years of age:

Procedure Codes									
Bacillus Calmette-Guérin (BCG)									
Refer to: Subsection 9.2.9, "Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer" in this handbook.									
Adenovirus									
90476	90477								
Anthrax									
90581									
Chikungunya Virus									
90589	90593								
Cholera									
90625									
COVID-19									
91320	91322								
Ebola Virus									
90758									
*** Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.**									

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Procedure Codes									
Hepatitis A and B									
90632	90633*	90636	90723*	90740	90743	90744*	90746	90747	90759
Providers must document in the client's medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Providers are expected to follow the ACIP recommendations for administration.									
Hepatitis B Immune Globulin									
90371	96372	96374	J1571	J1573					
Providers must document in the client's medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Intramuscular hepatitis B immune globulin (HBIg) may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIg is not provided through TVFC. Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code Z205. Only one HBIg procedure code will be paid if billed with the same date of service by any provider as any other HBIg procedure code. Procedure codes 96372 and 96374 may be reimbursed for HBIg administration. Providers are expected to follow the ACIP recommendations for administrations.									
Hib									
90647*	90648*								
Human Papilloma (HPV)									
90651*									
Influenza									
90655*	90656*	90657*	90658*	90660*	90661	90672*	90673	90674	90682
90685*	90686*	90687*	90688*	90756*					
Influenza vaccine is a benefit of Texas Medicaid for high-risk clients who are not covered by THSteps or TVFC or when the vaccine is not declared available through the TVFC. Texas Medicaid considers the influenza season in the United States to be October through the end of May.									
Japanese Encephalitis (JE)									
90738									
Measles, Mumps, Rubella Vaccine (MMR)									
90707*									
Measles, Mumps, Rubella, and Varicella Vaccine (MMRV)									
90710*									
Pneumococcal and Meningococcal									
90620*	90621*	90623†	90624*	90670*	90671*	90677*	90684	90732*	90734*
*** Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.**									

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Procedure Codes									
The pneumococcal polysaccharide vaccine (procedure code 90732) is a benefit for Texas Medicaid clients who are not covered by the THSteps or TVFC programs. The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. For high-risk clients, revaccination is recommended once in a lifetime five years after the initial dose. Revaccination after a second dose is not a benefit of Texas Medicaid. Pneumococcal polysaccharide vaccine is not recommended for children who are birth through 23 months of age. Providers are expected to follow the ACIP recommendations for administrations.									
Poliovirus (IPV)									
90713*									
Respiratory Syncytial Virus (RSV)									
90380*	90381*	90382*	90678*						
Rotavirus									
90680*	90681*								
Tetanus and Diphtheria									
90696*	90698*	90700*	90702*	90714*	90715*	90723*			
Tick-borne Encephalitis (TBE)									
90626	90627								
Typhoid Vaccine									
90690	90691								
Varicella Virus									
90716*									
Yellow Fever									
90717									
*** Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.**									

9.2.37 Immunizations for Clients Who Are 21 Years of Age or Older

Vaccines and toxoids may be reimbursed through Texas Medicaid at a fee determined by HHSC when the vaccine is medically necessary. Providers are expected to follow the ACIP recommendations for administration.

The following immunizations are identified and recommended by the ACIP for clients who are 21 years of age or older (this list is not all-inclusive):

Immunization Procedure Codes									
BCG									
Refer to: Subsection 9.2.9, "Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer" in this handbook.									
Adenovirus									
90476	90477								
Anthrax									
90581									
Chikungunya Virus									

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Immunization Procedure Codes									
90589	90593								
Cholera									
90625									
COVID-19									
91320	91322								
Ebola Virus									
90758									
Hepatitis A and B									
90632	90740	90746	90747	90759					
Providers must document in the client's medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Procedure codes 96372 and 96374 may be reimbursed for the administration of hepatitis B vaccine procedure codes 90740 and 90747.									
Hepatitis B Immune Globulin									
90371	96372	96374	J1571	J1573					
Providers must document in the client's medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Intramuscular HBIg may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIg is not provided through TVFC. Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code Z205. Only one HBIg procedure code will be paid if billed with the same date of service by any provider as any other HBIg procedure code. Procedure codes 96372 and 96374 may be reimbursed for HBIg administration.									
Hepatitis A and B									
90636									
Haemophilus Influenza Type B (Hib)									
90648									
Human Papilloma (HPV)									
90651									
Influenza									
90653	90656	90658	90660	90661	90662	90672	90673	90674	90682
90686	90688	90694	90756						
Influenza vaccine is a benefit of Texas Medicaid for all clients. Texas Medicaid considers the influenza season in the United States to be October through the end of May. The optimal time to receive influenza vaccine is as early in the season as it is available. However, clients should continue to receive influenza vaccine through March. The vaccine may be administered one time per influenza season.									
Japanese Encephalitis (JE)									
90738									
MMR									
90707									
Pneumococcal and Meningococcal									

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Immunization Procedure Codes									
90619	90620	90621	90623	90670	90671	90677	90684	90732	90734
The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. Revaccination is recommended five years (not interpreted to mean every five years) after the initial dose for high-risk individuals. Revaccination after a second dose is not reimbursed.									
Poliovirus (IPV)									
90713									
Respiratory Syncytial Virus (RSV)									
90678	90679	90683							
Shingles									
90736	90750								
Tetanus									
90714									
Tetanus, Diphtheria, and Acellular Pertussis Vaccine (Tdap)									
90715									
Tick-borne Encephalitis (TBE)									
90626	90627								
Typhoid Vaccine									
90690	90691								
Varicella Virus									
90716									
Yellow Fever									
90717									

The specific diagnosis necessitating the vaccine or toxoid is required when billing the administration fee procedure code in combination with the appropriate vaccine procedure code. Diagnosis code Z23 may also be included. The type of immunization given will be identified by the procedure code.

9.2.38 Rabies Prophylaxis

The rabies vaccine (procedure code 90675) and rabies immune globulin (procedure codes 90375, 90376, and 90377) are benefits of Texas Medicaid as part of rabies prophylaxis.

Rabies immune globulin is limited to clients with diagnosis code Z203.

9.2.38.1 Rabies Vaccine Availability and Animal Bite Reporting

Providers that determine a client requires the rabies vaccination series may obtain the biologicals directly from the manufacturer or through one of the Texas Department of State Health Services (DSHS) depots around the state.

Animal bites to people must be reported as soon as possible to the designated Local Rabies Control Authority (LRCA).

9.2.38.2 Prior Authorization for Postexposure Rabies Vaccine

Prior authorization is not required for postexposure rabies vaccine. The physician must maintain documentation of the exposure in the client's medical record.

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9.2.38.3 Limitations for Postexposure Rabies Vaccine

Reimbursement for postexposure rabies vaccine is limited to one per client per day, by any provider.

Reimbursement for postexposure rabies vaccine is limited to 5 occurrences per 90 rolling days. Claims billed for any vaccine given beyond 90 rolling days will be denied.

9.2.38.3.1 Obtaining Rabies Vaccine and HRIG from DSHS for PEP Use

Providers may obtain the vaccine and HRIG directly from the manufacturer. If a provider is not able to obtain the vaccine and/or HRIG directly, providers may contact DSHS local or state public health professionals.

For each potential rabies exposure, providers must consult with their local health department or the DSHS regional ZC program office that serves their area. Requests for consultations made to DSHS after-hours or on holidays should be directed to the DSHS On-Call Physician at 1-888-963-7111.

Local public health professionals or regional ZC staff will help providers determine whether or not the exposure situation warrants PEP. If the exposure situation is determined to be valid, providers will be given detailed information about how to obtain rabies vaccine and HRIG for the patient.

Providers can refer to the following DSHS web pages for the contact information of local public health professionals:

- Full Service Local Health Departments and Districts of Texas at www.dshs.texas.gov/regions/lhds.shtm
- Zoonosis Control Branch at www.dshs.texas.gov/idcu/health/zoonosis/contact/
- Use of a Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies, Recommendations of the Advisory Committee on Immunization Practices March 19, 2010 www.cdc.gov/mmwr/pdf/rr/rr5902.pdf
- DSHS rabies website at www.dshs.texas.gov/idcu/disease/Rabies/
- Regional DSHS ZC offices
- "Human Rabies Prevention—United States, 2008 Recommendations of the Advisory Committee on Immunization Practices"
- CDC rabies website at www.cdc.gov/rabies/

9.2.38.4 Smallpox and Mpox (Monkeypox) Vaccine

Procedure code 90611 may be reimbursed for clients who are 18 years of age or older.

Procedure code 90622 is informational only.

9.2.39 Respiratory Syncytial Virus (RSV)

The following procedure codes may be reimbursed for RSV monoclonal antibodies and RSV vaccines:

Procedure Code	Age Range	Number of Recognized Components
90380	Birth through 19 months of age	1
90381	Birth through 19 months of age	1
90382	Birth through 7 months of age	1
90678	10 years of age or older	1
90679	50 years of age or older	1
90683	50 years of age or older	1

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Because the ACIP reviews the composition of certain seasonal vaccines annually and frequently makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the RSV vaccines and RSV monoclonal antibodies that TVFC is distributing for clients who are birth through 18 years of age for the current RSV season.

RSV vaccine (procedure code 90678) may be reimbursed for clients who are:

- Pregnant and are 32 through 36 weeks gestation.
- 60 years of age or older.

RSV vaccine (procedure code 90679 and 90683) may be reimbursed for clients who are 50 years of age or older.

Vaccine administration (procedure code 90460 or 90471) must be used in conjunction with one of the RSV vaccine procedure codes (90678, 90679 or 90683) for reimbursement of RSV vaccine administration.

RSV monoclonal antibodies (nirsevimab, procedure codes 90380 and 90381) may be administered to clients who are birth through 19 months of age and are limited to two per lifetime.

RSV monoclonal antibodies (clesrovimab, procedure code 90382) may be administered to clients who are birth through 7 months of age and are limited to one per lifetime.

RSV monoclonal antibody administration (procedure code 96380 or 96381) must be used in conjunction with one of the monoclonal antibody procedure codes (90380, 90381, or 90382) for reimbursement of RSV monoclonal antibody administration.

9.2.40 Implantable Infusion Pumps

Implantable infusion pump (IIPs) are intended to provide long-term, continuous, or intermittent drug infusion. They may be medically necessary in the following circumstances:

- Administration of intrathecal or epidural antispasmodic drugs to treat refractory intractable spasticity
- Administration of Intrathecal, epidural, or central venous analgesic (opioid or non-opioid) drugs for treatment of severe chronic intractable pain
- Administration of intrahepatic chemotherapy for primary liver cancer or metastatic cancer with metastases limited to the liver
- Administration of intra-arterial chemotherapy in head and neck cancers

An implantable infusion pump is not a benefit for the following uses:

- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

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Providers may be reimbursed for implantable infusion pumps using procedure codes E0782, E0783, and E0786. If procedure codes E0782 and E0783 are billed with the same date of service, only one may be reimbursed.

9.2.40.0.1 Prior Authorization for Implantable Infusion Pumps

Implantable infusion pumps (procedure codes E0782, E0783, and E0786) require prior authorization.

Prior authorization is not required for the physician services associated with the insertion, revision, removal, refilling, or maintenance of the IIP.

Providers must request prior authorization through the Special Medical Prior Authorization (SMPA) department. The ASC or DME provider may submit a request for prior authorization using the Special Medical Prior Authorization (SMPA) Form, which must be completed and signed by a physician.

The completed, signed and dated SMPA form must be maintained by the provider and the prescribing physician in the client's medical record.

The completed SMPA Form must include the procedure code and quantity for the services that are requested. Documentation that is submitted with the prior authorization request must indicate whether the IIP will be provided by the ASC or the DME provider.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested IIP. The requesting provider may be asked for additional information to clarify or complete a request for the IIP.

Documentation submitted with the prior authorization request must indicate the client or caregiver has:

- The ability to provide a return demonstration performance.
- The attention, desire, interest, flexibility, and independence.
- An understanding of cause and effect and object permanence.

As indicated in the following sections, supporting documentation that is based on the type of IIP requested must be included with the request for prior authorization. All of the documentation listed under the specific type of IIP must be included with the request for prior authorization.

9.2.40.0.2 IIP for Administration of Anti-spasmodic Drug to Treat Severe Refractory Spasticity

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms:
- Degree of spasticity
- Affected muscle groups
- Functional impact
- Duration of symptoms
- Any recent hospitalizations (within past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- Treatment history of self-administration with evidence of:

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- A minimum of six weeks of non-invasive methods of spasticity control, including, but not limited to, oral antispasmodics, that either:
- Failed to adequately control the spasticity, or
- Produced intolerable side effects
- The role, participation, and compliance of the family or client that demonstrate the following:
- The ability to provide a return demonstration performance
- Attentiveness, desire, interest, flexibility, and independence
- An understanding of cause and effect and object permanence
- Favorable response to a trial intrathecal dose of the antispasmodic
- No contraindications to implantation exist, including, but not limited to, the following:
- Coagulopathy
- Infection
- Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
- Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
- Antispasmodic to be infused
- Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
- Expected outcome
- Treatment goals

9.2.40.1 IIP for Administration of Analgesic (Opioid or Nonopioid) Drug for Treatment of Severe Intractable Pain

The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms:
- Severity of pain
- Functional impact
- Source of pain or location, including whether pain is malignant or non-malignant
- Duration of symptoms
- Any recent hospitalizations (within the past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- A life expectancy of at least three months

Note: *The standard of care for treatment of severe intractable pain for a client with a life expectancy of less than three months is to use less invasive techniques such as an external infusion pump.*

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For malignant pain, the following documentation is required for prior authorization:

- Treatment history with evidence of a favorable response to a trial intrathecal dose of the analgesic drug, defined as a minimum of 50 percent reduction in pain
- Failure of more conservative methods of pain control, including, but not limited to, oral analgesics, surgery, or therapy, that were ineffective due to one of the following:
- Failed to adequately control the pain, or
- Produced intolerable side effects

Note: *The standard of care for treatment of severe intractable pain for a client with a life expectancy of less than three months is to use less invasive techniques such as an external infusion pump.*

For nonmalignant pain, the following documentation is required for prior authorization:

- A minimum of six months of more conservative methods of pain control, including but not limited to oral analgesics, surgery, attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated pain reaction, that were ineffective due to one of the following:
  - Failed to adequately control the pain, or
  - Produced intolerable side effects

Examples of non-malignant severe intractable pain include, but are not limited to, the following:

- Complex regional pain syndrome I & II (causalgia/RSD) refractory to other treatments.
- Post herpetic neuralgia
- Failed back syndrome
- Phantom limb pain
- Arachnoiditis (proven with MRI/increased CSF protein levels)
- Spinal cord myelopathy (refractory to conservative measurements)
- The role, participation, and compliance of the family or client that demonstrate the following:
- The ability to provide a return demonstration performance
- Attentiveness, desire, interest, flexibility, and independence
- An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
- Coagulopathy
- Infection
- Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
- Tumor encroachment on the thecal sac
- Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
- Analgesic to be infused
- Follow-up including pump refilling, maintenance, and monitoring of changes in infusion rate
- Expected outcome
- Treatment goals

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9.2.40.2 IIP for Administration of Intrahepatic Chemotherapy in Primary Liver Cancer or Colorectal Cancer with Liver Metastases

The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
- Diagnosis of one of the following:
- Primary liver cancer
- Metastatic cancer with metastases limited to the liver
- Any recent hospitalizations (within the past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- The role, participation, and compliance of the family and/or client demonstrating:
  - The ability to provide a return demonstration performance
  - Attentiveness, desire, interest, flexibility, and independence
  - An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
  - Coagulopathy
  - Infection
  - Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
  - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
  - Chemotherapeutic agent to be infused. The prescribed drug must be approved by the U.S. Food and Drug Administration (FDA) for the intended use and must be compatible with the implantable device (such as floxuridine or methotrexate)
  - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  - Expected outcome
  - Treatment goals

9.2.40.3 IIP for Administration of Intra-Arterial Chemotherapy in Head and Neck Cancers

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Diagnosis and site(s) of any metastases
- Any hospitalizations (within the past 12 months) and all other diagnoses
- All pertinent laboratory and radiology results
- The role, participation, and compliance of the family or client that demonstrates the following:
  - The ability to provide a return demonstrate performance

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- Attentiveness, desire, interest, flexibility, and independence
- An understanding of cause and effect and object permanence

- No contraindications to implantation exist, including, but not limited to, the following:
  - Coagulopathy
  - Infection
  - Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
  - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
  - Chemotherapeutic agent to be infused
  - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  - Expected outcome
  - Treatment goals

9.2.40.4 Replacement of an IIP

An IIP is expected to last a minimum of five years. Prior authorization for replacement of an IIP is considered within five years when one of the following occurs:

- There has been a significant change in the client's condition and the current equipment no longer meets the client's needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.
- Loss or irreparable damage to the IIP has occurred. The following must be submitted with the prior authorization request:
- A copy of the police or fire report, when appropriate
- A statement about the measures to be taken in order to prevent reoccurrence

Replacement of an IIP for a client who is birth through 20 years of age that does not meet the criteria above may be considered for prior authorization through CCP.

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver.

The DME provider must maintain the signed and dated form in the client's medical record.

Refer to: Subsection 2.8.3.5, "DME Certification and Receipt Form" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about this form.

9.2.40.5 Implantation of Catheters, Reservoirs, and Pumps

The following procedure codes may be used to bill the implantation of catheters and infusion pumps or devices for long term medication administration:

Procedure Codes				
62350	62351	62360	62361	62362

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Procedure code 62350 or 63251 may be reimbursed when billed for the same date of service as procedure code 62360, 62361, or 62362.

Procedure codes 62355 and 62365 do not require prior authorization.

The following procedure codes are denied as included in the total anesthesia time when billed with the same date of service as an anesthesia procedure by the same physician:

Procedure Codes						
62350	62351	62355	62360	62361	62362	62365

These procedure codes are considered for reimbursement according to multiple surgery guidelines when billed with the same date of service as another surgical procedure performed by the same physician.

Procedure codes 95990, 96521, and 96522 are considered for reimbursement when used for refilling an implantable pump.

Procedure codes 62367, 62368, 62369, and 62370 may be used to bill for electronic analysis of an implantable infusion pump.

Procedure codes 62369 and 62370 will be denied when billed for the same date of service by the same provider as procedure code 62362.

The following procedure codes may be used to bill the insertion, revision, removal, or repair associated with implantable infusion pumps:

Procedure Codes						
36260	36261	36262	36563	36576	62355	62365

9.2.40.6 Drug Monitoring Services

Providers must use the most appropriate procedure codes when submitting claims for drug monitoring services that monitor prescribed medications that can be abused when used for the treatment of chronic pain. These claims are subject to retrospective review. Claims may be reprocessed and recouped if they are submitted for these drug monitoring services in the office setting using a procedure code for a quantitative test rather than a qualitative or semiquantitative test.

An enzyme immunoassay (EIA) device can be used to provide preliminary qualitative or semiquantitative test results for point-of-care monitoring purposes. EIA devices and the reagents used to perform in-office drug testing are cleared by the FDA only to obtain qualitative or semiquantitative initial screen or preliminary results.

Immunoassay and enzyme assay are tests that produce qualitative and semiquantitative results, so these tests must not be reported with procedure codes for quantitative tests. A qualitative or semiquantitative test is not a quantitative test and must not be billed as such.

The initial drug screen or preliminary result testing yields qualitative and semiquantitative results, which must be reported with an appropriate drug testing procedure code, as categorized in the CPT manual as "Drug Testing." Only those procedure codes that are a benefit of Texas Medicaid may be reimbursed.

CPT-categorized "Chemistry" and "Therapeutic Drug Assay" procedure codes are for quantitative tests and must not be reported for an initial screen or preliminary result that was performed in the point-of-care setting.

Refer to: The CPT manual for drug testing, chemistry, and therapeutic drug assay procedure codes, and to the Texas Medicaid fee schedule for procedure codes that may be reimbursed by Texas Medicaid.

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Using procedure codes for quantitative tests to report preliminary qualitative or semiquantitative test results is considered systematic upcoding and may lead to administrative sanctions, civil monetary penalties, and criminal prosecution.

Providers may refer to the CMS website for more information about laboratory tests that may be rendered in the office setting. For tests that require a CLIA certificate of waiver, CMS publishes a list of all waived tests. The list is updated quarterly and includes the procedure code to use when billing a test.

9.2.41 Joint Injections and Trigger Point Injections

Injectable medication and the administration of medications through the intramuscular (IM), subcutaneous (SQ), or intravenous (IV) route are a benefit of Texas Medicaid.

Viscosupplementation agents include hyaluronic acid, which is injected into the knee joint to relieve pain associated with osteoarthritis.

The following viscosupplement procedure codes must be used to submit claims for osteoarthritis of the knee:

Procedure Codes									
J3470	J3471	J3472	J3473	J7318	J7320	J7321	J7322	J7323	J7324
J7325	J7326	J7328	J7329						

If an administration procedure code is billed with one of the following viscosupplement procedure codes without a qualifying diagnosis code, the claim will be denied.

Texas Medicaid may reimburse claims for viscosupplement procedure codes that are submitted with the following approved diagnosis codes:

Diagnosis Codes							
M170	M1710	M1711	M1712	M172	M1730	M1731	M1732
M174	M175	M179					

The following procedure codes must be used to submit claims for injections into joints:

Procedure Codes						
20600	20604	20605	20606	20610	20611	20612

The following procedure codes must be used to submit claims for trigger point injections:

Procedure Codes					
20526	20527	20550	20551	20552	20553

Joint injections and trigger point injections are valid only in the treatment of acute problems or the exacerbation of a chronic condition. The provider must use the AT modifier to indicate an acute condition and use modifiers LT (left) and/or RT (right) as appropriate.

The cost of the injection does not include the drugs used. The drug can be reimbursed separately. Multiple joint injections may be reimbursed when billed with the same date of service if the claim indicates the specific site of each injection. The first injection or aspiration is reimbursed at the full profile allowance and any subsequent injections are reimbursed at half allowance.

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9.2.42 Laboratory Services

Texas Medicaid benefits are provided for professional and technical services ordered by a physician and provided under the supervision of a physician in a setting other than a hospital (inpatient or outpatient). All laboratory services must be documented in the client's medical record as medically necessary and referenced to an appropriate diagnosis. Texas Medicaid does not reimburse baseline or screening laboratory studies.

Providers may bill only for laboratory tests that are actually provided in their office. Any test sent to an outside laboratory must not be billed on the provider's claim. Laboratories bill Texas Medicaid directly for the tests they perform.

Unless otherwise noted, interpretation of laboratory tests is considered part of the provider's professional services (hospital, office, or emergency room visits) and must not be billed separately. Modifier Q4 is required for laboratory, radiology, and ultrasound interpretations by any provider other than the attending physician.

Laboratory tests that are generally considered part of a laboratory panel (e.g., chemistries, CBCs, urinalyses [UAs]) and that are performed on the same day must be billed as a panel regardless of the method used to perform the tests (automated or manual).

Physician interpretations that are requested of a consulting pathologist and require professional reading and reporting of results may be billed to Texas Medicaid separately as a professional charge.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA cannot be reimbursed for laboratory services.

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The TMHP website Required CLIA Lab Certifications web page at www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

Subsection 2.2.5, "Automated Laboratory Tests and Laboratory Paneling" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for claims processing instructions.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.4.2, "Reimbursement" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for claims processing instructions.

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

9.2.42.1 THSteps Laboratory Services

Refer to: Subsection 4.3.12.6, "Laboratory Test" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.42.2 Laboratory Handling Charge

The laboratory handling charge covers the expense of obtaining and packaging the specimen and sending it to a reference laboratory.

A laboratory handling charge (procedure code 99000) may be billed if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The reference laboratory name and address or NPI must be listed in Block 32 of the CMS-1500 claim form, and Block 20 must be completed.

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The provider is required to forward the client's name, address, Medicaid ID number, and diagnosis, if appropriate, with the specimen to the reference laboratory so the laboratory may bill Texas Medicaid for its services.

A provider may bill only one laboratory handling charge per client visit unless the specimen is divided and sent to different laboratories or different specimens are collected and sent to different labs. The claim must indicate the name and/or address of each laboratory to which a specimen is sent for more than one laboratory handling fee to be paid. This laboratory handling benefit does not apply to THSteps medical checkup providers who must submit specimens to the DSHS Laboratory.

9.2.42.3 Blood Counts

Texas Medicaid considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. CBCs should be individualized and based on client history, clinical indications, or proposed therapy and will not be reimbursed for screening purposes.

Refer to: Subsection 2.2.6, "Complete Blood Count (CBC)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about blood counts.

9.2.42.4 Clinical Lab Panel Implementation

Refer to: Subsection 2.2.5, "Automated Laboratory Tests and Laboratory Paneling" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about laboratory panels.

9.2.42.5 Clinical Pathology Consultations

Clinical pathology consultations (procedure code 80503, 80504, 80505, or 80506) are a benefit of Texas Medicaid for services rendered by a consultant who is either a clinical pathologist or a geneticist. In a clinical pathology consultation, the consultant may also help the ordering physician determine whether further study is appropriate, based on test results.

Providers may be reimbursed for clinical pathology consultations when the claim indicates the following information:

- The name, address, and NPI of the physician who requested the consultation.
- A written narrative report describing the findings of the consultation, which will also be included in the client's medical record.

Note: *To submit claims for interpretation, the provider must document an interaction that clearly shows that the consultant interpreted the test results and made specific recommendations to the attending physicians.*

If the claim does not include all of this information, the clinical pathology consultation will be denied.

Note: *Geneticists who provide a pathology consultation must submit claims using their acute care NPI.*

Routine conversations held between a consultant and attending physicians about test orders or results are not consultations. Information that can be furnished by a non-physician laboratory specialist does not qualify as a consultation service.

9.2.42.6 * Cytogenetics Testing

Cytogenetics testing is a group of laboratory tests involving the study of chromosomes.

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias and lymphomas, especially in children. The detection of the well-defined recurring genetic abnormalities often enables a correct diagnosis with important prognostic information that affects the treatment protocol.

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Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

[Revised] Diagnosis Codes							
C8280	C8281	C8282	C8283	C8284	C8285	C8286	C8287
C8288	C8289	C828A	C8291	C8292	C8293	C8294	C8295
C8296	C8297	C8298	C8299	C829A	C8310	C8311	C8312
C8313	C8314	C8315	C8316	C8317	C8318	C8319	C831A
C8380	C8381	C8382	C8383	C8384	C8385	C8386	C8387
C8388	C8389	C838A	C8440	C8441	C8442	C8443	C8444
C8445	C8446	C8447	C8448	C8449	C844A	C8461	C8462
C8463	C8464	C8465	C8466	C8467	C8468	C8469	C846A
C8471	C8472	C8473	C8474	C8475	C8476	C8477	C8478
C8479	C847A	C847B	C8581	C8582	C8584	C8585	C8586
C8587	C8588	C8589	C858A	C8840	C8841	C8880	C8881
C9012	C9100	C9101	C9102	C9110	C9111	C9112	C9190
C9191	C9192	C91Z0	C91Z1	C91Z2	C9200	C9201	C9202
C9210	C9211	C9212	C9220	C9221	C9222	C9230	C9231
C9232	C9240	C9241	C9242	C9250	C9251	C9252	C9260
C9261	C9262	C9290	C9291	C9292	C92A0	C92A1	C92A2
C92Z0	C92Z1	C92Z2	C9300	C9301	C9302	C9310	C9311
C9312	C9330	C9331	C9390	C9391	C9392	C93Z0	C93Z1
C93Z2	C9400	C9401	C9402	C9420	C9421	C9422	C9430
C9431	C9432	C9480	C9481	C9482	C9500	C9501	C9502
C9510	C9511	C9512	C9590	C9591	C9592	D45	D821
E230	E291	E300	E3430	E3431	E34328	E34329	E3439
E83110	E8359	F70	F71	F72	F73	F78A1	F78A9
F800	F801	F802	F804	F8089	F810	F812	F8181
F8189	F819	F82	F840	F88	F900	F901	F902
F908	H0589	H9325	I77810	I77811	I77812	I77819	M2600
M2601	M2602	M2603	M2604	M2605	M2606	M2607	M2609
N4601	N4611	N6482	N910	N911	N913	N914	N949
N970	N978	O010	O011	O019	O021	O0289	O09511
O09512	O09513	O09521	O09522	O09523	O3500X0	O3500X1	O3500X2
O3500X3	O3500X4	O3500X5	O3500X9	O3501X0	O3501X1	O3501X2	O3501X3
O3501X4	O3501X5	O3501X9	O3502X0	O3502X1	O3502X2	O3502X3	O3502X4
O3502X5	O3502X9	O3503X0	O3503X1	O3503X2	O3503X3	O3503X4	O3503X5
O3503X9	O3504X0	O3504X1	O3504X2	O3504X3	O3504X4	O3504X5	O3504X9
O3505X0	O3505X1	O3505X2	O3505X3	O3505X4	O3505X5	O3505X9	O3506X0
O3506X1	O3506X2	O3506X3	O3506X4	O3506X5	O3506X9	O3507X0	O3507X1
O3507X2	O3507X3	O3507X4	O3507X5	O3507X9	O3508X0	O3508X1	O3508X2
O3508X3	O3508X4	O3508X5	O3508X9	O3509X0	O3509X1	O3509X2	O3509X3
O3509X4	O3509X5	O3509X9	O3510X0	O3510X1	O3510X2	O3510X3	O3510X4

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[Revised] Diagnosis Codes							
O3510X5	O3510X9	O3511X0	O3511X1	O3511X2	O3511X3	O3511X4	O3511X5
O3511X9	O3512X0	O3512X1	O3512X2	O3512X3	O3512X4	O3512X5	O3512X9
O3513X0	O3513X1	O3513X2	O3513X3	O3513X4	O3513X5	O3513X9	O3514X0
O3514X1	O3514X2	O3514X3	O3514X4	O3514X5	O3514X9	O3515X0	O3515X1
O3515X2	O3515X3	O3515X4	O3515X5	O3515X9	O3519X0	O3519X1	O3519X2
O3519X3	O3519X4	O3519X5	O3519X9	O352XX0	O352XX1	O352XX2	O352XX3
O352XX4	O352XX5	O352XX9	P2930	P2938	Q000	Q001	Q002
Q010	Q011	Q012	Q018	Q02	Q030	Q031	Q038
Q040	Q041	Q042	Q045	Q046	Q048	Q050	Q051
Q052	Q054	Q055	Q056	Q057	Q058	Q062	Q064
Q068	Q0701	Q0702	Q0703	Q078	Q079	Q100	Q101
Q102	Q103	Q104	Q106	Q107	Q110	Q111	Q112
Q113	Q120	Q121	Q123	Q124	Q128	Q129	Q130
Q131	Q132	Q133	Q134	Q135	Q1381	Q1389	Q140
Q141	Q142	Q143	Q148	Q150	Q158	Q159	Q160
Q161	Q162	Q163	Q164	Q165	Q169	Q170	Q171
Q172	Q173	Q174	Q175	Q178	Q179	Q180	Q181
Q182	Q183	Q184	Q185	Q186	Q187	Q188	Q189
Q200	Q201	Q202	Q203	Q204	Q205	Q206	Q208
Q209	Q210	Q2110	Q2111	Q2112	Q2113	Q2114	Q2115
Q2116	Q2119	Q2120	Q2121	Q2122	Q2123	Q213	Q214
Q218	Q219	Q220	Q221	Q222	Q223	Q224	Q225
Q228	Q230	Q231	Q232	Q233	Q234	Q2381	Q2382
Q2388	Q240	Q241	Q242	Q243	Q244	Q245	Q246
Q248	Q249	Q250	Q251	Q2521	Q2529	Q253	Q2540
Q2541	Q2542	Q2543	Q2544	Q2545	Q2546	Q2547	Q2548
Q2549	Q2572	Q259	Q260	Q261	Q262	Q263	Q265
Q266	Q268	Q269	Q270	Q271	Q272	Q2730	Q2731
Q2732	Q2733	Q2734	Q274	Q278	Q279	Q280	Q281
Q282	Q283	Q288	Q289	Q300	Q301	Q302	Q303
Q308	Q309	Q310	Q311	Q312	Q313	Q315	Q318
Q320	Q321	Q322	Q323	Q324	Q330	Q331	Q332
Q333	Q334	Q335	Q336	Q338	Q339	Q348	Q349
Q351	Q353	Q359	Q360	Q369	Q370	Q371	Q372
Q373	Q374	Q375	Q380	Q381	Q382	Q383	Q384
Q385	Q386	Q387	Q388	Q391	Q392	Q393	Q394
Q395	Q396	Q398	Q400	Q401	Q402	Q408	Q409
Q410	Q411	Q412	Q419	Q420	Q421	Q422	Q423
Q428	Q430	Q431	Q432	Q433	Q434	Q435	Q437
Q438	Q440	Q441	Q442	Q443	Q444	Q445	Q446

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[Revised] Diagnosis Codes							
Q4470	Q4471	Q4479	Q450	Q451	Q452	Q453	Q458
Q459	Q5001	Q5002	Q501	Q502	Q5031	Q5032	Q5039
Q504	Q505	Q506	Q510	Q5110	Q5111	Q5121	Q5122
Q5128	Q515	Q516	Q517	Q51811	Q51821	Q51828	Q520
Q5210	Q52120	Q52121	Q52122	Q52123	Q52124	Q52129	Q522
Q523	Q524	Q525	Q526	Q5270	Q5271	Q5279	Q528
Q529	Q5300	Q5301	Q5302	Q5310	Q53111	Q53112	Q5312
Q5313	Q5320	Q53211	Q53212	Q5322	Q5323	Q539	Q540
Q541	Q542	Q543	Q544	Q548	Q550	Q551	Q5521
Q5522	Q5523	Q5529	Q553	Q554	Q555	Q5561	Q5562
Q5563	Q5564	Q5569	Q558	Q559	Q560	Q561	Q562
Q563	Q564	Q600	Q601	Q603	Q604	Q606	Q6101
Q6119	Q612	Q613	Q614	Q615	Q618	Q619	Q6211
Q6212	Q622	Q6231	Q6239	Q624	Q625	Q6261	Q6262
Q6263	Q628	Q630	Q631	Q632	Q633	Q638	Q640
Q6410	Q6411	Q6412	Q6419	Q642	Q6431	Q6432	Q6433
Q6439	Q644	Q645	Q646	Q6471	Q6472	Q6473	Q6474
Q6475	Q649	Q6501	Q6502	Q651	Q6531	Q6532	Q654
Q6581	Q6582	Q6589	Q6600	Q6601	Q6602	Q6610	Q6611
Q6612	Q66211	Q66212	Q66219	Q66221	Q66222	Q66229	Q6630
Q6631	Q6632	Q6640	Q6641	Q6642	Q6651	Q6652	Q666
Q6670	Q6671	Q6672	Q6681	Q6682	Q6689	Q6690	Q6691
Q6692	Q670	Q671	Q672	Q673	Q674	Q675	Q676
Q677	Q678	Q680	Q681	Q682	Q683	Q684	Q688
Q690	Q691	Q692	Q699	Q7001	Q7002	Q7003	Q7011
Q7012	Q7013	Q7021	Q7022	Q7023	Q7031	Q7032	Q7033
Q709	Q7101	Q7102	Q7103	Q7111	Q7112	Q7113	Q7131
Q7132	Q7133	Q7141	Q7142	Q7143	Q7151	Q7152	Q7153
Q7161	Q7162	Q7163	Q71811	Q71812	Q71813	Q71891	Q71892
Q71893	Q7191	Q7192	Q7193	Q7201	Q7202	Q7203	Q7211
Q7212	Q7213	Q7231	Q7232	Q7233	Q7241	Q7242	Q7243
Q7251	Q7252	Q7253	Q7261	Q7262	Q7263	Q7271	Q7272
Q7273	Q72811	Q72812	Q72813	Q72891	Q72892	Q72893	Q7291
Q7292	Q7293	Q730	Q731	Q738	Q740	Q742	Q743
Q748	Q749	Q75001	Q75002	Q75009	Q7501	Q75021	Q75022
Q75029	Q7503	Q75041	Q75042	Q75049	Q75051	Q75052	Q75058
Q7508	Q751	Q752	Q753	Q754	Q755	Q758	Q759
Q760	Q761	Q762	Q763	Q76411	Q76412	Q76413	Q76414
Q76415	Q76425	Q76426	Q76427	Q76428	Q7649	Q765	Q766
Q767	Q768	Q770	Q771	Q772	Q774	Q775	Q776

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[Revised] Diagnosis Codes							
Q777	Q780	Q781	Q782	Q783	Q784	Q788	Q789
Q790	Q791	Q792	Q793	Q794	Q7959	Q7960	Q7961
Q7962	Q7963	Q7969	Q798	Q799	Q800	Q801	Q802
Q803	Q804	Q808	Q820	Q821	Q822	Q823	Q824
Q825	Q826	Q828	Q830	Q831	Q832	Q833	Q838
Q840	Q841	Q842	Q843	Q844	Q845	Q846	Q848
Q849	Q8503	Q851	Q8581	Q8582	Q8583	Q8589	Q859
Q870	Q8711	Q8719	Q87410	Q87418	Q8742	Q8743	Q8782
Q8783	Q8784	Q8785	Q8786	Q8787	Q8788	Q87A	Q8901
Q8909	Q891	Q892	Q893	Q894	Q897	Q8981	Q8989
Q899	Q900	Q901	Q902	Q909	Q910	Q911	Q912
Q913	Q914	Q915	Q916	Q917	Q920	Q921	Q922
Q925	Q9261	Q9262	Q927	Q928	Q930	Q931	Q932
Q933	Q934	Q9351	Q9352	Q9359	Q937	Q9381	Q9382
Q9388	Q9389	Q950	Q952	Q958	Q960	Q961	Q962
Q963	Q964	Q968	Q969	Q970	Q971	Q972	Q973
Q978	Q980	Q981	Q984	Q985	Q986	Q987	Q988
Q990	Q991	Q992	Q99811	Q99812	Q99813	Q99818	Q99819
Q9989	Q999	R480	Z31430	Z31438	Z315	Z317	Z360
Z361	Z362	Z363	Z364	Z365	Z3681	Z3682	Z3683
Z3684	Z3688	Z3689	Z368A	Z369	Z810	Z8279	Z8482
Z8489							

Cytogenetics testing may be reimbursed with the following procedure codes and limitations:

Procedure Code	Quantity Allowed
Tissue Culture Procedure Codes and Limitations	
88230	1 per day any provider
88233	1 per day any provider
88235	1 per day any provider
88237	1 per day any provider
88239	1 per day any provider
Chromosome Analysis Procedure Codes and Limitations	
88245	1 per day any provider
88248	1 per day any provider
88249	1 per day any provider
88261	1 per day any provider
88262	1 per day any provider
88263	1 per day any provider
88264	1 per day any provider
88280	1 per day any provider

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Procedure Code	Quantity Allowed
88283	1 per day any provider
88285	1 per day any provider
88289	1 per day any provider
Molecular Cytogenetics Procedure Codes and Limitations	
88271	16 per provider per day
88272	10 per provider per day
88273	3 per provider per day
88274	5 per provider per day
88275	10 per provider per day
Interpretation and Report Procedure Code	
88291	As medically necessary

9.2.42.7 Maternal Serum Alpha-Fetoprotein (MSAFP)

MSAFP may be reimbursed once per pregnancy per provider for all pregnant women eligible for Medicaid. For additional services, payment is allowed with documentation attached to the claim. Procedure code 82105 should be used for MSAFP.

9.2.43 Pharmacogenetics

Pharmacogenetic testing of cytochrome p450 (CYP450) metabolic pathway may be considered medically necessary only if the results of the testing are necessary to differentiate between treatment options.

The use of pharmacogenetics may be considered medically necessary once in a lifetime to determine effective response to drug therapy for the following:

Procedure Code	Drug Treatment	Diagnosis Restriction	Prior Authorization
81225	Clopidogrel		Required
81226	Eliglustat	E7522	Required for repeat testing
	Tetrabenzine in a dosage greater than 50mg per day	G10	
81227	Warfarin		Required

9.2.43.1 Testing of Polymorphic 2C19

Pharmacogenetics testing of polymorphic 2C19 (procedure code 81225) may be considered for clopidogrel treatment and requires prior authorization and may be considered medically necessary when all of the following conditions are met:

- The client has never received genetic testing of the 2C19 alleles.
- The client has never received clopidogrel treatment.
- The clopidogrel treatment will be used for one of the following diseases or conditions:
  - ST elevated and non-ST elevated myocardial infarction (STEMI and NSTEMI)
  - Subsequent STEMI and NSTEMI
  - Dressler's syndrome
  - Unstable angina

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- Cerebral infarction due to embolism of cerebral arteries
- Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction
- Peripheral vascular disease, including unspecified

Note: *The routine use of genetic testing to screen patients treated with clopidogrel who are undergoing percutaneous coronary intervention (PCI) is not a benefit of Texas Medicaid.*

9.2.43.2 Testing of Polymorphic 2D6

Pharmacogenetics testing of polymorphic 2D6 (procedure code 81226) may be considered medically necessary when all of the following conditions are met:

- Group one:
  - The client has never received genetic testing of the 2D6 alleles
  - The client has a diagnosis of Gaucher disease type 1
  - Treatment with eliglustat (Cerdelga®) is being considered
- Group two:
  - The client has never received genetic testing of the 2D6 alleles
  - The client has a diagnosis of Huntington's disease
  - Treatment with tetrabenzine (Xenazine®) is being considered in a dosage greater than 50mg per day.

Prior authorization is not required for the initial pharmacogenetic testing of polymorphic 2D6 (procedure code 81226) that is performed on a client. Prior authorization is required for repeat testing.

9.2.43.3 Testing of Polymorphic 2C9

Pharmacogenetics testing of polymorphic 2C9 (procedure code 81227) requires prior authorization and may be considered for warfarin treatment and may be considered medically necessary when all of the following conditions are met:

- The client has never received genetic testing of the 2C9 alleles
- The client has never received warfarin (vitamin K antagonists) treatment
- The warfarin treatment will be used for one of the following diseases or conditions:
  - Irregular heartbeat or rhythm
  - Prosthetic (replacement or mechanical) heart valves
  - Myocardial infarction
  - Risk of venous thrombosis (swelling and blood clot in a vein)
  - Risk of pulmonary embolism (a blood clot in the lung)

9.2.43.4 Prior Authorization Requirements

Prior authorization is required for requests for pharmacogenetic testing for more than once in a lifetime. Prior authorization requests must be submitted on the Special Medical Prior Authorization (SMPA) Request Form. The form must be completed, signed, dated, and submitted by the prescribing or ordering provider.

Prior authorization requests from laboratories will not be processed. The requesting provider must share the prior authorization number with the laboratory submitting the claim.

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The prior authorization request must include the following:

- Laboratory NPI in section D of the SMPA Request Form
- Proposed or current treatment plan, including the drug name, dosage, and frequency that support the medical necessity of the service requested
    - This information may be documented in the "Statement of medical necessity" field under Section C of the SMPA Request Form or submitted separately with the prior authorization request.
- For prior authorization of procedure code 81225, the ordering provider must include a statement on the SMPA Request Form attesting that the client has never received clopidogrel treatment.
- For prior authorization of procedure code 81227, the ordering provider must include a statement on the SMPA Request Form attesting that the client has never received warfarin treatment.

Prior authorization requests to repeat the same test (procedure code 81225, 81226, or 81227) will be reviewed by the medical director when one of the following criteria is met:

- The client has Huntington's disease and a history of pharmacogenetic testing of 2D6 (procedure code 81226) for tetrabenzine treatment, and the new request is for the same testing of 2D6 but for eliglustat to treat Gaucher disease type 1.
- The client has Gaucher disease type 1 and a history of pharmacogenetic testing of 2D6 (procedure code 81226) for eliglustat treatment, and the new request is for the same testing of 2D6 but for tetrabenzine to treat Huntington's disease.
- Previous test results are unavailable. Every reasonable effort must be made to obtain the test results from the client's provider or laboratory who previously ordered or conducted testing. Documentation of these efforts must be submitted with the prior authorization request.

9.2.43.5 Exclusions

The following services are not a benefit of Texas Medicaid:

- Pharmacogenetics tests of polymorphisms in a p450 superfamily other than 2D6, 2C19, or 2C9, which are performed for the purpose of aiding in the choice of drug or dose to increase efficacy or avoid toxicity, as they are considered experimental and investigational
- The routine clinical use of genetic testing to screen patients treated with clopidogrel who are undergoing percutaneous coronary intervention (PCI)
- The use of any of the 2D6, 2C19, or 2C9 tests for the following conditions, drugs, or treatments:
    - Opioid pain medicines (codeine, oxycodone, hydrocodone, tramadol, fentanyl, and methadone)
    - Selective serotonin reuptake inhibitors (SSRIs)
    - Selective norepinephrine reuptake inhibitors (SNRIs)
    - Beta blockers
    - Selective tricyclic antidepressants
    - Selective antipsychotic drugs
    - Efavirenz and other antiretroviral therapies for human immunodeficiency virus (HIV) infection
    - Immunosuppressants for organ transplantation
    - Aricept® (donepezil) for individuals with Alzheimer's disease
    - p450 polymorphisms test panels for any of the 3 alleles 2C19, 2D6, or 2C9

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9.2.44 Lung Volume Reduction Surgery (LVRS)

LVRS is a benefit for clients who are not high risk but have a presence of severe, upper-lobe emphysema (as defined by radiologist assessment of upper-lobe predominance on CT scan) or who are not high risk but have a presence of severe, non-upper-lobe emphysema with low exercise capacity.

Note: *Clients who have low exercise capacity are those whose maximal exercise capacity is at or below 25 watts for women and 40 watts for men after completion of the pre-operative therapeutic program in preparation for LVRS. Exercise capacity is measured by incremental, maximal, symptom-limited exercise with a cycle ergometer utilizing a 5- or 10-watt-per-minute ramp on 30-percent oxygen after 3 minutes of unloaded pedaling.*

LVRS must be performed in a facility that meets at least one of the following requirements:

- Certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission on Accreditation of Health Care Organization
- Approved by Medicare as a lung or heart-lung transplant facility

The surgery must be both preceded and followed by a program of diagnostic and therapeutic services that are consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the client's potential to successfully undergo and recover from surgery. The program must meet all of the following requirements:

- Include a 6- to 10-week series of at least 16, and no more than 20, pre-operative sessions, each lasting a minimum of 2 hours
- Include at least 6, and no more than 10, post-operative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks after the LVRS
- Be consistent with the care plan that was developed by the treating physician following the performance of a comprehensive evaluation of the client's medical, psychosocial, and nutritional needs
- Be arranged, monitored, and performed under the coordination of the facility where the surgery takes place

Clients must have surgical clearance by a licensed cardiologist for any of the following conditions:

- Unstable angina
- Left ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram
- LVEF less than 45 percent
- Dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction
- Arrhythmia (more than 5 premature ventricular contractions (PVC) per minute)
- Cardiac rhythm other than sinus
- PVCs on electrocardiogram (EKG) at rest

For clients with cardiac ejection fraction less than 45 percent, there must be no history of congestive heart failure or myocardial infarction within six months of consideration for surgery.

Clients must have surgical clearance by a licensed pulmonologist, thoracic surgeon, and anesthesiologist after completion of pre-operative rehabilitation.

Procedure codes 32491, G0302, G0303, G0304, and G0305 are limited to one per rolling year per client for any provider.

Pre-operative pulmonary rehabilitation services for preparation for LVRS (procedure codes G0302, G0303, and G0304) and post-discharge pulmonary surgery services LVRS (procedure code G0305) will be restricted to diagnosis codes J430, J431, J432, J438, and J983.

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Procedure code G0305 may be reimbursed only if a claim for LVRS (procedure code 32491) has been submitted within the past 12 months.

9.2.44.1 Prior Authorization for Lung Volume Reduction Surgery

LVRS must be prior authorized and is limited to clients who have severe emphysema, disabling dyspnea, and evidence of severe air trapping. The following documentation must be submitted with the request for prior authorization:

- The client's history and physical examination is consistent with emphysema
- BMI less than 31.1 kg/m2 (men) or less than 32.3 kg/m2 (women)
- Pulmonary status that is stable with less than 20 mg prednisone (or equivalent) per day
- A radiographic high resolution computer tomography (HRCT) scan has been conducted that shows evidence of bilateral emphysema.
- The forced expiratory volume in one second (FEV1) (maximum of pre- and postbronchodilator values) is less than or equal to 45 percent of the predicted value. If the client is 70 years of age and older, FEV1 is 15 percent of the predicted value or more.
- The total lung capacity (TLC) greater than 100 percent predicted postbronchodilator
- Residual volume (RV) greater than 150 percent predicted postbronchodilator found on prerehabilitation pulmonary function study.
- Arterial blood gas level (pre-rehabilitation):
  - Partial pressure of carbon dioxide (PaCO2) less than or equal to 60 mm Hg (PaCO2 less than or equal to 55 mm Hg if one mile above sea level)
  - Partial pressure of oxygen (PaO2) greater than or equal to 45 mm Hg on room air (PaO2 greater than or equal to 30 mm Hg if one mile above sea level)
- The plasma cotinine is less than or equal to 13.7 ng/ml (if the client is not using nicotine products) or the carboxyhemoglobin is less than or equal to 2.5 percent (if the client is using nicotine products).
- Nonsmoking for four months prior to initial interview and throughout evaluation for surgery
- Successful 6-minute walk test equal to or greater than 140 meters following pre-operative rehabilitation
- Successful completion of three minute unloaded pedaling in an exercise tolerance test both before and after pre-operative rehabilitation

To complete the prior authorization process, a provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity.

- Requisition forms from the laboratory are not sufficient for verification of the personal and family history.
- Medical documentation that is submitted by the physician must verify the client's diagnosis or family history.

Prior authorization is not required for the associated preoperative pulmonary surgery services for preparation for LVRS (procedure codes G0302, G0303, and G0304) or the associated postdischarge pulmonary surgery services after LVRS (procedure code G0305).

9.2.44.1.1 Noncovered Conditions

LVRS is not a benefit in any of the following clinical circumstances:

- A client with characteristics that carry a high risk for perioperative morbidity and/or mortality

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- A disease that is unsuitable for LVRS
- A medical condition or other circumstance that makes it likely that the client will be unable to complete the preoperative and postoperative pulmonary diagnostic and therapeutic program required for surgery
- The client presents with FEV1 less than or equal to 20 percent of predicted value, and either a homogeneous distribution of emphysema on the CT scan or a carbon monoxide diffusing capacity of less than or equal to 20 percent of predicted value (a high-risk group identified in October 2001 by the NETT)
- The client satisfies the criteria outlined above and has severe, non-upper-lobe emphysema with a high-exercise capacity. High-exercise capacity is defined as a maximal workload at the completion of the preoperative diagnostic and therapeutic program that is above 25 watts for women or 40 watts for men (under the measurement conditions for cycle ergometry).
- A previous LVRS (laser or excision) on the same lung
- A pleural or interstitial disease which precludes surgery
- A giant bulla (greater than 1/3 the volume of the lung in which the bulla is located)
- A clinically significant bronchiectasis
- A pulmonary nodule requiring surgery
- A previous lobectomy
- Uncontrolled hypertension (systolic greater than 200 mm Hg or diastolic greater than 110 mm Hg)
- Oxygen requirement greater than 6 liters per minute during resting to keep oxygen saturation greater than or equal to 90 percent
- A history of recurrent infections with clinically significant production of sputum
- Unplanned weight loss greater than 10 percent within 3 months before the consideration of surgery
- Pulmonary hypertension, defined as the mean pulmonary artery pressure of 35 mmHg or greater on the right heart catheterization or peak systolic pulmonary artery pressure of 45 mmHg or greater. Right heart catheterization is required to rule out pulmonary hypertension if the peak systolic pulmonary artery pressure is greater than 45 mmHg on an echocardiogram
- Resting bradycardia (less than 50 beats per minute)
- Frequent multifocal premature ventricular contractions (PVCs) of complex ventricular arrhythmia or sustained supraventricular tachycardia (SVT)
- Evidence of a systemic disease or neoplasia that is expected to compromise survival

9.2.45 Diagnostic and Therapeutic Breast Procedures

Diagnostic, mastectomy, and breast reconstruction procedures are benefits of Texas Medicaid.

These are physician-directed services including, but not limited to diagnostic and surgical breast procedures provided by physicians in the office, outpatient, or inpatient hospital settings, and external breast prostheses provided by durable medical equipment (DME) providers in the home setting.

Categories of service include:

- Diagnostic breast procedures
- Mastectomy
- Reconstructive breast procedures
- Treatment of complications of breast reconstruction

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- External breast prostheses

9.2.45.1 Diagnostic Procedures

Diagnostic breast procedures for a condition or malignancy of the breast may include:

- Puncture aspiration
- Mastotomy
- Injection procedure for ductogram or galactogram
- Percutaneous biopsy, with or without imaging guidance
- Incisional biopsy
- Nipple exploration
- Excision of the following:
  - Lactiferous duct fistula
  - Benign or malignant breast lesion
  - Chest wall tumor

The following procedure codes may be reimbursed for diagnostic breast procedures:

Procedure Codes									
19000	19001	19020	19030	19081	19082	19083	19084	19085	19086
19100	19101	19110	19112	19120	19125	19126	19281	19282	19283
19284	19285	19286	19287	19288					

The following services are not benefits of Texas Medicaid:

- Mastectomy for a diagnosis of fibrocystic disease in the absence of documented risk factors.
- Cosmetic services performed primarily to improve appearance.
- Commercial or "decorative" tattooing.
- Replacement of external breast prostheses when the damage is due to abuse or neglect by the client, client's family, or the caregiver.

9.2.45.2 Therapeutic Procedures

9.2.45.2.1 Mastectomy Procedures

Mastectomy and partial mastectomy (e.g., lumpectomy, tylectomy, quadrantectomy, and segmentectomy) are benefits when it is medically necessary to remove a breast or portion of a breast for conditions including, but not limited to:

- Developmental abnormality
- Congenital defect
- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

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The following procedure codes for mastectomy are benefits of Texas Medicaid:

Procedure Codes					
19301	19302	19303	19305	19306	19307

Procedure codes 19301, 19302, 19303, 19305, 19306, and 19307 may be reimbursed without prior authorization for services rendered to male or female clients who are 18 years of age and older.

Prior authorization is required for services rendered to clients who are 17 years of age and younger.

Procedure codes 19303, 19305, 19306, and 19307 are limited to 1 service per breast per lifetime.

9.2.45.2.2 Prophylactic Mastectomy

Prophylactic mastectomy is a benefit after a thorough assessment of a client's unique risk factors, health, and the level of concern. Prophylactic mastectomy is limited to clients who are at moderate- to high-risk for the development of breast cancer.

Moderate- to high-risk clients are those who meet one or more of the following criteria for development of breast cancer:

- Current or previous diagnosis of breast cancer
- Family history of breast cancer in mother, sister, or daughter, especially before the age of 50
- Presence of any of the following genetic mutations:
  - Breast cancer gene 1 (BRCA1)
  - Breast cancer gene 2 (BRCA2)
  - Tumor protein 53 (TP 53)
  - Phosphatase and tensin homolog (PTEN)
- Lobular carcinoma in situ (LCIS)
- Radiation therapy to the chest before a client reaches 30 years of age

Refer to: Subsection 3.5, "Breast Cancer Gene 1 and 2 (BRCA) Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Documentation that supports medical necessity for prophylactic mastectomy must include the information listed above.

Documentation that as a candidate for prophylactic mastectomy, the client has undergone counseling regarding cancer risks. Counseling must include assessment of all of the following:

- The client's ability to understand the risks and long-term implications of the surgical procedure, and
- The client's informed choice to proceed with the surgical procedure.

9.2.45.2.3 Mastectomy for Pubertal Gynecomastia

Mastectomy for pubertal gynecomastia is a benefit with prior authorization for males who are 20 years of age and younger. Procedure code 19300 may be reimbursed for mastectomy for pubertal gynecomastia.

The following documentation must be submitted with the prior authorization request for procedure code 19300:

- The gynecomastia classification (grade II, III, or IV) as defined by the American Society of Plastic Surgeons classification.
- Evidence that puberty is near completion, as indicated by the following:

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  - 95 percent of adult height based on bone age, and
  - Tanner stage V has been achieved.
- Evidence that the client has been off gynecomastia inducing drugs or other substances for a minimum of one year when this is identified as the cause of the gynecomastia.
- Evidence of resolution as supported by appropriate test results and treatment for hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas, and hypogonadism, for a minimum of one year when identified as the cause of the gynecomastia.
- Evidence of a psychiatric assessment performed by a psychiatrist or psychologist.
- Client's history and treatment plan including planned surgical procedure and timelines.
- Identification of which breast or breasts, require mastectomy.

Documentation that supports medical necessity for mastectomy for pubertal gynecomastia must be maintained in the client's medical record, and must include the following:

- A complete medical and family history, including:
  - Gynecomastia classification
  - Bone age
  - Tanner stage
  - Use of any gynecomastia inducing drugs or substances and date last ingested
  - Hormonal causes of gynecomastia, treatment, and length of treatment
  - Psychiatric assessment performed by a psychiatrist or psychologist and outcome
  - Affected breast or breasts
- A thorough physical examination
- Medically indicated laboratory testing and any other testing including results

9.2.45.3 Breast Reconstruction

Breast reconstruction may be performed in a single stage or several stages. Breast reconstruction is a benefit when all of the following criteria are met:

- The client has a documented history of one or more of the following:
  - Mastectomy
  - Congenital defect
  - Developmental abnormality
  - Trauma or injury to the chest wall
- The client meets age and gender criteria for the requested procedure.
- The physician has documented a treatment plan in the client's medical record that addresses the recommended breast reconstruction.
- Reconstruction to attain symmetry is required and may include a surgical procedure to the contralateral breast and may be either a reduction or an augmentation.

Procedure options for breast reconstruction following a mastectomy include, but are not limited to the following:

- Superficial inferior epigastric artery (SIEA) flap
- Deep inferior epigastric artery (DIEP) flap

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- Transverse rectus abdominis myocutaneous (TRAM) flap
- Breast implants (saline or silicone)
- Reduction mammoplasty
- Mastopexy
- Reconstruction of the nipple or areola (small flaps)
- Tattooing to correct color defects of the skin
- Treatment for complications of breast reconstruction

Documentation that supports medical necessity for breast reconstruction, including tattooing, must include the following:

- Diagnosis resulting in the need for breast reconstruction,
- Date of mastectomy, when appropriate,
- Date of any previous breast reconstruction procedures, when appropriate,
- Treatment plan to include planned surgical procedures and timeline for completion, and
- When appropriate, identification of the complication.

All Medicaid services, including breast reconstruction after breast cancer surgery, are covered for Medicaid Breast and Cervical Cancer (MBCC) clients who are receiving active cancer treatment. "Active treatment" is defined as medical treatment following a cancer diagnosis that is intended to cure or otherwise treat a diagnosed cancer.

Active treatment may include some or all of the following:

- Surgery
- Chemotherapy
- Radiotherapy
- Medication (e.g., ongoing hormonal treatments for estrogen and progesterone breast cancer)
- Active disease surveillance for triple negative receptor breast cancer

Reconstructive surgery (e.g., breast reconstruction) is considered "active treatment" if it is intended to permanently correct a physical condition resulting from either the diagnosed cancer or the treatment of the diagnosed cancer.

Ongoing treatment of a persistent condition resulting from a diagnosed cancer or treatment of a diagnosed cancer is not considered "active treatment" if cancer is no longer present or in need of treatment.

The following breast reconstruction procedure codes may be reimbursed without prior authorization for services rendered to clients who are 18 years of age and older:

Procedure Codes									
11970	11971	19316*	19325*	19340*	19342*	19350	19355	19357*	19361
19364	19367	19368	19369	19396*	S2068				
***Procedure codes are limited to females only.**									

Prior authorization is required for services rendered to clients who are 17 years of age and younger or when the client does not meet gender or age criteria.

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Procedure codes 11920, 11921, and 11922 may be reimbursed when performed as part of breast reconstruction.

Breast reconstruction claims denied for no history of previous mastectomy may be appealed with supporting documentation indicating the date of mastectomy, or the identified trauma, injury, or congenital or developmental abnormality.

9.2.45.3.1 Tattooing to Correct Color Defects of the Skin

Tattooing to correct color defects of the skin (procedure codes 11920, 11921, and 11922) are limited to two services per lifetime.

Tattooing claims denied for no history of breast reconstruction may be appealed with supporting documentation indicating the date of breast reconstruction, or the identified trauma, injury, or congenital or developmental abnormality.

9.2.45.3.2 Treatment for Complications of Breast Reconstruction

The treatment of complications related to breast reconstruction may be reimbursed using procedure codes 19328, 19330, 19370, 19371, and 19380.

Procedure codes 19328, 19330, 19370, and 19371 may be reimbursed for services rendered to female clients only.

9.2.45.3.3 Chest Wall Procedures

Excision of chest wall tumors may be reimbursed using procedure codes 21601, 21602, and 21603.

Procedure code 21603 is limited to once per lifetime.

9.2.45.3.4 External Breast Prostheses

External breast prostheses are available through a durable medical equipment (DME) provider for a female client with a history of a medically necessary mastectomy procedure.

The following procedure codes may be reimbursed for external breast prostheses services rendered to female clients of any age:

Procedure Codes									
L8000	L8001	L8002	L8015	L8020	L8030	L8031	L8032	L8033	L8035
L8039									

To be considered for reimbursement, an LT or RT modifier must be appropriately appended to the submitted diagnostic and therapeutic breast procedure codes or external breast prostheses procedure codes.

The external breast prosthesis procedure codes are limited as follows:

Procedure Code	**Limitation**
L8000	4 per rolling year
L8001	4 per rolling year, per modifier
L8002	4 per rolling year
L8015	2 per rolling year
L8020	1 per 6 rolling months
L8030	per 2 rolling years
L8031	per 2 rolling years
L8032	8 per rolling year

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Procedure Code	Limitation
L8033	8 per rolling year
L8035	Requires prior authorization
L8039	Requires prior authorization

Replacement of external breast prostheses may be considered at any time, through the prior authorization with documentation.

For a new or replacement external breast prosthesis procedure code outside the limitations, all of the following documentation must be submitted with the prior authorization request:

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8035 (custom prosthesis), all of the following documentation must be submitted with the prior authorization request:

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8039 (other prosthesis), all of the following documentation must be submitted with the prior authorization request:

- A clear, concise description of the breast prosthesis requested
- Reason for recommending the requested prosthesis
- A CPT or HCPCS procedure code, which is comparable to the procedure being requested
- Documentation that this breast prosthesis is not investigational or experimental
- The provider's intended fee for the requested prosthesis

9.2.45.4 Prior Authorization Requirements for Diagnostic and Therapeutic Breast Procedures

Prior authorization is not required for the following when all of the following criteria are met:

- The procedure is a mastectomy or breast reconstruction for clients who are 18 year of age or older.
- The request is for one of the following external breast prosthesis procedure codes: L8000, L8001, L8002, L8015, L8020, or L8030.
- The procedure is for partial mastectomy procedure codes 19301 and 19302 for clients of any age.

Prior authorization is required for the following:

- Mastectomy or breast reconstruction when the client is 17 years of age or younger, or does not meet gender criteria
- Mastectomy for pubertal gynecomastia
- Procedure code 19499 (unlisted procedure)
- External breast prosthesis procedure codes L8035 (custom prosthesis) and L8039 (other prosthesis)
- Any request for new or replacement external breast prosthesis outside of the limitations

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9.2.45.4.1 Unlisted Breast Procedure

All of the following documentation must be submitted for procedure code 19499 with the prior authorization request:

- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code, which is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- Place of service the procedure is to be performed
- The provider's intended fee for this procedure

9.2.45.4.2 Documentation Requirements

In addition to documentation requirements outlined in the "Prior Authorization Requirements" section above, the following requirements apply:

- All services are subject to retrospective review. Documentation in the client's medical record must be maintained by the physician and must support the medical necessity for the services provided.
- Services not supported by documentation are subject to recoupment.

9.2.46 Neurostimulators

Neurostimulator and neuromuscular stimulator procedures and the rental or purchase of devices and associated supplies, such as leads and form fitting conductive garments are a benefit of Texas Medicaid when medically necessary.

Durable medical equipment (DME) is defined as medical equipment/appliances that are manufactured to withstand repeated use, ordered by a physician or allowed practitioner for use in the home, and required to correct or ameliorate the client's disability, condition, or illness. Since there is no single authority (such as a federal agency) that confers the official status of "durable medical equipment" on any device or product, the Health and Human Services Commission (HHSC) retains the right to make such determinations with regard to DME provided by Texas Medicaid. DME provided by Texas Medicaid must either have a well-established history of efficacy, or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a Medicaid-eligible medical condition or functional disability.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or clinical nurse specialist (CNS).*

Neurostimulator devices are considered DME, so providers must complete both the Home Health (Title XIX) DME/Medical Supplies Physician Order Form (Title XIX Form) to prescribe the DME and the DME Certification and Receipt Form to show receipt of the DME by the client. Both forms must be maintained in the client's medical record.

Refer to: Subsection 2.2.2, "Durable Medical Equipment (DME) and Supplies" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for more information about DME.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

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Items and/or services addressed in the sections below are either reimbursed at a maximum fee determined by HHSC or are manually priced. If an item is manually priced, the manufacturer's suggested retail pricing (MSRP) must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are reimbursed at the MSRP minus a discount (18 percent) as determined by HHSC.

9.2.46.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator or neuromuscular stimulator device require prior authorization.

A completed Special Medical Prior Authorization (SMPA) Request Form prescribing the device and related procedures must be signed and dated by a physician familiar with the client before requesting prior authorization for the device and related procedures. The completed SMPA Request Form must include the procedure codes and quantities for services requested.

Note: *It is not necessary to include the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form when submitting the SMPA Prior Authorization Request Form.*

The completed SMPA Request Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To complete the prior authorization process by paper, the requesting provider must fax or mail the completed form to the SMPA Department. To complete the prior authorization process electronically, the requesting provider must submit the prior authorization requirements through any approved electronic methods.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment, supplies and services requested and is subject to retrospective review. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the equipment and supplies.

A neurostimulator device that has been purchased is anticipated to last a maximum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. At that time, replacement of the device will be considered. Replacement devices require prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

9.2.46.2 Neuromuscular Electrical Stimulation (NMES)

NMES application and the rental or purchase of devices and conductive garments are a benefit of Texas Medicaid when medically necessary and prior authorized. Prior authorization requests for NMES must include documentation of a spinal cord injury or disuse atrophy that is refractory to conventional therapy.

NMES may be reimbursed using the following procedure codes:

Procedure Codes									
64580	E0731	E0745	E0762	E0764	A4556	A4557	A4560	A4595	

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9.2.46.2.1 NMES Rental

The rental of a NMES device may be considered before purchase and is limited to a one-month trial period with consideration for one additional month's trial with documentation of medical necessity. Supplies are considered to be part of the rental and will not be separately reimbursed. Garments may be considered for reimbursement during the rental period when medically necessary.

9.2.46.2.2 NMES Purchase

The purchase of a NMES device is limited to once per five years, and may be reimbursed when there is documentation of successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by the following:

- A demonstrated increase in range of motion.
- The client's improved ability to complete activities of daily living or perform activities outside the home.

Garments may be considered for reimbursement during the purchase period when medically necessary.

9.2.46.2.3 NMES for Muscle Atrophy

NMES may be reimbursed when used to treat muscle disuse atrophy when brain, spinal cord, and peripheral nerve supply to the muscle is intact, as well as other non-neurological conditions. Examples of NMES treatment for non-neurological conditions include, but are not limited to, casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery until orthotic training begins.

9.2.46.2.4 NMES for Walking in Clients with Spinal Cord Injury (SCI)

The type of NMES that is used to enhance the ability to walk of SCI clients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

The use of NMES/FES is limited to SCI clients who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three months.

The trial period of physical therapy will enable the treating physician or allowed practitioner to properly evaluate the client's ability to use NMES/FES devices frequently and for the long term.

Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program. The goal of physical therapy must be to train SCI clients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

NMES/FES is a benefit for SCI clients who have all of the following characteristics:

- Clients with intact lower motor unit (L1 and below) (both muscle and peripheral nerve).
- Clients with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright posture while standing independently for at least three minutes.
- Clients who demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction.
- Clients who possess high motivation, commitment, and cognitive ability to use such devices for ambulation, as established by provider interview and documentation.
- Clients who can transfer independently.
- Clients who can demonstrate hand and finger function to manipulate controls.
- Clients with at least six-month post recovery spinal cord injury and restorative surgery.

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- Clients with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.

NMES and FES used for walking is not a benefit in SCI clients with any of the following:

- Cardiac pacemakers
- Severe scoliosis or severe osteoporosis
- Skin disease or cancer at area of stimulation
- Irreversible contracture
- Autonomic dysflexia

9.2.46.3 Transcutaneous Electrical Nerve Stimulation (TENS)

TENS involves the attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated.

TENS may be reimbursed for the treatment of acute postoperative pain or chronic pain that is refractory to conventional therapy.

TENS may be reimbursed using the following procedure codes:

Procedure Codes									
E0720	E0730	E0731	E0733	E0736	A4556	A4557	A4595		

Procedure code E0733 requires prior authorization and is limited to diagnosis code G500.

Procedure code E0736 is limited to clients who are 18 years of age or older.

TENS is for the treatment of overactive bladder (OAB) and is limited to clients who have had the following:

- An evaluation that has been performed by an appropriate specialist, usually a urologist or urogynecologist, who has determined that the client is a candidate for posterior tibial nerve stimulation (PTNS)
- A medical record that includes the following documentation:
  - The client has been compliant with and has failed a trial of symptom-appropriate behavioral therapy of sufficient length to evaluate potential efficacy.
  - The client has been compliant with and has failed or been unable to tolerate a trial of at least two appropriate medications administered for four to eight weeks.
  - The client's voiding diary shows continued findings of OAB.
  - The client has documented a willingness to attend in-office treatment sessions, to comply with behavioral therapies, and to continue to keep voiding diaries that include documentation of behavioral therapy compliance.

9.2.46.3.1 TENS Rental

Rental of a TENS device will be considered for prior authorization when there is documentation of a condition that indicates acute postoperative pain or chronic pain that is refractory to conventional therapy.

The rental of a TENS device is limited to one-month trial period with consideration for one additional month's trial with documentation of medical necessity. Supplies, such as lead wires and electrodes, are considered to be part of the rental and will not be separately reimbursed. Garments may be considered during the rental period when medically necessary.

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When the TENS device is rented for a trial period rather than supplied by the provider, the combined payment made for professional services and the rental of the stimulator must not exceed the amount which would be reimbursed for the total service, including the stimulator, if furnished by the provider alone.

9.2.46.3.2 TENS Purchase

The purchase of a TENS device is limited to once every five years and may be reimbursed with prior authorization when there is documentation of the following:

- A condition that indicates chronic pain that is refractory to conventional therapy.
- A successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by demonstrated increase in range of motion.
- The client's improved ability to complete activities of daily living or perform activities outside the home.

9.2.46.4 NMES and TENS Garments

The rental of the NMES/TENS garment is not covered during the trial rental period unless the client has a documented skin problem prior to the start of the trial period, and HHSC or its designee determines that use of such an item is medically necessary for the client based on the documentation submitted.

The purchase of conductive garments for NMES/TENS devices may be considered when:

- The garment has been prescribed by a physician or allowed practitioner for use in providing covered NMES/TENS treatment.
- A NMES/TENS device has been purchased for the client's use.
- The conductive garment is necessary for one of the medical indications outlined below:
  - The client cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
  - The client cannot manage the treatment for chronic intractable pain without the conductive garment because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
  - The client has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes, and lead wires.

9.2.46.5 NMES and TENS Supplies

Supplies for purchased devices are limited as follows:

- Procedure code A4438 is limited to clients who are 18 years of age or older.
- Procedure codes A4541 and A4595 are limited to 1 per month.
- Procedure code A4541 is restricted to diagnosis code G500.
- If additional electrodes are required, procedure code A4556 may be considered for reimbursement at a maximum of 15 per month.
- If additional lead wires are required, procedure code A4557 may be considered for reimbursement at a maximum of 2 per month.
- Procedure code A4560 is limited to 1 unit every 12 weeks, or 4 units per year.

Supplies are included in the rental and will not be reimbursed separately.

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Supply procedure codes A4438, A4541, A4556, A4557, A4560 or A4595 may be reimbursed for clients with a purchased device and a claims history of an NMES/TENS procedure within the last five years. Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number, and purchasing entity of the device may be required.

9.2.46.6 Diaphragm-Pacing Neuromuscular Stimulation

Diaphragm-pacing neuromuscular stimulation is a benefit of Texas Medicaid when medically necessary and prior authorized.

Diaphragm-pacing neuromuscular stimulation is the electrical stimulation to one or both of the phrenic nerves or to the phrenic motor point regions of the diaphragm muscles that cause contraction of one or both of the two hemidiaphragms rhythmically to produce inspiration.

Diaphragm-pacing neuromuscular stimulation implantation may be reimbursed when billed with the following procedure codes:

Procedure Codes									
33276	33277	33278	33279	33280	33281	33287	33288	64575	64590
93150	93151	93153							

9.2.46.6.1 Prior Authorization for Diaphragm-Pacing Neuromuscular Stimulation

The surgical implantation of the diaphragm-pacing neuromuscular stimulator and purchase of a device are considered for prior authorization when medically necessary for individuals with severe, chronic respiratory failure that requires mechanical ventilation for any of the following reasons:

- Improvement of ventilatory function in stable, non-acute members with spinal cord injury (SCI) with high quadriplegia at or above C-3
- Alveolar hypoventilation, either primary or secondary to brainstem disorder
- Amyotrophic lateral sclerosis

Prior authorization for diaphragm-pacing neuromuscular stimulation may be considered with any of the following diagnosis codes:

Diagnosis Codes							
G1220	G1222	G1223	G1224	G1225	G1229	G128	G129
G4735	G8250	G8251	G8252	G8253	G8254	G8389	J9610
J9611	J9612	J9620	J9621	J9622	R0681	Z9911	

All of the following criteria must be met:

- The phrenic nerves are viable
- Diaphragmatic function is sufficient to accommodate chronic stimulation
- Pulmonary function is known to be adequate
- The client has normal chest anatomy, a normal level of consciousness, and has the ability to participate in and complete the training and rehabilitation associated with the use of the device

9.2.46.7 Dorsal Column Neurostimulator (DCN)

DCN involves the surgical implantation of neurostimulator electrodes within the dura mater (endodural) or the percutaneous insertion of electrodes in the epidural space. The neurostimulator system stimulates pain-inhibiting nerve fibers, masking the sensation of pain with a tingling sensation (paresthesia).

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DCN implantation may be reimbursed using procedure codes 63650, 63655, or 63685.

Conditions that may indicate chronic intractable pain include, but are not limited to, the following:

- Post-amputation "ghost" pain
- Cancer with bone metastasis
- Causalgia of upper/lower limb
- Herniated disc
- Radiculitis
- Spinal stenosis
- Spinal surgery
- Tic douloureux (trigeminal neuralgia)

9.2.46.7.1 Prior Authorization for Dorsal Column Neurostimulators

DCN electrode implantation and the purchase of devices is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation of DCN device may be considered for prior authorization for clients who have chronic intractable pain with documentation that indicates the following:

- Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation.
- There has been evidence of pain relief during a trial period for DCN with a temporarily implanted electrode or electrodes preceding the permanent implantation.

  Note: *A trial period including device and supplies is considered part of DCN procedures and will not be separately reimbursed.*

- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and the client's follow-up are available.

9.2.46.8 Gastric Electrical Stimulation (GES)

GES involves electrical stimulation of the lower stomach (antrum) with a fully implantable system that consists of two unipolar intramuscular leads (thin wires) and a neurostimulator device.

GES is a benefit of Texas Medicaid when medically necessary and prior authorized for the treatment of chronic intractable nausea and vomiting that is secondary to gastroparesis that has proven to be refractory to medical management.

GES may be reimbursed with procedure codes 43647, 43881, and 64590.

GES is a benefit for Texas Medicaid clients with the following conditions:

- Organic obstruction or pseudo-obstruction
- A primary eating or swallowing disorder
- Chemical dependency
- Pregnancy

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9.2.46.8.1 Prior Authorization for GES

The surgical implantation of a GES and purchase of a device are considered for prior authorization for chronic intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology when all of the following criteria are met:

- Gastric emptying is significantly delayed as documented by standard scintigraphic imaging of solid food.
- Patient is refractory or intolerant of two out of three classes of prokinetic medications and two out of three antiemetic medications.
- The client's nutritional status is sufficiently low that all of the following criteria for total parenteral nutrition are met:
  - Adequate trials of dietary adjustment, oral supplements, or tube enteral nutrition have demonstrated that the patient can receive no more than 30 percent of his/her caloric needs orally and/or by tube.
  - The patient must be in a stage of wasting as indicated by all of the following:
    - Weight is significantly less than normal body weight for a patient's height and age in comparison with pre-illness weight.
    - Serum albumin is less than 3.4 grams.
    - BUN is less than 10 mg.
    - Phosphorus level is less than 2.5 mg.

9.2.46.9 Intracranial Neurostimulators

The surgical implantation, revision, and removal of intracranial deep brain stimulators (DBS) are a benefit for the relief of chronic intractable pain when more conservative methods, such as TENS, PENS, or pharmacological management have failed or were contraindicated.

Intracranial neurostimulation may be reimbursed using the following procedure codes:

Procedure Codes								
61781	61850	61860	61863	61864	61867	61868	61885	61886

9.2.46.9.1 Prior Authorization for Intracranial Neurostimulators

Intracranial neurostimulation involves the stereotactic implantation of electrodes in the brain and is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation and purchase of an intracranial neurostimulation device may be considered for prior authorization for chronic intractable pain or treatment of intractable tremors.

Requests for prior authorization must include documentation of the following:

- Other treatment modalities, including pharmacological, surgical, physical, and psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and assessment by a multidisciplinary team prior to implantation.
- The client has reported pain relief with a temporarily implanted electrode preceding the permanent implantation.
- All the facilities, equipment, and support personnel required for the proper assessment, treatment, training, and client's follow-up are available.

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Prior authorization will not be given for the treatment of motor function disorders such as multiple sclerosis; however, the implantation, revision, and removal of deep brain stimulators may be reimbursed for the treatment of intractable tremors due to the following:

- Idiopathic Parkinson's disease
- Essential tremor

9.2.46.10 Pelvic Floor Stimulation

Purchase of a non-implantable pelvic floor stimulator (procedure code E0740) is a benefit of Texas Medicaid for the treatment of stress or urge incontinence in clients who have failed conservative treatment, such as Kegel exercises, behavior management, bladder training, or medication.

Purchase of the pelvic floor stimulator device is limited to once per five years. All accessories and supplies are considered part of the purchase price and are not reimbursed separately.

9.2.46.10.1 Prior Authorization for Pelvic Floor Stimulation

Prior authorization is required for the purchase of a pelvic floor stimulator device.

Documentation submitted with the prior authorization request must demonstrate that the client:

- Has a diagnosis of stress or urge incontinence.
- Has completed a six-month trial of pelvic muscles exercises with no significant clinical improvement.

9.2.46.11 Percutaneous Electrical Nerve Stimulation (PENS)

PENS is a benefit of Texas Medicaid when medically necessary and prior authorized. Devices and supplies are considered a part of the service and are not separately reimbursable.

PENS is a diagnostic procedure for the treatment of chronic pain involving the stimulation of peripheral nerves by a needle electrode inserted through the skin.

9.2.46.11.1 Prior Authorization for PENS

PENS services may be reimbursed with prior authorization for clients who meet the following criteria:

- The client has a diagnosis that indicates chronic pain, which is refractory to conventional therapy.
- Treatment with TENS has failed or is contraindicated for the client.

PENS may be reimbursed using the following procedure codes: 64553, 64555, 64590, 64596, 64597, or 64598. The revision or removal of a peripheral neurostimulator used in PENS therapy may be reimbursed without prior authorization using procedure code 64595.

9.2.46.12 Sacral Nerve Stimulators (SNS)

SNS are a benefit of Texas Medicaid when medically necessary and prior authorized. SNS implantation may be reimbursed using procedure code 64561, 64581, or 64590.

SNS involves the use of pulse generators that transmit electrical impulses to the sacral nerves through a surgically implanted wire for treatment of urinary retention, urinary frequency, and urinary/fecal incontinence.

9.2.46.12.1 Prior Authorization for SNS

The surgical implantation of SNS and purchase of a device may be considered for prior authorization with the following:

- Urinary incontinence secondary to urethral instability and/or detrusor muscle instability.
- Chronic voiding dysfunction.

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- Non-obstructive urinary retention.
- Fecal incontinence.

Additionally, the medical record of the client must have documentation of the following:

- The urinary retention, urinary frequency, and urinary/fecal incontinence are refractory to conventional therapy (documented behavioral, pharmacological, and/or surgical corrective therapy).
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

9.2.46.13 Vagal Nerve Stimulators (VNS)

VNS are a benefit of Texas Medicaid when medically necessary and prior authorized, for the treatment of intractable partial onset seizures.

VNS involves the use of devices that deliver electrical pulses to the cervical portion of the vagus nerve by an implanted generator.

9.2.46.13.1 Prior Authorization for VNS

The surgical implantation and purchase of VNS devices may be considered for prior authorization for clients with partial onset intractable seizures when there is failure, contraindication, or intolerance to all suitable medical and pharmacological management.

The surgical implantation of VNS may be reimbursed using procedure code 61885, 61886, 64553, or 64568.

VNS are not a benefit of Texas Medicaid in the following cases:

- For the treatment of clients with an absent left vagus nerve
- For the treatment of clients with depression
- For the treatment of clients with diseases or conditions with a poor prognosis or are progressively terminal in nature

Incapacities due to intellectual disabilities or cerebral palsy may confound the assessment of benefits resulting from VNS. When a diagnosis of intellectual disabilities or cerebral palsy exists, the treating physician must document in the client's medical record how VNS will measurably benefit the client in spite of intellectual disabilities or cerebral palsy.

9.2.46.14 Hypoglossal Nerve Stimulators (HNS)

Hypoglossal Nerve Stimulators (HNS) is a benefit of Texas Medicaid when medically necessary and prior authorized, for the treatment of obstructive sleep apnea (OSA) and seizures.

HNS involves the use of devices that deliver electrical pulses to the hypoglossal nerve by an implanted generator.

The surgical implantation of HNS may be reimbursed using procedure codes 64582, C8007, or C8011.

The revision or removal of HNS may be reimbursed using procedure codes 64583, 64584, C8008, C8009, C8012, or C8013. Procedure codes 64583, 64584, C8008, C8009, C8012, and C8013 do not require prior authorization.

9.2.46.14.1 Prior Authorization for HNS

The surgical implantation of HNS (procedure code) and purchase of a device may be considered for prior authorization with documentation of the following criteria:

- Client has a documented diagnosis of OSA or seizures by a qualified health care provider.

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- For an OSA diagnosis, documentation that continuous positive airway pressure (CPAP) compliance for a minimum of 1 month (5 nights per week for at least 4 hours per night) has not been successful or is unable to be tolerated.
- For an OSA diagnosis, absence of complete concentric collapse at the soft palate level as seen in a drug-induced sleep endoscopy (DISE) procedure.
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

9.2.46.15 Prior Authorization of Neurostimulator Devices Procedure Codes

The following device procedure codes may be reimbursed with prior authorization:

Procedure Codes									
C1607	L8681	L8682	L8683	L8684	L8685	L8686	L8687	L8688	L8689
L8695									

Neuromuscular devices and the implantation codes must be billed on the same day by any provider.

To identify the service as a VNS device, procedure code L8686 must be submitted with modifier TG. Only one similar device code may be reimbursed per date of service for any provider.

9.2.46.16 * Supplies for Neurostimulators

[Revised] Supply procedure codes A4290, C1883, C1897, L8678, L8680, and L8697 may be reimbursed for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator implantation within the past five years. Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number and purchasing entity of the initial implantable device may be required. Supplies for implantable devices may be considered for reimbursement on appeal with documentation of a prior neurostimulator or a neuromuscular stimulator implantation procedure for clients with a history that is more than five years or for those who have a neurostimulator that was not received through Texas Medicaid.

To identify the service as a VNS implantable electrode, procedure code L8680 must be submitted with modifier TG.

9.2.46.17 Electrocorticogram of Implanted Neurostimulator

Electrocorticogram (procedure code 95836) is a benefit of Texas Medicaid and may be reported only once per each 30 day period.

9.2.46.18 Electronic Analysis for Neurostimulators

The following procedure codes may be reimbursed without prior authorization for the electronic analysis of the implanted neurostimulator and neuromuscular stimulation:

Procedure Codes									
95970	95971	95972	95976	95977	95980	95981	95982	95983	95984

9.2.46.19 Revision or Removal of Neurostimulator Devices

The revision or removal of implantable neurostimulators may be reimbursed without prior authorization using the following procedure codes:

Procedure Codes									
43648	43882	61781	63661	63662	63663	63664	63688	61880	61888
64569	64570	64585	64595						

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9.2.46.20 Noncovered Neurostimulator Services

The following services are not a benefit of Texas Medicaid:

- VNS is not a benefit when provided for the treatment of depression.
- Neurostimulation and neuromuscular stimulation services for indications other than those outlined above.

9.2.47 Newborn Services

The newborn period is defined as the time from birth through 28 days of life. This section addresses routine newborn care, attendance at delivery, newborn resuscitation, neonatal critical care, and intensive (noncritical) low birth weight services.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.

All newborn E/M procedure codes must have a newborn outcome diagnosis code included on the claim. Modifier 25 may be used to identify a significant separately identifiable E/M provided on the same day by the same physician as a procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Note: *Some of the services addressed in this section may also be used for care beyond 28 days of life.*

Refer to: Subsection 9.2.60, "Physician Evaluation and Management (E/M) Services" in this handbook.

Refer to: Subsection 2.2.23.13, "Cardiorespiratory Monitor (CRM)" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for authorization of cardiorespiratory monitors.

9.2.47.1 Circumcisions for Newborns

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54160.

9.2.47.2 Hospital Visits and Routine Care

The following procedure codes may be reimbursed for neonatal care and intensive care services:

Service	Procedure Code(s)	Benefit(s) and Limitation(s)
Initial hospital E/M admission	99221 99222 99223	If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission. Reimbursed one per day, any provider.
Hospital discharge	99238 99239	Reimbursed for the client's discharge from the hospital.
Subsequent hospital and hospital consultation services	99252 99253 99254 99255	Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99252, 99253, 99254, and 99255).
Initial newborn care	99460*	May be reimbursed once per lifetime, any provider.

*** Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.**
**** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).**

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Service	Procedure Code(s)	Benefit(s) and Limitation(s)
Normal newborn care	99461*	May be reimbursed once per lifetime, any provider. Subsequent visits must be billed using an appropriate visit code based on the place of service.
Subsequent hospital care	99462	Reimbursable once per day in the hospital and limited to a total of seven days. Restricted to clients who are birth through seven days of age. If the client is diagnosed with a condition that requires more complex care and/or must stay more than 8 days, the provider must bill subsequent neonatal and pediatric care critical or intensive care (procedure codes 99469, 99478, 99479, or 99480). If the client is readmitted, the provider must bill an initial hospital E/M admission (procedure code 99221, 99222, 99223, or 99468) and the appropriate code for inpatient neonatal critical care (procedure code 99469). Procedure code 99462 is not reimbursable in the birthing center.
Newborn admission and discharge, same date	99463**	May be reimbursed once per lifetime when submitted by any provider. Reimbursed for newborns who are admitted and discharged on the same day from the hospital or birthing room setting (either hospital or birthing center).
Attendance at delivery	99464	May be reimbursed once, and only on the day of delivery, when billed by a physician other than the delivering physician.
Newborn resuscitation	99465	Reimbursed for the resuscitation of the newborn.
Initial hospital care and initial intensive care	99477	Reimbursed for those neonates who require intensive observation, frequent interventions, and other intensive services. Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Initial neonatal critical and intensive care (procedure codes 99468 and 99477) may be reimbursed once per admission, any provider. ***Note:*** *For subsequent admissions during the first 28 days of life, procedure codes 99468 and 99477 may be considered for reimbursement upon appeal.*

*** Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.**
**** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).**

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Service	Procedure Code(s)	Benefit(s) and Limitation(s)
Subsequent intensive care	99478 99479 99480	Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Subsequent critical and intensive care (procedure codes 99469, 99478, 99479, and 99480) will be considered for reimbursement once per day, any provider. Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99252, 99253, 99254, and 99255). Procedure codes 99478, 99479, and 99480 must be billed for subsequent neonatal intensive (noncritical) services. The present body weight of the neonate or infant determines the appropriate procedure code that must be billed. When the present body weight of a neonate exceeds 5,000 grams, a subsequent hospital care service (procedure code 99231, 99232, or 99233) must be billed.
*** Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.** **** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).**		

Note: *Services for a newborn's unsuccessful resuscitation may be billed under the mother's Texas Medicaid number using procedure code 99499.*

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for a list of the required components for an initial THSteps exam.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.

In the following table, procedure codes in Column A will be denied when billed with the same date of service by the same provider as a procedure code in Column B:

Column A (Denied)	Column B
99238, 99239	99460, 99461, 99463
99462	99238, 99239
36410, 96361, 99292, 99307	99468, 99469
36410, 96361, 99471, 99472	99477
36410, 96361, 99291, 99292, 99307, 99471, 99472, 99478	99478
36410, 94761, 96361, 99291, 99292, 99307, 99471, 99472, 99478, 99479	99479
36410, 96361, 99291, 99292, 99307, 99308, 99309, 99310, 99471, 99472, 99478, 99479, 99480	99480

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9.2.47.3 Newborn Hearing Screening

The newborn hearing screening procedure is a screening procedure, not diagnostic, and will not be reimbursed separately from the usual inpatient newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants. For more information on newborn hearing screening, providers may contact:

Texas Early Hearing Detection and Intervention
PO Box 149347, MC-1918
Austin, TX. 78714-9347
1-512-458-7111, Ext. 2600
www.dshs.texas.gov/tehdi

Refer to: Section 2, "Nonimplantable Hearing Aid Devices and Related Services" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.3.12.2.3, "Hearing Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about hearing screenings.

9.2.48 Occupational Therapy (OT) Services

Occupational therapy (OT) is a payable benefit to physicians.

Refer to: Section 4, "Therapy Services Overview" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about occupational therapy services provided by a physician.

9.2.49 Ophthalmology

When an ophthalmologist sees a client for a minor condition that does not require a complete eye exam, such as conjunctivitis, providers are to use the appropriate office E/M code.

Providers are to use the eye exam procedure codes with a diagnosis of ophthalmological disease or injury.

Refer to: Subsection 4.3.5, "Vision Testing" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.49.1 Corneal Transplants

Corneal transplants are benefits of Texas Medicaid. Corneal transplants are subject to global surgery fee guidelines. Procedure codes 65710, 65730, 65750, 65755, 65756, and 65757 are used for this surgery.

Bioengineered cornea transplants remain investigational at this time and are not considered for reimbursement under Texas Medicaid.

Procurement of the cornea is not reimbursed separately.

9.2.49.2 Eye Surgery by Laser

Eye surgery by laser is a benefit of Texas Medicaid when medically necessary and meets the conditions and limitations stated in this section.

Authorization is not required for eye surgery by laser.

All procedure codes in this section are subject to multiple surgery guidelines. For bilateral procedures, the following modifiers must be added to the claim to indicate that the procedures were performed on the right and left eyes:

- Modifier RT to indicate the right eye
- Modifier LT to indicate the left eye

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All procedures may be reimbursed only to physicians and are limited to reimbursement once every 90 days for the same eye with the exception of infants from birth through 23 months of age. Procedures performed on infants from birth through 23 months of age are not subject to any frequency restrictions.

9.2.49.2.1 Other Eye Surgery Procedures

Anterior Segment of the Eye–The Cornea

Laser surgery to the cornea by laser-assisted in situ keratomileusis (LASIK) or photorefractive keratectomy (PRK) for the purpose of correcting nearsightedness (myopia), farsightedness (hyperopia), or astigmatism is not a benefit of Texas Medicaid.

Reimbursement for laser surgery to the cornea, procedure codes 65450, 65855, and 65860 is limited to once every 90 days for the same eye.

Anterior Segment of the Eye–The Iris, Ciliary Body

Laser surgery to the anterior segment of the eye–the iris, ciliary body may be reimbursed only when billed with one of the following procedure codes:

Procedure Codes									
66600	66605	66710	66711	66761	66762	66770			

Reimbursement for procedure codes 66600, 66605, 66710, 66711, 66761, 66762, and 66770 is limited to once every 90 days for the same eye.

Claims for iridectomy (66600, 66605, 66625, 66630, or 66635) or iridotomy (66500 or 66505) are not reimbursed when billed for the same date of service as a trabeculectomy (66170 or 66172). These claims are considered for review when filed on appeal with documentation of medical necessity. The iridectomy is considered part of a trabeculectomy. An iridectomy billed with any other eye surgery on the same day suspends for review.

An iridectomy is also considered part of certain types of cataract extractions. An iridectomy (66600 or 66605) is not reimbursed when billed for the same date of service as the cataract surgeries listed in the following table. The iridectomy is considered part of the cataract surgery. These claims are considered for review when filed on appeal with documentation of medical necessity.

Procedure Codes									
65920	66840	66850	66852	66920	66930	66940	66983	66984	66985
66986									

Posterior Segment of the Eye–Retina or Choroid

Laser surgery to the retina or choroid may be reimbursed only when billed with one of the following procedure codes:

Procedure Codes									
67105	67107	67108	67110	67113	67145	67210	67220	67221	67225
67228	67229	G0186							

Procedure code 67229 is restricted to clients who are birth through 1 year of age.

When billed for the same date of service, same eye, any provider, procedure code 67031 will be denied as part of any of the following procedure codes:

Procedure Codes									
67036	67108	67110	67120	67121	67141	67145	67208	67210	67218

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Procedure Codes									
67227	67228								

When billed for the same date of service, same eye, any provider, only one of the following procedure codes may be reimbursed: 67220, 67221, 67225, or G0186.

When billed for the same date of service, same eye, by any provider, procedure codes 67025, 67028, 67031, 67036, 67039, 67040, and 67105 will be denied as part of 67108.

Posterior Segment of the Eye, Vitreous–Vitrectomy

Laser surgery to the vitreous may be reimbursed only when billed with one of the following procedure codes: 67031, 67039, 67040, and 67043.

Reimbursement for procedure codes 67031, 67039, 67040, and 67043 is limited to once every 90 days for the same eye.

When billed for the same date of service, same eye, any provider procedure code 67500 will be denied as part of 66821.

Procedure code 66821 is denied as part of 66830, 67031, and 67228.

Procedure codes 66820, 66984, 66985, and 67036 will pay according to multiple surgery guidelines when billed with procedure code 66821.

When billed for the same date of service, same eye, different provider procedure codes 66821, 67005, and 67010 will be denied as part of 67031.

When billed for the same date of service, same eye, any provider procedure code 67031 will be denied as part of any of the following procedure codes: 67036, 67108, 67110, 67120, 67121, 67208, 67218, 67227, and 67228.

9.2.49.3 Eye Surgery by Incision

The following restrictions apply to vitrectomy and cataract surgeries:

- Procedure codes 66500, 66505, 66605, 66625, 66630, and 66635 are denied as part of another procedure when billed with the following cataract surgeries: 65920, 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984, 66985, and 66986. Claims may be appealed with additional documentation to demonstrate the medical necessity.
- Procedure code 66020 is denied as part of another procedure when billed with any related eye surgery procedure code.
- Procedure code 67036 may be reimbursed when billed alone.
- Procedure code 67036 is denied as part of another procedure when billed with procedure codes 67039, 67040, 67041, 67042, 67043, or 67108.
- Procedure codes 67039 and 67040 are combined and reimbursed as procedure code 67108 when billed by the same provider for the same date of service.
- For clients who are 8 years of age and younger, the following cataract extraction and vitrectomy procedure codes, performed on the same eye, will be considered for payment per multiple surgery guidelines:

Procedure Codes									
66840	66850	66852	66920	66930	66940	66983	66984	67005	67010
67015	67025	67027	67028	67030	67031	67036	67039	67040	67041
67042	67043								

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- For clients who are nine years of age and older, the following procedure codes will be paid when performed on the same eye as a cataract extraction:

Procedure Codes									
67005	67010	67015	67025	67027	67028	67030	67031	67036	67039
67040	67041	67042	67043						

- For clients who are nine years of age and older, the following procedure codes will be denied as part of the codes listed above, when performed on the same eye:

Procedure Codes									
66840	66850	66852	66920	66930	66940	66983	66984		

Reimbursement for procedure codes 67041, 67042, and 67043 is limited to once every 90 days for the same eye.

9.2.49.4 Intraocular Lens (IOL)

An IOL (V2630, V2631, and V2632) may be reimbursed only to physicians in the office setting (POS 1). Providers must submit a copy of the manufacturer's invoice for procedure code V2631 to TMHP with their claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (taking into account any discount) plus a handling fee not to exceed five percent of the acquisition cost.

Medicaid does not reimburse physicians who supply IOLs to ASCs/HASCs.

Reimbursement for the surgical procedure necessary to implant an IOL remains unchanged.

9.2.49.5 Intravitreal Drug Delivery System

Procedure codes 67027 and 67121 pertain to the procurement, implantation, and removal of an intravitreal drug delivery system (e.g., a ganciclovir implant). They are set to deny when billed concurrently.

9.2.49.6 Other Eye Surgery Limitations

The following procedure codes require modifier LT or RT to identify the eye for which the surgery is being performed:

Procedure Codes									
65205	67311	67312	67314	67316	67318	67320	67331	67332	67334
67345	67414	67800	67801	67805	67808	V2790			

In the following table, the procedure codes in Column A may be reimbursed only when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

Column A Procedure Codes	Column B Procedure Codes
66990	65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, or 67113
67320, 67331, 67332, 67334	67311, 67312, 67314, 67316, or 67318
67335, 67340	67311, 67312, 67314, 67316, 67318, 67320, 67331, 67332, or 67334
V2790	65780

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9.2.50 Extracapsular Cataract Removal

Extracapsular cataract removal (procedure codes 66989 and 66991) is a benefit of Texas Medicaid for clients who are 21 years of age or older.

Procedure codes 66989 and 66991 are limited to the following diagnosis codes:

Diagnosis Codes					
H401111	H401112	H401121	H401122	H401131	H401132

Procedure codes 66989 and 66991 are limited to two services per lifetime, and must be billed with modifier LT or RT to identify the eye on which the service was performed.

Procedure code 66989 is denied if billed on the same date of service by the same provider as procedure code 67015, 67025, 67027, 67030, or 67031.

9.2.51 Organ/Tissue Transplants

Organ/tissue transplants that include bone marrow, peripheral stem cell, heart, intestine, lung, liver, kidney, or pancreas are a benefit of Texas Medicaid.

Solid organ transplants are a benefit of Texas Medicaid when medically necessary based on safety and efficacy, as demonstrated by scientific evidence and by controlled clinical studies, in accordance with the Texas Administrative Code (TAC). Solid organ transplants are limited to clients with a critical medical condition who are expected to have a successful clinical outcome that will result in a return to improved functional independence. Benefits are not available for the following experimental or investigational services:

- Artificial and bioartificial livers
- Xenotransplantation of solid organs

Solid organ transplants and post-transplant care will only be covered if the organ procurement is in alignment with the National Organ Transplant Act (NOTA). Only organs harvested voluntarily from within the United States under the oversight of the Health Resources and Services Administration (HRSA) and the United Network of Organ Sharing (UNOS) will be covered. Organs harvested for a fee or sponsorship or organs obtained from any country outside of the United States will not be covered for transplant or post-transplant care.

Coverage is limited to one transplant per organ system (or organ systems for combined transplants) per lifetime except for one subsequent transplant because of organ rejection.

Solid organ transplants require prior authorization and may be reimbursed only when performed in a Medicaid-enrolled facility that is a designated children's hospital with a transplant unit or program, or certified for the procedure by the United Network for Organ Sharing (UNOS).

The facility must be in Texas, unless there are no Texas facilities certified by UNOS or designated as a Children's Hospital with a transplant unit or program for the requested procedure.

All requests for out-of-state (OOS) services, whether for pre-transplant evaluation, transportation, or post-transplant monitoring, must be sent to the medical director for prior authorization review. Texas Medicaid will consider authorizing OOS services when the following criteria are met:

- The client does not leave Texas to receive care that can be received in Texas.
- An in-state facility approved for the procedure has declined to accept the client and documentation is submitted to explain why the in-state team cannot perform the procedure.
- There is no physician provider or facility with the level of expertise required to perform the necessary procedure available in Texas, or the client has received an initial transplant at the OOS facility and requires additional transplant services due to complications or graft loss.

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- There is reasonable assurance that the client meets the clinical criteria required by Texas Medicaid for transplant approval.
- The service is necessary, reasonable, and federally allowable, and the facility and physicians agree to accept Medicaid reimbursement for these services.
- The OOS facility must be certified by UNOS or designated as a Children's Hospital with a transplant unit or program.

When requesting an OOS prior authorization for a pre-transplant evaluation, the provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an OOS solid organ pre-transplant evaluation.

When requesting an OOS prior authorization for transplant of a solid organ, the provider must submit a copy of the transplant evaluation performed by a Texas facility and a copy of the transplant evaluation performed by the OOS facility to support the need for an OOS solid organ transplant.

When requesting an OOS prior authorization for post-transplant monitoring or other post-transplant services, the provider must submit documentation that the client received the initial transplant at the same OOS facility to include complications or graft loss if present, in order to support the need for OOS solid organ post-transplant monitoring or other post-transplant services.

Expenses incurred for the procurement of a living donor's organ are not a benefit of Texas Medicaid.

Refer to: Subsection 3.2.5, "Organ and Tissue Transplant Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the transplant facility approval criteria.

Subsection 3.2.5.2, "Transplant Benefits and Limitations" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about organ/tissue transplant program limitations.

9.2.51.1 General Prior Authorization Requirements

Solid organ transplant prior authorization requests must include all of the following:

- A complete history and physical
- A statement of the current medical conditions and status of the transplant recipient
- Documentation of how the client meets the prior authorization criteria specified for the transplant requested
- Documentation of the absence of co-morbidities or contraindications such as the following:
  - Severe pulmonary hypertension
  - End-stage cardiac, renal, hepatic, or other organ dysfunction unrelated to the primary disorder
  - Uncontrolled HIV infection or AIDS defining illness
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure
  - Ongoing or recurrent active infections that are not effectively treated
  - Psychiatric instability severe enough to jeopardize incentive for adherence to medical regimen
  - Active alcohol or chemical dependency that might interfere with compliance to a medical regimen
- History of compliance with other medical treatments, regimen, and plan of care

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Backbench procedures do not require prior authorization but may only be reimbursed when a corresponding transplant procedure has been paid for the same date of service.

Note: *Clients who are birth through 20 years of age and who do not meet the criteria for coverage may be considered through the Comprehensive Care Program (CCP).*

Additional prior authorization criteria, if applicable, specific to each type of transplant are outlined in the following sections.

If prior authorization is not obtained for a solid organ transplant, services directly related to the transplant within the three-day preoperative and six-week postoperative period are also denied regardless of who provides the services (e.g., laboratory services, status post visits, radiology services). However, coverage for other services needed as a result of complication of the transplant or for services unrelated to the transplant may be considered when medically necessary, reasonable, and federally allowable.

Claims for transplant clients are placed on active review when the transplant was not prior authorized so that the services related to the transplant can be monitored.

9.2.51.2 Heart Transplants

9.2.51.2.1 Prior Authorization for Heart Transplants

A heart transplant to a client for primary heart dysfunction must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Procedure code 33945 may be considered for prior authorization with medical necessity documentation that indicates a New York Heart Association (NYHA) Class III or IV cardiac disease with one of the following medical conditions:

- Congenital heart disease
- Valvular heart disease
- Viral cardiomyopathy
- Familial and restrictive cardiomyopathy

9.2.51.3 Intestinal Transplants

An intestinal transplant may be considered for clients who are dependent on parental nutrition and have compromised venous access, have had two or more episodes of central line sepsis, or who have begun to manifest progressive parental nutrition associated liver dysfunction. Procedure codes 44135 and 44136 must be prior authorized.

Small bowel transplantation is considered medically necessary in clients with irreversible intestinal failure including, but not limited to:

- Short bowel syndrome
- Pseudo-obstruction
- Microvillus inclusion
- Tumor

The prior authorization request must include documentation of irreversible intestinal failure with failed total parenteral nutrition (TPN) therapy. The client has experienced TPN failure if any one of the following criteria is met:

- Impending or overt liver failure due to TPN-induced liver injury. Clinical indictors include the following:
  - Increased serum bilirubin levels
  - Increased liver enzyme levels

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- Splenomegaly
- Thrombocytopenia
- Gastroesophageal varices
- Coagulopathy
- Stomal bleeding
- Hepatic fibrosis
- Cirrhosis

- Thrombosis of major central venous channels (subclavian, jugular, or femoral veins). Thrombosis of two or more of these vessels is considered a life-threatening complication and TPN failure.
- Frequent central line-related sepsis. Two or more episodes of central-line-induced systemic sepsis per year that require hospitalization are considered TPN failure. A single episode of central-line-related fungemia, septic shock, or acute respiratory distress syndrome is considered TPN failure.
- Frequent episodes of severe dehydration despite TPN and intravenous fluid supplement. Under certain medical conditions, such as secretory diarrhea and nonconstructable gastrointestinal tract, the loss of combined gastrointestinal and pancreatobiliary secretions exceed the maximum intravenous infusion rates that can be tolerated by the cardiopulmonary system.

Diagnoses that indicate intestinal failure include, but are not limited to, the following:

- Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment
- Small bowel syndrome resulting from postsurgical conditions due to resections
- Intestinal cysts
- Mesenteric cysts
- Small bowel or other tumors involving small bowel
- Crohn's disease
- Mesenteric thrombosis
- Volvulus
- Short-gut syndrome in which there is liver function impairment (usually secondary to TPN)

9.2.51.4 Kidney Transplants

9.2.51.4.1 Prior Authorization for Kidney Transplants

Procedure codes 50360 and 50365 must be prior authorized. Medical necessity documentation of one of the following is required:

- Hemodialysis or continuous ambulatory peritoneal dialysis (CAPD).
- Chronic renal failure with anticipated deterioration to end-stage renal disease.
- End-stage renal disease, evidenced by a creatinine clearance below 20 ml/min or development of symptoms of uremia.
- End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12- to 18-month period.

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9.2.51.4.2 Cytogam

Procedure code J0850 is reimbursable by Texas Medicaid. Cytogam is indicated for the attenuation of primary cytomegalovirus disease in seronegative kidney transplant recipients who receive a kidney from a seropositive donor. Payment of cytogam is limited to diagnosis code Z940, Z941, Z942, Z943, Z944, or Z9483. Cytogam is payable only in the office or outpatient setting.

Refer to: Subsection 3.2.5, "Organ and Tissue Transplant Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the transplant facility approval criteria.

9.2.51.5 Liver Transplants

9.2.51.5.1 Prior Authorization for Liver Transplants

For a client to be considered for coverage of a liver transplant, the medical records for the client must include documentation showing the client is unresponsive to more conventional and/or standard therapies.

Authorization of procedure codes 47133 and 47135 requires medical necessity documentation of liver disease in one of the following categories:

- Primary cholestatic liver disease
- Other cirrhosis:
  - Alcoholic
  - Hepatitis C, non-A, non-B, and Hepatitis B
- Fulminant hepatic failure
- Metabolic diseases
- Malignant neoplasms
- Benign neoplasms
- Biliary atresia

9.2.51.6 Lung Transplants

9.2.51.6.1 Prior Authorization for Lung Transplants

A lung transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization of procedure codes 32851, 32852, 32853, 32854, and S2060 may be considered with medical necessity documentation of the following:

- Symptoms at rest directly related to chronic pulmonary disease and resultant severe functional limitation
- End-stage pulmonary diseases in one of these categories:
  - Obstructive lung disease
  - Restrictive lung disease
  - Cystic Fibrosis
  - Pulmonary hypertension

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9.2.51.7 Pancreas Transplant

9.2.51.7.1 Prior Authorization for Pancreas Transplant

A pancreas/simultaneous kidney-pancreas transplant must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

For prior authorization of procedure codes 48160 and 48554, medical necessity documentation must be submitted that shows the following:

- Recurrent, acute, and severe metabolic and potentially life-threatening complications requiring medical attentions such as:
  - Hypoglycemia
  - Hyperglycemia
  - Ketoacidosis
  - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy
  - Insensibility to hypoglycemia; or
- Satisfactory kidney function (creatinine clearance greater than 40mL/min), except for kidney-pancreas transplants; and
- Type 1 diabetes with secondary diabetic complications that are progressive despite the best medical management; and
- At least two of the following secondary complications:
  - Diabetic neuropathy
  - Retinopathy
  - Gastroparesis
  - Autonomic neuropathy
  - Extremely labile (brittle) insulin-dependent diabetes mellitus

9.2.51.8 Multi-Organ Transplants

Procedure codes 33935, S2053, and S2054 may be considered for prior authorization if medical necessity documentation meets the requirements for each organ.

Procedure code S2065 may be considered for prior authorization if medical necessity documentation indicates the client meets criteria for a pancreas transplant and has end-stage renal disease that requires dialysis or is expected to require dialysis within the next 12 months.

9.2.51.9 Nonsolid Organ Transplants

Nonsolid organ transplants covered by Texas Medicaid include allogeneic and autologous stem cell transplantation, allogeneic and autologous bone marrow transplantation, autologous islet cell transplantation, and hematopoietic progenitor cell (HPC) boost infusion.

9.2.51.9.1 Allogeneic and Autologous Bone Marrow and Stem Cell Transplantation

Stem cell transplantation is a process in which stem cells are obtained from either a client's or donor's bone marrow, peripheral blood, or umbilical cord blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy and/or radiotherapy used to treat various malignancies, and also can be used to restore function in clients having an inherited or acquired deficiency or defect.

Benefits are not available for any experimental or investigational services, supplies, or procedures.

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Coverage of bone marrow and stem cell transplantation is limited to the following procedure codes: 38206, 38230, 38232, 38240, 38241, 38242, and S2142.

Texas Medicaid recognizes the following covered indications for stem cell transplants:

- Allogeneic
  - Hematological malignancy
  - Lymphatic malignancy
  - Bone marrow disorders
  - Hemoglobinopathies
  - Platelet function disorders
  - Immunodeficiency disorders
  - Inherited metabolic disorders
  - Multiple myeloma/plasma cell disorders
- Autologous
  - Hematological malignancy
  - Lymphatic malignancy
  - Germ cell tumors
  - Brain tumors
  - Small round blue cell tumors of childhood
  - Multiple myeloma/plasma cell disorders
- Indications for additional infusions
  - Infusion of stem cells for failure to graft (autologous)
  - Donor leukocyte infusion for persistent or relapsed malignant disease (allogeneic)
- Indications for re-transplantation
  - Relapse of disease
  - Failure to engraft or poor graft function

9.2.51.9.2 Autologous Islet Cell Transplantation

Autologous islet cell transplantation associated with the complete or partial removal of the pancreas (procedure code 48160) is a benefit of Texas Medicaid only for clients with a diagnosis of chronic pancreatitis.

Allogeneic islet cell transplantation is not a benefit.

9.2.51.9.3 HPC Boost Infusion

Prior authorization is required for HPC boost infusion procedure code 38243. The prior authorization request must include documentation of a prior stem cell transplant.

Requests for more than two boost procedures per lifetime requires medical necessity review and approval by the medical director.

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9.2.51.9.4 Prior Authorization for Nonsolid Organ Transplants

All nonsolid organ transplants require mandatory prior authorization and must be performed in a Texas facility that is a designated children's hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). Prior authorization is effective for the date span specified on the prior authorization approval letter. If the transplant has not been performed by the end of the authorization period, the physician must apply for an extension.

Documentation supplied with the prior authorization request must include the following:

- A complete history and physical.
- A statement of the client's current medical condition and the expected long-term prognosis for the client from the proposed procedure.

Each subsequent transplant must be prior authorized separately.

Peripheral or umbilical cord blood stem cell transplantation may be authorized in lieu of bone marrow transplantation (BMT), but will not be approved when performed simultaneously.

If a stem cell transplant has been prior authorized for a client who is 21 years of age or older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Bone marrow harvesting (38230) or peripheral stem cell harvesting (38206) for autologous bone marrow or stem cell transplants are a benefit of Texas Medicaid and require prior authorization.

Autologous harvesting of stem cells (single or multiple sessions) may be reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient setting (POS 5). Harvesting of stem cells performed in the inpatient setting (POS 3) is included in the DRG and will not be reimbursed separately.

Physician services for the storage of stem cells are not a benefit of Texas Medicaid.

Donor expenses are included in the global fee for the transplant recipient and are not reimbursed separately. Therefore, allogeneic bone marrow or stem cell harvesting procedures are not a benefit of Texas Medicaid.

Stem cell transplants for other conditions may be considered on a case by case basis. Documentation for prior authorization must be submitted to determine whether the transplant is medically necessary and appropriate.

9.2.51.10 Organ Procurement

The appropriate DRG reimbursement coverage to the approved institution for a prior authorized solid organ transplant procedure includes procurement of the organ and services associated with the organ procurement as specified by HHSC or its designee. Documentation of organ procurement must be maintained in the hospital medical records.

9.2.52 Orthognathic Surgery

Orthognathic surgery is a benefit of Texas Medicaid only when it is necessary for medical reasons, or when it is necessary as part of an approved plan of care in the Texas Medicaid Dental Program. Orthognathic surgery is administered and may be reimbursed as part of the medical/surgical benefit of Texas Medicaid and not as part of the Texas Medicaid Dental Program.

Treatment of malocclusion is a benefit of the Texas Medicaid Dental Program. Orthognathic surgery is a benefit when it is necessary as part of the approved dental benefit.

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Maxillary and/or mandibular facial skeletal deformities are associated with clearly abnormal masticatory malocclusion.

Orthognathic surgery may be considered medically necessary for the following client conditions:

- Producing signs or symptoms of masticatory dysfunction
- Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies
- Facial skeletal discrepancies associated with documented speech impairments
- Structural abnormalities of the jaws secondary to infection, trauma, neoplasia, or congenital anomalies

Orthognathic surgery may be considered for reimbursement when required for the client to access a dental service. Orthognathic surgery that is done primarily to improve appearance and not for reasons of medical necessity is considered cosmetic and is not a benefit of Texas Medicaid.

9.2.52.1 Prior Authorization for Orthognathic Surgery

The following orthognathic medical surgical services may be considered for reimbursement to oral and maxillofacial surgeons with prior authorization. A narrative explaining medical necessity must be provided with the authorization request.

Procedure Codes									
21010	21031	21032	21050	21060	21073	21100	21110	21120	21121
21122	21123	21125	21127	21137	21138	21139	21141	21142	21143
21145	21146	21147	21150	21151	21154	21155	21159	21160	21172
21175	21179	21180	21181	21182	21183	21184	21188	21193	21194
21195	21196	21198	21199	21206	21208	21209	21210	21215	21230
21235	21240	21242	21243	21244	21247	21255	21256	21260	21261
21263	21267	21268	21270	21275	21295	21296	21299	29800	29804
40840	40842	40843	40844	40845					

9.2.53 Osteopathic Manipulative Treatment (OMT)

OMT, when performed by a physician (MD or DO), is a benefit of Texas Medicaid for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury with a neurological component.

OMT is covered when it is performed with the expectation of restoring the patient's level of function, which has been lost or reduced by injury or illness. Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. A model of documentation that supports medical necessity for the treatment plan includes the following:

- Specific modalities/procedures to be used in treatment
- Diagnosis
- Region treated
- Degree of severity
- Impairment characteristics
- Physical examination findings (X-ray or other pertinent findings)
- Specific statements of long- and short-term goals

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- Reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and techniques used

The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

Reimbursement is contingent on correct documentation of the condition. The acute modifier AT must be submitted with the claim for payment to be made. Paper claims submitted without modifier AT will be denied; electronic claims will be rejected. The AT modifier is described as representing treatment provided for an acute condition or an exacerbation of a chronic condition that persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

The following procedure codes are payable when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions: 98925, 98926, 98927, 98928, and 98929.

OMT will be denied when billed on the same date of service by the same provider as any of the following procedure codes:

Procedure Codes									
00640	51701	51702	51703	64400	64405	64408	64412	64415	64416
64417	64418	64420	64421	64425	64430	64435	64445	64446	64447
64448	64449	64450	64470	64472	64475	64476	64479	64480	64483
64484	64505	64510	64517	64520	64530	96360	96365	96372	96374
96375	99202	99203	99204	99205	99211	99212	99213	99214	99215
99221	99222	99223	99231	99232	99233	99234	99235	99236	99238
99239	99242	99243	99244	99245	99252	99253	99254	99255	99281
99282	99283	99284	99285	99291	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348
99349	99350	99460	99461	99462	99463	99464	99465	99468	99469
99471	99472	99478	99479	99480					

When multiples of procedure codes 98925, 98926, 98927, 98928, and 98929 are billed on the same day by any provider, the most inclusive code is paid and the others are denied.

An E/M or initial or subsequent care visit or consultation may be paid in addition to OMT billed on the same day if the client's condition requires a visit for a significant and separately identifiable service above and beyond the usual pre- and post-care associated with the OMT procedure, even if the visit and OMT are related to the same symptom or condition. Modifier 25 must be submitted with the E/M procedure code to identify a separate and distinct service rendered on the same day as OMT.

Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Procedure code 97140 will be denied as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

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9.2.54 Pain Management

Pain management is a benefit of Texas Medicaid.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as another surgical procedure performed by the same physician are paid according to multiple surgery guidelines.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as an anesthesia procedure performed by the same physician are denied as included in the total anesthesia time.

Reimbursement to the physician for the surgical procedure is based on the assigned RVUs or maximum fee. Outpatient facilities are reimbursed at their reimbursement rate. Inpatient facilities are reimbursed under the assigned diagnosis-related group (DRG). No separate payment for the intrathecal pump is made.

Use the following procedure codes when billing for the implantation/revision/replacement of the pump/catheter:

Procedure Codes									
62350	62351	62355	62360	62361	62362	62365			

Procedure codes 62367 and 62368 do not require prior authorization and are payable as a medical service only.

Refer to: Subsection 9.2.40, "Implantable Infusion Pumps" in this handbook for more information about implanted pumps.

9.2.54.1 Ongoing Evaluation and Management of Chronic Pain and Chronic Pain Management (CPM)

Pain Management as part of Implantable infusion pumps (IIPs) services (procedure codes G3002 and G3003) is a benefit of Texas Medicaid.

Acute pain is defined as pain caused by occurrences such as trauma, a surgical procedure, or a medical disorder manifested by increased heart rate, increased blood pressure, increased respiratory rate, shallow respirations, agitation or restlessness, facial grimace, or splinting.

Chronic pain is defined as persistent or recurrent pain, lasting more than three months; symptoms are manifested similarly to that of acute pain.

Postoperative refers to the time frame immediately following a surgical procedure in which a catheter is maintained in the epidural or subarachnoid space for the duration of the infusion of pain medication.

The first time that procedure code G3002 is billed, the physician or qualified health practitioner must see the client in person. After the initial visit, any of the CPM in-person components included in procedure codes G3002 and G3003 may be provided through telehealth, as clinically appropriate, to increase access to care for Medicaid clients.

When using procedure code G3002, 30 minutes must be met or exceeded. List procedure code G3003 separately in addition to procedure code G3002. When using procedure code G3003, 15 minutes must be met or exceeded.

Additionally, both evaluation and management services and CPM may be billed on the same day if all requirements to report each service are met, and the time spent providing CPM services does not represent time spent for providing any other reported service.

9.2.54.2 Epidural and Subarachnoid Infusion

Epidural and subarachnoid infusion for pain management is payable for acute, chronic, and postoperative pain management.

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Procedure code 01996 is limited to once per day and is denied when billed on the same day as a surgical/anesthesia procedure. Procedure code 01996 billed longer than 30 days requires medical necessity documentation. Cancer diagnoses are excluded from the 30-day limitation.

Procedure code 01996 is payable to CRNAs and physicians.

9.2.55 Palivizumab Injections

RSV immune globulin, intramuscular palivizumab (*Synagis*) must be obtained through the Texas VDP. Providers must obtain prior authorization through the VDP.

Providers may not bill Texas Medicaid for RSV prophylaxis that was obtained through VDP; however providers may be reimbursed for administering the drug. Providers may refer to the HHSC Texas Medicaid/CHIP Vendor Drug Program website at www.txvendordrug.com/formulary/respiratory-syncytial-virus-treatment for more information about obtaining palivizumab for Texas Medicaid clients.

9.2.56 Panniculectomy and Abdominoplasty

Procedure codes 15830 and 15847 are benefits of Texas Medicaid when prior authorized.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation establishing medical necessity of the service requested. This documentation must remain in the client's medical record and is subject to retrospective review.

9.2.56.1 Panniculectomy

A panniculectomy (procedure code 15830) may be reimbursed with prior authorization for one of the following conditions when the panniculus hangs to or below the level of the pubis:

- A panniculus has recurrent non-healing ulcers.
- Client is insulin dependent with recurring infection and causing the prolapse of a ventral hernia.
- Panniculus directly causes significant clinical functional impairment.

Panniculectomy is not a benefit when one of following is the primary purpose:

- To remove excess skin and fat from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To minimize the risk of ventral hernia formation of recurrence.
- For the sole purpose of treating neck or back pain.

Panniculectomy may be prior authorized when the client meets one of the following:

- Panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery.
- Panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis.
- Panniculectomy is planned with history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery.

If a panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery, or a panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis, one of the following must be met:

- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription.

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- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

If a panniculectomy is planned with a history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery, the following must be met:

- Documentation that the panniculus hangs to or below the level of the pubis and the client has maintained a significant (100 pounds or more), stable weight loss for at least six months. Documentation must include the weight loss history, prior and current height, prior and current weight, and the history and physical including all previous surgeries.
- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription. The 12-month post-gastric bypass requirement may be waived.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia. The 12-month post-gastric bypass requirement may be waived.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. The 12-month post-gastric bypass requirement may be waived. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

All medical record documentation pertinent to the client's evaluation and treatment must support medical necessity of the panniculectomy. Documentation may include the following:

- Office records
- Consultation reports
- Operative reports
- Other hospital records (examples: pathology report, history and physical)

Documentation to support the panniculectomy must be submitted with the request for prior authorization. In addition to medical record documentation, the provider may also submit a letter of support or an explanation to substantiate medical necessity.

This service is typically expected to be limited to once per lifetime, by the same provider. Repeat panniculectomies may be considered for prior authorization upon submission of supporting documentation as outlined above.

A panniculectomy provided as a secondary surgery may be considered for prior authorization when the panniculus interferes with a medically necessary intra-abdominal surgery (e.g., abdominal hernia repair or hysterectomy) or to facilitate an improved anatomical field in order to provide radiation treatment to the abdomen. Documentation of medical necessity must include:

- The comorbidity for the diagnosis of the primary surgery or for the nature of the condition undergoing radiation treatment.
- Documentation supporting the need for the panniculectomy as the panniculus hangs below the level of the pubis and will significantly interfere with a planned surgical procedure, or the abdominal structures identified as requiring radiation therapy will not be adequately treated due to the size of the panniculus.

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A panniculectomy provided as a secondary surgery may be considered when the primary surgery was performed for an urgent condition defined as a symptom or condition that is not an emergency, but requires further diagnostic workup or treatment within 24 hours to avoid a subsequent emergent situation.

The need for the panniculectomy as a secondary surgery in conjunction with a primary urgent surgery must be supported by retrospective review of submission of all of the following documentation:

- History and physical and the operative report.
- The panniculus hangs below the level of the pubis and would have significantly interfered with the urgent primary surgical procedure.

9.2.56.2 Abdominoplasty

An abdominoplasty (procedure code 15847) is a benefit for clients who are birth through 20 years of age and may be reimbursed with prior authorization for one of the following conditions:

- Prune belly
- Diastasis recti in the presence of a true midline hernia (ventral or umbilical)

Abdominoplasty is not a benefit when one of the following is the primary purpose:

- To remove excess skin and fat and tighten abdominal wall from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To repair diastases recti (unless prior authorization criteria has been met).

Abdominoplasty may be prior authorized when the client meets all of the following criteria:

- Documented diagnosis of prune belly (i.e., Eagle Barret syndrome) or repair of diastasis recti in the presence of a true midline hernia (ventral or umbilical).
- Documentation for reconstructive surgery that must include appropriate historical medical record documentation and may include any of the following:
  - Consultation reports
  - Operative reports or other applicable hospital records (examples: pathology report, history and physical)
  - Office records
  - Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)
- For repair of diastasis recti with a true midline hernia, documentation must also include all of the following:
  - The size of the hernia
  - Whether it is reducible, painful, or other symptoms
  - Whether there is a defect rather than just thinning of the abdominal fascia

This service is typically expected to be limited to once per lifetime, by the same provider. Consideration of other abdominal diagnoses may be considered for prior authorization with the submission of additional supporting documentation that may include the following:

- Consultation reports

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- Operative reports or other applicable hospital records (examples: pathology report, history and physical)
- Office records
- Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)

9.2.57 Penile and Testicular Prostheses

The following services are a benefit of Texas Medicaid for male clients:

- Removal of a penile prosthesis without replacement (procedure codes 54406 and 54415).
- Insertion of testicular prosthesis for the replacement of congenitally absent testes or testes lost due to disease, injury, or surgery (procedure code 54660)—prior authorization is required.

Procedure code 54660 is a benefit for clients who are birth through 20 years of age. Insertion of a testicular prosthesis may be prior authorized with the following criteria:

- The client has lost a testicle as a result of cancer or trauma or has congenital absence of a testicle.
- The loss of the testicle has resulted in detrimental psycho-social sequelae, as evidenced by a psychiatric evaluation.

Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form. The request must be submitted with documentation that supports medical necessity.

9.2.58 Percutaneous Transluminal Coronary Interventions

Percutaneous transluminal coronary interventions are a therapeutic option for clients who have arteriosclerotic heart disease.

When any of the following procedure codes are performed on the same date of service and on the same vessel as intracoronary vessel stenting, any provider, only the stenting procedure code will be considered for reimbursement: 92973, 92982, 92984, 92995, and 92996.

Angioplasty, atherectomy, or thrombectomy performed on different coronary vessels may be reimbursed separately. When different coronary vessels are not indicated, only the stenting procedure will be paid.

9.2.59 Physical Therapy (PT) Services

Physical therapy (PT) is a payable benefit to physicians.

Refer to: Section 4, "Therapy Services Overview" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about physical therapy services provided by a physician.

9.2.60 Physician Evaluation and Management (E/M) Services

E/M is a benefit of Texas Medicaid. Providers must follow guidelines established in the Current Procedural Terminology (CPT) Manual for Evaluation and Management Services when selecting the level of service provided.

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

- Domiciliary, rest home, or custodial care services
- Emergency department services
- Group clinical visits

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- Home services
- Hospital services including inpatient, observation, critical care, discharge, and concurrent care services (includes consultation and prolonged services)
- Nursing facility services
- Office or other outpatient services for new and established patients (includes consultation and prolonged services)
- Preventive care visits
- Services outside of business hours
- Tobacco use cessation

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

Inpatient claims must indicate the facility's NPI in Block 32 or in the appropriate field of electronic software.

9.2.60.1 Office or Other Outpatient Hospital Services

9.2.60.1.1 New and Established Patient Services

A new patient is one who has not received any professional services from a physician or from another physician of the same specialty who belongs to the same group practice, within the past three years. Providers must use procedure codes 99202, 99203, 99204, and 99205 when billing for new patient services provided in the office or an outpatient or other ambulatory facility. New patient visits are limited to one every three years, per client, per provider.

An established patient is one who has received professional services from a physician or from another physician of the same specialty within the same group practice, within the last three years. Providers must use procedure codes 99211, 99212, 99213, 99214, and 99215 when billing for established patient services provided in the office or an outpatient or other ambulatory facility.

Established E/M services are limited to one per day, same provider. When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.

Modifier 25 must be submitted when the services rendered are performed for a significant separately identifiable service by the same physician or physician group on the same date of service. Modifier 25 is required when the provider submits a claim with the following:

- A second office or outpatient visit on the same day as another office or outpatient visit
- An office or outpatient visit beyond the usual preoperative care associated with the procedure that was performed

Note: *Office or outpatient visits provided on the same date of service as a planned procedure (minor or extensive) are included in the cost of the procedure and are not separately reimbursed.*

Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request. The documentation must clearly indicate what the significant problem/abnormality was, including the important, distinct correlation with signs and symptoms to demonstrate a distinctly different problem that required additional work and must support that the requirements for the level of service billed were met or exceeded.

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The date and time of both services performed must be outlined in the medical record and the time of the second service must be different than the time of the first service, although a different diagnosis is not required.

Examples of additional visits to which Modifier 25 must be appended include, but are not limited to:

- A second E/M service for the same date of service as a group visit with the required E/M visit.
- An established patient E/M service for the same date of service as a THSteps medical checkup.
- An E/M service for the same date of service as a scheduled procedure.

Office visits (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) provided on the same date of service as a planned procedure (minor or extensive) are included in the cost of the procedure and are not separately reimbursed.

Office visit procedure code 99211, 99212, 99213, 99214, or 99215 must be billed by the same provider with the same date of service as a group clinical visit.

9.2.60.2 Office or Other Outpatient Services by Telemedicine

Providers must defer to the needs of the client receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the client's choice and not provider convenience.

Providers must provide the services to Medicaid eligible clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Synchronous Audiovisual Technology

The following office and other outpatient services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the client receiving services. New and established patient services provided by synchronous audiovisual technology must be billed with modifier 95.

The following procedure codes may be reimbursed for telemedicine (physician-delivered) evaluation and management to new and established clients:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

Synchronous Telephone (Audio-Only) Technology

For the diagnosis, evaluation and treatment of a mental health or substance use condition, as well as non-behavioral health conditions, the following office and other outpatient services may be provided by synchronous telephone (audio-only) technology if clinically appropriate and safe, as determined by the provider, and agreed to by the client receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology for telemedicine and telehealth services. Therefore, providers must document in the client's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. Established patient services for mental health or

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substance use conditions provided by synchronous telephone (audio-only) technology must be billed using modifier FQ. Established patient services for non-behavioral health conditions provided by synchronous telephone (audio-only) technology must be billed using modifier 93.

Procedure codes 99212, 99213, 99214, and 99215 may be billed for established patient services.

Procedure code 99211 may be delivered by synchronous telephone (audio-only) technology during certain public health emergencies only.

Modifiers - Office and Other Outpatient Services - Psychiatric Care Only	Description
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
FQ	The service was furnished using audio-only communication technology

Modifiers – Office and Other Outpatient Services Non–Psychiatric Care	Description
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. The documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth requirements to include documentation, informed consent, privacy, and security requirements.

9.2.60.3 Group Clinical Visits

Texas Medicaid may reimburse physicians for group clinical visits (procedure code 99078) providing clinical services and educational counseling to a group of clients with the same condition.

To be considered for reimbursement, procedure code 99078 must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215.

Group clinical visits may be reimbursed for established patients only. The client's plan of care must be determined and documented in the medical record by the physician before attending group clinical visits.

Participation of established patients in a group clinical visit is optional. Informed consent must be obtained from the client and maintained in the medical record before rendering group clinical visit services.

The physician leading the group clinical visit is responsible for the effectiveness and content of the information provided during the group clinical visit.

Nationally approved curriculum on asthma and diabetes, such as that available through the American Association of Diabetic Educators and Asthma Education and Prevention Programs consistent with the National Asthma Management Guidelines and must be incorporated into the educational portion of group clinical visits.

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Group clinical visits must last at least 1 hour, but no longer than 2 hours, with a minimum of 2 clients and a maximum of 20.

To promote self-management of the chronic disease, the group visit must include a presentation that instructs and informs the client about clinical issues, including how to prevent disease exacerbation or complications, properly use medications and other therapeutic techniques, or live with chronic illness topics. Group visit presentations must include:

- Diabetic education consisting of the following:
  - What diabetes is
  - Nutrition
  - Exercise and physical activity
  - Prevention of acute complications
  - Prevention of chronic complications
  - Monitoring
  - Medication
- Asthma education consisting of the following:
  - What is asthma?
  - What are symptoms of asthma?
  - What happens during an episode of asthma?
  - What exacerbates asthma?
  - How is asthma controlled?
  - What physical activities can people with asthma do?
  - A question and answer period
  - A short (approximately 5 to 15 minutes per client) one-on-one private direct (face-to-face) encounter with the physician consisting of:
    - A physical exam
    - The gathering, monitoring, and reviewing of laboratory and diagnostic tests
    - Medical decision making that includes an individual treatment plan

Documentation in the client's medical record must support level of E/M service as per the CMS and CPT manual approved guidelines.

The documentation of the individual treatment plan retained in the client's medical record must include data collected (physical exam and lab findings), educational services provided, patient participation, and the beginning and ending time of the visit.

Group visits for conditions of diabetes or asthma are limited to a maximum of four per year for any provider.

9.2.60.3.1 Group Clinical Visits for Diabetes

Group clinical visits are benefits of Texas Medicaid for the management of the condition of diabetes when submitted with one of the following diagnosis codes:

Diagnosis Codes							
E0800	E0801	E0810	E0811	E0821	E0822	E0829	E08311

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Diagnosis Codes							
E08319	E083211	E083212	E083213	E083219	E083291	E083292	E083293
E083299	E083311	E083312	E083313	E083319	E083391	E083392	E083393
E083399	E083411	E083412	E083413	E083419	E083491	E083492	E083493
E083499	E083511	E083512	E083513	E083519	E083521	E083522	E083523
E083529	E083531	E083532	E083533	E083539	E083541	E083542	E083543
E083549	E083551	E083552	E083553	E083559	E083591	E083592	E083593
E083599	E0836	E0837X1	E0837X2	E0837X3	E0837X9	E0839	E0840
E0841	E0842	E0843	E0844	E0849	E0851	E0852	E0859
E08610	E08618	E08620	E08621	E08622	E08628	E08630	E08638
E08641	E08649	E0865	E0869	E088	E089	E0900	E0901
E0910	E0911	E0921	E0922	E0929	E09311	E09319	E093211
E093212	E093213	E093219	E093291	E093292	E093293	E093299	E093311
E093312	E093313	E093319	E093391	E093392	E093393	E093399	E093411
E093412	E093413	E093419	E093491	E093492	E093493	E093499	E093511
E093512	E093513	E093519	E093521	E093522	E093523	E093529	E093531
E093532	E093533	E093539	E093541	E093542	E093543	E093549	E093551
E093552	E093553	E093559	E0936	E093591	E093592	E093593	E093599
E0937X1	E0937X2	E0937X3	E0937X9	E0939	E0940	E0941	E0942
E0943	E0944	E0949	E0951	E0952	E0959	E09610	E09618
E09620	E09621	E09622	E09628	E09630	E09638	E09641	E09649
E0965	E0969	E098	E099	E1010	E1011	E1021	E1022
E1029	E10311	E10319	E103211	E103212	E103213	E103219	E103291
E103292	E103293	E103299	E103311	E103312	E103313	E103319	E103391
E103392	E103393	E103399	E103411	E103412	E103413	E103419	E103491
E103492	E103493	E103499	E103511	E103512	E103513	E103519	E103521
E103522	E103523	E103529	E103531	E103532	E103533	E103539	E103541
E103542	E103543	E103549	E103551	E103552	E103553	E103559	E103591
E103592	E103593	E103599	E1036	E1037X1	E1037X2	E1037X3	E1037X9
E1039	E1040	E1041	E1042	E1043	E1044	E1049	E1051
E1052	E1059	E10610	E10618	E10620	E10621	E10622	E10628
E10630	E10638	E10641	E10649	E1065	E1069	E108	E109
E10A0	E10A1	E10A2	E1100	E1101	E1110	E1111	E1121
E1122	E1129	E11311	E11319	E113211	E113212	E113213	E113219
E113291	E113292	E113293	E113299	E113311	E113312	E113313	E113319
E113391	E113392	E113393	E113399	E113411	E113412	E113413	E113419
E113491	E113492	E113493	E113499	E113511	E113512	E113513	E113519
E113521	E113522	E113523	E113529	E113531	E113532	E113533	E113539
E113541	E113542	E113543	E113549	E113551	E113552	E113553	E113559
E113591	E113592	E113593	E113599	E1136	E1137X1	E1137X2	E1137X3
E1137X9	E1139	E1140	E1141	E1142	E1143	E1144	E1149

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Diagnosis Codes							
E1151	E1152	E1159	E11610	E11618	E11620	E11621	E11622
E11628	E11630	E11638	E11641	E11649	E1165	E1169	E118
E119	E11A	E1300	E1301	E1310	E1311	E1321	E1322
E1329	E13311	E13319	E133211	E133212	E133213	E133219	E133291
E133292	E133293	E133299	E133311	E133312	E133313	E133319	E133391
E133392	E133393	E133399	E133411	E133412	E133413	E133419	E133491
E133492	E133493	E133499	E133511	E133512	E133513	E133519	E133521
E133522	E133523	E133529	E133531	E133532	E133533	E133539	E133541
E133542	E133543	E133549	E133551	E133552	E133553	E133559	E133591
E133592	E133593	E133599	E1336	E1337X1	E1337X2	E1337X3	E1337X9
E1339	E1340	E1341	E1342	E1343	E1344	E1349	E1351
E1352	E1359	E13610	E13618	E13620	E13621	E13622	E13628
E13630	E13638	E13641	E13649	E1365	E1369	E138	E139

9.2.60.4 Group Clinical Visits for Asthma

Group clinical visits are benefits of Texas Medicaid for the management of the condition of asthma when submitted with one of the following diagnosis codes:

Diagnosis Codes							
J440	J441	J4489	J449	J4520	J4521	J4522	J4530
J4531	J4532	J4540	J4541	J4542	J4550	J4551	J4552
J45901	J45902	J45909	J45990	J45991	J45998		

9.2.60.4.1 Group Clinical Visits for Pregnancy

Group clinical visits are benefits of Texas Medicaid for the management of the condition of pregnancy when submitted with procedure code 99078 and modifier TH, along with one of the following diagnosis codes:

Diagnosis Codes							
O0900	O0901	O0902	O0903	O0910	O0911	O0912	O0913
O09211	O09212	O09213	O09219	O09291	O09292	O09293	O09299
O0930	O0931	O0932	O0933	O0940	O0941	O0942	O0943
O09511	O09512	O09513	O09519	O09521	O09522	O09523	O09529
O09611	O09612	O09613	O09619	O09621	O09622	O09623	O09629
O0970	O0971	O0972	O0973	O09811	O09812	O09813	O09819
O09821	O09822	O09823	O09829	O09891	O09892	O09893	O09899
O0990	O0991	O0992	O0993	O09A0	O09A1	O09A2	O09A3
Z331	Z3400	Z3401	Z3402	Z3403	Z3480	Z3481	Z3482
Z3483	Z3490	Z3491	Z3492	Z3493			

Providers are encouraged to provide a comprehensive curriculum or use materials from the Centering Pregnancy Program that will be incorporated into the educational portion of the group clinical visit.

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Comprehensive curriculums will allow clinical issues to be identified to promote a healthy pregnancy. The education material may include screenings and preparations, health maintenance, counseling, and birth plans:

- Screenings and preparations may consist of the following:
  - Expected course of the pregnancy
  - Anticipated outline of the scheduled visits
  - Signs and symptoms, which should be reported to the physician as soon as possible
  - Laboratory services
  - Appropriate use of medications
  - Proper weight monitoring
  - Immunizations (e.g., hepatitis, varicella, or RhoGAM)
  - Complications of pregnancy that may occur (e.g., preeclampsia, diabetes, or edema)
- Health maintenance may consist of the following:
  - Hygiene (e.g., hot tubs or baths)
  - Sexual activity
  - Exercise
  - Nutrition and dietary needs
- Counseling may consist of the following:
  - Use of seat belts
  - Job activity
  - Air travel
  - Dental care appointments
  - Domestic abuse or violence
  - Tobacco or drug use
- Birth planning may consist of the following:
  - What to expect during labor and delivery
  - Pain control during labor
  - Complications during delivery that may occur (e.g., Caesarean section or episiotomy)
  - Breast feeding
  - Newborn care
  - Postpartum adjustments

Group clinical visits for the management of pregnancy are restricted to female clients who are 10 through 55 years of age and are limited to a maximum of 10 visits per 270 days for any provider.

To be considered for reimbursement, procedure code 99078 with modifier TH must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215 with modifier TH.

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9.2.60.4.2 Preventive Care Visits

Adult preventive services must be provided in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations with grades A or B. USPSTF recommendations, with specific age and frequency guidelines, are listed on the USPSTF website. The following are recommended screens in addition to USPSTF and are covered separately:

- Tuberculosis screening
- Prostate cancer screening; prostate specific antigen (PSA) for men who are 50 through 64 years of age

Preventive care services are comprehensive visits that may include counseling, anticipatory guidance, and risk-factor-reduction interventions. Documentation must indicate the anticipatory guidance rendered.

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

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.3.12.2.3, "Hearing Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about hearing screenings.

Adult preventive services (procedure codes 99385, 99386, 99387, 99395, 99396, and 99397) are a benefit of Texas Medicaid for clients who are 21 years of age and older. Adult preventive services are limited to one service per rolling year, any provider, and must be billed with diagnosis code Z0000, Z0001, Z01411, or Z01419.

The following USPSTF recommendations are not reimbursed separately but must be provided, when applicable, as part of the routine preventive exam:

- Counseling to prevent tobacco use and tobacco-caused disease
- Behavioral counseling in primary care to promote a healthy diet
- Behavioral interventions to promote breast feeding
- Screening for obesity in adults (with intensive counseling and interventions)
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse
- Screening for depression

The USPSTF recommendation of chemoprevention of breast cancer is not a benefit of Texas Medicaid.

Laboratory, immunization, and diagnostic procedures recommended by USPSTF are covered benefits and may be billed separately, as clinically indicated, using the most appropriate diagnosis code that represents the client's condition. Diagnosis code Z0000 or Z0001 may each be used once per rolling year for each screen if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.

Services that exceed USPSTF recommendations are not considered part of a screening and require medical documentation to justify medical necessity of the services performed.

For clients who are 21 years of age and older, breast exams and Pap smears are available through programs related to women's health, including Texas Medicaid family planning services and the Healthy Texas Women (HTW) program.

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Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 2, "Healthy Texas Women (HTW) Program Overview" in the *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*).

9.2.60.4.3 Smoking and Tobacco Use Cessation Counseling

Smoking and tobacco use cessation counseling is a benefit for male and female clients who are 10 years of age and older and must be submitted with procedure codes 99406 and 99407. Smoking and tobacco use cessation counseling services delivered in a group setting will be limited to a maximum of 8 participants per group and must be submitted with modifier HQ.

Modifier	Description
HQ	Group Counseling

Procedure codes 99406 and 99407 may be reimbursed when submitted with the following diagnosis codes:

Diagnosis Codes							
F17200	F17201	F17203	F17208	F17209	F17210	F17211	F17213
F17218	F17219	F17220	F17221	F17223	F17228	F17229	F17290
F17291	F17293	F17298	F17299				

Procedure codes 99406 and 99407 may be billed in any combination by the same or a different provider, whether individual or group counseling, and are limited to eight services per rolling year.

Additional services require documentation of medical necessity to exceed the established limit.

Procedure codes 99406 and 99407 are limited to once per day, same or different procedure code, any provider.

Refer to: Subsection 4.1.16, "Smoking and Tobacco Use Cessation Counseling" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information related to the smoking and tobacco use cessation counseling and additional covered diagnoses related to pregnancy.

9.2.60.4.4 Office and Outpatient Consultation Services

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

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

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

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

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

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

Providers must use procedure code 99242, 99243, 99244, or 99245 when billing new or established patient consultations in the office, or in an outpatient or other ambulatory facility.

Office or outpatient consultations are limited to one consultation every six months by the same provider for the same diagnosis. Subsequent office or outpatient consultation visits during this six-month period will be denied.

9.2.60.4.5 Physician Services Provided in the Emergency Department

Providers must use procedure codes 99281, 99282, 99283, 99284, and 99285 when billing emergency department services. If an emergency department visit is billed by the same provider with the same date of service as an office visit, outpatient consultation, inpatient consultation, or subsequent nursing facility service, the emergency department visit may be reimbursed and the other services will be denied.

If an emergency department visit is billed by the same provider with the same date of service as an initial nursing facility service, the initial nursing facility service may be reimbursed and the emergency department visit will be denied.

Multiple emergency department visits provided by the same provider for the same client on the same day must have the times for each visit documented on the claim form. Also, more than one visit billed with the same date of service can be indicated by adding the appropriate modifier to the claim form. Medical documentation is required to support this service.

Reimbursement for physicians in the emergency department is based on Section 104 of TEFRA. TEFRA requires that Medicaid limit reimbursement for nonemergent and nonurgent physicians' services furnished in hospital outpatient settings that also are ordinarily furnished in physician offices. The emergency department procedure code that is submitted on the claim is used to determine the appropriate reimbursement for these services. The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered by the physician in the hospital's emergency department. The reimbursement for each service is determined by multiplying the base allowable fee by 60 percent.

Refer to: Section 4, "Outpatient Hospital (Medical and Surgical Acute Care Outpatient Facility)" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for information on emergency department services by facilities (room and ancillary).

Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information.

9.2.60.4.6 After-Hours Services

Texas Medicaid limits reimbursement for after-hours charges to office-based providers rendering services after routine office hours.

An office-based provider must bill an after-hours charge in addition to a visit charge for providing services after routine office hours. This after-hours charge must be billed when a provider judges it medically necessary to provide after-hours care for a patient with an emergent condition. A provider's routine office hours are the hours posted at the physician's office as the usual office hours. Medicaid reimburses office-based physicians an inconvenience or after-hours charge when any of the following situations exist:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician's routine office hours.

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- The physician is interrupted from routine office hours to attend to another client's emergency outside of the office.

Charges for inconvenience or after-hours services by emergency department-based physicians or emergency department-based groups are not allowed.

After-hours procedure codes are limited to one per day, same provider.

Providers must use procedure codes 99050, 99056, or 99060 to report after-hours services.

9.2.60.5 Other Inpatient and Outpatient Hospital Services

A hospital care visit submitted by the same provider for the same client within three days of a new patient office, home, nursing facility, or skilled nursing facility (SNF) visit, for the same or for a similar diagnosis must be submitted as a subsequent care visit.

Refer to: Subsection 9.2.74.6, "Global Fees" in this handbook for more information about global services.

9.2.60.6 Prolonged Physician Services

Prolonged services (procedure code 99417 or 99418) involve face-to-face patient contact and may be utilized in the office, outpatient hospital, or inpatient hospital settings. The face-to-face patient contact must exceed the time threshold of the following E/M procedure codes submitted for the date of service and be beyond the usual service.

Procedure Codes									
99202	99203	99204	99205	99211	99212	99213	99214	99215	99221
99222	99223	99231	99232	99233	99242	99243	99244	99245	99252
99253	99254	99255	99341	99342	99344	99345	99347	99348	99349
99350									

Prolonged services that are less than 30 minutes in duration cannot be reported separately.

Procedure code 99417 should only be used when an office or other outpatient services, office consultation, or other outpatient evaluation and management service has been selected using time alone as the basis, and the time required to report the highest level (procedure code 99205, 99215, 99245, 99345, or 99350) service has been exceeded by 15 minutes.

Procedure code 99418 is only used when an inpatient or observation evaluation and management service has been selected using time alone as the basis, and only after the time required to report the highest level service (procedure code 99223, 99233, 99236, 99255, 99306, or 99310) has been exceeded by 15 minutes.

Procedure code 99417 and 99418 are limited to 4 units (1 hour) per day and should not be used to report an additional time increment of less than 15 minutes.

Prolonged services in the inpatient setting involving face-to-face client contact that is beyond the usual service may be reimbursed when provided on the same day as an initial hospital visit (procedure codes 99221, 99222, 99223, 99252, 99253, 99254, and 99255) or a subsequent hospital visit (99231, 99232, 99233).

Prolonged physician services are denied when billed with critical care or emergency room visits billed with the same date of service, same provider.

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Prolonged physician services without a face-to-face contact (procedure codes 99358 and 99359) are not a benefit of Texas Medicaid.

Note: *For non-face-to-face prolonged physician services, and for use of the unlisted evaluation and management procedure code for clients who are birth through 20 years of age, refer to subsection 2.6.1.1.5, "Non-Face-to-Face Prolonged Services" in the Children's Services Handbook (Vol. 2, Provider Handbooks).*

Refer to: Subsection 4.2.2, "Psychotherapy Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about prolonged psychotherapy services.

Physician standby services are not a benefit of Texas Medicaid.

9.2.60.6.1 Inpatient or Observation Services

Inpatient hospital visits must be submitted using procedure codes 99221, 99222, 99223, 99231, 99232, and 99233.

If a subsequent hospital visit (procedure code 99231, 99232, or 99233) following admission is billed by the same provider with the same date of service as any of the following emergency department visits, office visits, or outpatient consultations, the subsequent hospital visit may be reimbursed and the other visits will be denied:

Procedure Code									
99281	99282	99283	99284	99285	99202	99203	99204	99205	99211
99212	99213	99214	99215	99242	99243	99244	99245		

Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period for the same diagnosis. Additional initial hospital visits with the same diagnosis within a 30-day period will be denied.

A subsequent hospital visit (procedure code 99231, 99232, or 99233) will be denied when billed on the same day to the same provider as critical care services (procedure codes 99291 and 99292).

E/M services provided in a hospital setting following a major procedure and provided by the same provider or in direct follow-up for postsurgical care are included in the surgeon's global surgical fee and are denied as included in another procedure.

Refer to: Subsection 9.2.47, "Newborn Services" in this handbook for information about newborn services.

Hospital observation is for professional services for a period of more than 6 hours but fewer than 24 hours regardless of the hour of the initial contact, even if the client remains under physician care past midnight.

If dialysis treatment and physician observation visits are billed on the same day by the same provider, and same specialty other than an internist or nephrologist, the dialysis treatment will be paid and the physician observation visit will be denied.

9.2.60.6.2 Concurrent Care

Concurrent care exists when services are provided to a patient by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances require the skills of different specialties to successfully manage the patient in accordance with accepted standards of good medical practice. Concurrent care may be reimbursed to providers of different specialties when the services are for unrelated diagnoses involving different organ systems.

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Concurrent care will be denied when billed for providers of the same specialty for the same or related diagnoses. Denied concurrent care may be appealed when accompanied by documentation of medical necessity.

Each appeal submitted for concurrent care must contain the following information:

- Documentation of the medical necessity for the physician's services (care and treatment)
- Diagnosis and indication of the severity of the client's condition (acute or critical)
- Role of the physician in the care of the client, including the name of the admitting physician
- Specialty and subspecialty of each physician and any limitations of practice

Claims appealed without clear documentation of medical necessity as described above will be denied.

Important: *If the attending physician requests only a consultation, the request must be clearly stated in the orders.*

All concurrent care is subject to retrospective review. Documentation of medical necessity for concurrent care must be retained by the physician as required by federal law and must include, but is not limited to, documentation of:

- The orders for concurrent care or valid reasons for the request by the attending physician.
- The name of the requesting physician by the physician rendering concurrent care.

9.2.60.6.3 Consultations

Consultations provided to hospital inpatients, observation patients, residents of nursing facilities, or patients in a partial hospital setting must be billed using procedure codes 99252, 99253, 99254, and 99255.

One initial inpatient or observation consultation (procedure code 99252, 99253, 99254, or 99255) is allowed for each hospitalization within a 30-day period for the same diagnosis. Subsequent consultations billed as initial consultations during this time period will be denied.

Refer to: Subsection 9.2.60.4.4, "Office and Outpatient Consultation Services" in this handbook for additional criteria information.

9.2.60.6.4 Critical Care

Critical care includes the care of critically ill clients that require the constant attention of the physician. The physician must either be at bedside or immediately available to the client. The physician's full attention must be devoted to the client so that the physician cannot render E/M to any other client during the same period of time. Critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, neonatal intensive care unit, or the emergency department care facility. The following procedure codes are used to bill critical care services:

Procedure Code	Limitations
99291	A per day charge for the first 30 to 74 minutes of critical care (time spent by the physician does not have to be continuous on that day).
99292	A per day charge for each additional 30 minutes beyond the first 74 minutes of critical care for up to 6 units or 3 hours per day.*
99471	A per day charge for initial inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.
99472	A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.
*** If the number of units is not stated on the claim, a quantity of one is allowed.**	

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Procedure Code	Limitations
99475	A per day charge for initial inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.
99476	A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.
*** If the number of units is not stated on the claim, a quantity of one is allowed.**	

Services for a client who is not critically ill and unstable but who was treated in a critical care unit must be reported using subsequent hospital visit codes or hospital consultation codes.

If the same provider who performed a major surgery must also perform critical care on the same day for the same client, the provider must bill the critical care with documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure.

Critical care (procedure codes 99291, 99292, 99471, 99472, 99475, and 99476) may be reimbursed only to the provider rendering the critical care service at the time of crisis. Critical care involves high-complexity decision-making to access, manipulate, and support vital system functions. While providers from various specialties may be consulted to render an opinion and assist in the management of a particular portion of the care, only the provider managing the care of the critically ill patient during a life threatening crisis may bill the critical care procedure codes.

Critical care procedure codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous.

Actual time spent with the individual client must be recorded in the client's record and reflect the time billed on the claim. The time that can be reported as critical care is the time spent engaged in work directly related to the individual client's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.

Time spent under the following circumstances may not be reported as critical care:

- Activities that occur outside of the unit or off the floor
- Activities that do not directly contribute to the treatment of the client
- While performing separately reportable procedures or services

Critical care of less than 30 minutes total duration per day must be reported with the appropriate E/M procedure code.

If critical care that meets the initial 30-minute time requirement is provided to the same client by different physicians, the initial provider's claim may be reimbursed. The second provider's claim will be denied but may be appealed. The time spent by each physician cannot overlap; two physicians cannot bill critical care for care delivered at the same time. Supporting medical record documentation that includes the time in which the critical care was rendered must be provided by the second physician. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill patient during the life threatening crisis.

If the provider's time exceeds the 74-minute threshold for procedure code 99291, procedure code 99292 may be billed for each additional 30 minutes. Procedure code 99292 must be billed by the same performing provider or by a member of the same performing provider's group practice and is limited to 6 units per day for any provider.

Inpatient critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care procedure codes 99471 and 99472. The pediatric critical care procedure codes are reported as long as the infant or young child qualifies for critical care services during the hospital stay through 24 months of age.

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Pediatric critical care (procedure codes 99471, 99472, 99475, and 99476) is a per-day charge. Only one physician can bill pediatric critical care per day. If an inpatient or outpatient E/M service is billed by the same provider with the same date of service as pediatric critical care, the E/M service is denied.

Critical care provided to a neonatal, pediatric, or adult client in an outpatient setting (e.g., emergency room), which does not result in admission must be billed using procedure codes 99291 and 99292. Critical care provided to a neonatal or pediatric client in both the outpatient and inpatient settings on the same day must be billed using the appropriate neonatal or pediatric critical care procedure code.

If critical care (procedure code 99291 or 99292) is provided to a patient at a distinctly separate time from another outpatient E/M service by the same provider, both services may be reimbursed with supporting medical record documentation.

Claims may be subject to retrospective review to ensure documentation supports the medical necessity of the service when billing the claim.

Critical care procedure codes 99291 and 99292 will be denied when submitted with the same date of service by the same provider as neonatal intensive care procedure code 99468, 99469, 99478, 99479, or 99480.

9.2.60.6.5 Hospital Inpatient or Observation Discharge

Hospital inpatient or observation discharge must be submitted using procedure code 99238 or 99239.

Hospital inpatient or observation discharge management billed by the same provider with the same date of service as the admission will be denied.

Discharge management billed by the same provider with the same date of service as an emergency room visit will be considered for reimbursement and the emergency visit will be denied.

Subsequent hospital inpatient or observation visits billed by the same provider with the same date of service as discharge management will be denied.

9.2.60.6.6 Nursing Facility Services

Providers must use the following procedure codes when billing initial nursing facility assessments, subsequent nursing facility care, and annual nursing facility assessments in a nursing facility:

Procedure Codes									
99304*	99305*	99306*	99307	99308	99309	99310	99315	99316	

Initial nursing facility assessments (marked with an asterisk in the table above) include all services related to an admission to the nursing facility.

Comprehensive initial nursing facility assessments performed by the same provider for the same diagnosis are limited to one every six months. The second initial nursing facility assessment within the six-month period will be denied.

Prolonged services in the nursing facility involving direct (face-to-face) patient contact that is beyond the usual service may be reimbursed on the same day as a nursing facility visit (procedure code 99304, 99305, 99306, 99307, 99308, 99309, or 99310).

All E/M services, regardless of setting, are considered part of the initial nursing facility care when performed by the same provider on the same day as the admission.

Subsequent nursing facility care E/M procedure codes 99307, 99308, 99309, and 99310 are limited to one per day regardless of diagnosis.

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9.2.60.6.7 Observation

When a patient is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This is an acceptable billing practice under Texas Medicaid when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement.

9.2.60.7 Home or Residence Services

Home or residence services are provided in a private residence, temporary lodging, or short-term accommodation (e.g, hotel, campground, hostel, or cruise ship), assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility. New patient visits are limited to once every three years. Providers may use procedure codes 99341, 99342, 99344, and 99345 when billing for new patient services provided in the home/residence setting.

Providers must use procedure codes 99347, 99348, 99349, and 99350 when billing established patient services provided in the home setting.

A subsequent home or residence visit (procedure codes 99347, 99348, 99349, and 99350) billed with the same date of service as a new patient home or residence visit (procedure codes 99344 and 99345) by the same provider will be denied as part of another procedure, regardless of the diagnosis.

Established E/M services are limited to one per day, same provider.

9.2.60.8 Referrals

A *referral* is defined as the transfer of the total or specific care of a patient from one physician to another; a referral does not constitute a consultation. These services must be billed using the appropriate E/M visit code.

When a Texas Medicaid provider refers a Texas Medicaid client to another provider for additional treatment or services, the referring provider must forward notification of the client's eligibility and his NPI. The client must be made aware that the provider he/she is referred to does or does not participate in Texas Medicaid. Some clients not eligible for Medicaid are eligible for family planning through the HHSC Family Planning Program. These clients should be referred to contracted agency providers for family planning services.

9.2.60.8.1 Referral Requirements for Children with Disabilities

All health-care professionals are required by state and federal legislation to refer children who are 35 months of age or younger with developmental delays to early childhood intervention services provided under the authority of the Texas Health and Human Services Commission (HHSC).

Refer to: Subsection 2.9, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.61 Physician Services in a Long Term Care (LTC) Nursing Facility

HHSC requires initial certification and recertification of Medicaid clients in nursing facilities by physicians in accordance with guidelines set forth in federal regulations. Physician visits for certification and recertification are considered medically necessary, and are reimbursable by Medicaid whether performed in the physician's office or the nursing facility.

Additional information is available on the HHSC website at https://hhs.texas.gov.

9.2.62 Podiatry and Related Services

Podiatry and related services are a benefit of Texas Medicaid.

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9.2.62.1 Clubfoot Casting

Procedure code 29450 is limited to clients who are birth through 3 years of age and is payable to a physician in the management of clubfoot when a previous surgery has been performed. The physician may bill the appropriate E/M code with a casting code and be reimbursed for both. Procedure code 29750 is limited to clients who are birth through 3 years of age and is payable to a physician in addition to the initial casting or strapping procedure.

Use modifiers LT (left) and RT (right) with all procedures, as appropriate.

Casting and wedging are benefits if the client has one of the following conditions:

Diagnosis Codes							
M21541	M21542	M21549	Q6600	Q6601	Q6602	Q6610	Q6611
Q6612	Q66211	Q66212	Q66219	Q66221	Q66222	Q66229	Q6630
Q6631	Q6632	Q6640	Q6641	Q6642	Q6651	Q6652	Q666
Q6670	Q6671	Q6672	Q6681	Q6682	Q6689	Q6690	Q6691
Q6692							

9.2.62.2 Flat Foot Treatment

Reimbursement for treatment of deformities of the foot and lower extremity that includes flat foot as a component of the deformity may be considered when the client presents with significant pain in the foot, leg, or knee, resulting in a loss of or decrease in function, along with a secondary condition such as valgus deformity or plantar fasciitis.

Treatment of flat foot (flexible pes planus) that is solely cosmetic in nature is not a benefit of Texas Medicaid.

9.2.62.3 Routine Foot Care

Routine foot care must be medically necessary and billed with the following procedure codes. No specific diagnosis restrictions exist. The following procedures are limited to one service every six months per client, regardless of provider specialty: 11055, 11056, 11057, 11719, and G0127.

9.2.63 Prostate Procedures for Benign Prostatic Hyperplasia (BPH)

Prostate procedures are a benefit of Texas Medicaid and include surgical, minimally invasive, and laser procedures. Prostate procedures treat lower urinary tract symptoms (LUTS) attributed to benign prostatic hyperplasia (BPH).

BPH is an overgrowth of cells in the prostate gland and is increasingly common as men age. BPH does not require treatment and is not the target of interventions; however, BPH can lead to an enlargement of the prostate (benign prostatic enlargement [BPE]).

BPE can result in lower urinary tract symptoms (LUTS) which includes urinary frequency, urinary retention, inability to completely empty the bladder, blood in the urine, and kidney disease. Symptoms can be mild, moderate or severe.

LUTS attributable to BPH may significantly worsen the quality of life of male patients.

Treatment of LUTS attributable to BPH include a continuum of interventions ranging from lifestyle modifications, pharmacological management, minimally invasive therapy (MIST), laser therapy, to surgery.

Various prostate procedure services may be provided in the inpatient hospital, outpatient hospital, ambulatory surgical center or office settings.

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In some cases, surgical or minimally invasive therapies might be appropriate as a first line of therapy without a trial of pharmacological management for reasons of patient preference or for reasons including inability to empty the bladder, urinary reflux, kidney disease, repeated urinary infections, kidney stones, or hematuria resulting from BPH.

Pharmacological management may be the first line treatment of BPH. Medication therapy may not be tolerated due to adverse effects including low blood pressure, dizziness, fatigue, and impaired sexual function.

Surgical therapies may have longer durability, but often require an inpatient setting using general anesthesia and result in a longer recovery time.

TURP (Transurethral Resection of the Prostate) has been a preferred surgical treatment of BPH for many years and is the standard by which other treatments are compared. TURP may have a high rate of durability which may be contrasted with an increased rate of complications.

Minimally invasive therapies (MISTs) have developed as an alternative to the surgical approach of TURP, however they may have less durability than TURP.

MIST may be performed in an office setting, ambulatory surgical center or outpatient hospital under local anesthesia.

MIST may offer a short recovery time and patients are able to return to normal activity faster. MIST often preserves sexual functioning. After lifestyle modifications and medication, the next line of treatment may include minimally invasive therapy.

9.2.63.1 Minimally Invasive Therapies (MIST) for BPH

Minimally invasive therapy is an option for patients who wish a less invasive technique that may be performed in a lower acuity setting, as well as higher surgical risk patients.

9.2.63.1.1 Types of Minimally Invasive Therapy

Prostatic Urethral Lift (PUL) involves placement of one or more implants in the lateral lobes of the prostate using a transurethral delivery device, with minimal side effects. Procedure codes 52441, 52442, C9739, and C9740, are a covered benefit when the following restrictions are met:

- Client is 45 years of age and older
- Prostate gland volume is ≤ 80 gm and verified absence of an obstructive middle lobe
- International Prostate Symptom Score (IPSS) ≥ 12
- Pharmacological management has been unsuccessful or side effects intolerable
- No current urinary tract infection
- No allergy to nickel
- Surgical intervention is required

Transurethral water vapor therapy, also known as water vapor energy ablation (procedure code 53854) causes transurethral destruction of prostate tissue by radiofrequency and is indicated in prostate volumes <80 gm.

Transurethral Microwave Thermotherapy (TUMT) (procedure code 53850) is indicated for BPH when patients have a prostate length of 30-55 mm and have failed pharmacological management. The procedure is contraindicated for patients with:

- Prostate cancer
- Penile or metallic implants
- Lack of bladder control due to nerve problems

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- Nerve problems caused by diabetes
- Narrowing of the urethra due to scarring
- Prior prostate surgery or pelvic radiation therapy

Transurethral Needle Ablation (TUNA) (procedure code 53852) destroys prostate tissue by radiofrequency thermotherapy and is suitable for prostates ≤ 60 gm with predominantly lateral lobes. The procedure is an option when invasive surgery is not possible due to comorbidities.

Laser Therapy as an option for treating BPH, is indicated when there is an increased bleeding risk.

9.2.63.1.2 Types of Laser Procedures

Photoselective Vaporization of the Prostate (PVP), procedure code 52648, is a laser vaporization of prostate suitable for all patients, including those taking anticoagulation or antiplatelet medication.

Contact Laser ablation of the Prostate (CLAP) (procedure code 52648) may be reimbursed when the following is present:

- High risk of bleeding
- Prostates >100 gm
- Urinary retention

Holmium Laser Procedures of the Prostate (HoLAP), Holmium Laser Enucleation of the Prostate (HoLEP), and Homium Laser Resection of the Prostate (HoLRP), (procedure code 52649) may be used for all patients, but particularly if anticoagulant or antiplatelet therapy is used.

Surgical Therapy is a first-line treatment if the patient is unable to completely empty the bladder, has urinary reflux possibly resulting in backflow of urine into the kidney causing swelling of the kidney, or kidney disease caused by BPH, frequent urinary infections, kidney stones, bladder stones, or continuing blood in the urine caused by BPH. Surgical therapy may be necessary after failing medications or other treatments.

9.2.63.1.3 Types of Surgical Therapy

Transurethral resection of the prostate (TURP) (procedure codes 52597, 52601, 52630, and 52640) are the gold standard for treating moderate to severe BPH after failing medication and when minimally invasive procedures are contraindicated.

Procedure code 52597 is restricted to diagnosis codes N400 and N401.

Transurethral incision of the prostate (TUIP) (procedure code 52450) is utilized when minimally invasive procedures are contraindicated, and patient is not a good candidate for TURP. Usually used to treat small prostates ≤ 30 grams and it has a lower risk of blood transfusion than TURP. Services are limited to once per day.

Prostatectomy Perineal (procedure code 55801), Suprapubic (procedure code 55821), and Retropubic, (procedure code 55831) are suitable treatments for larger prostates > 50 grams and for men who are also good surgical candidates.

Prostatectomy, Laparoscopy (procedure code 55867) is a procedure suitable for prostates > 100 grams and for men who are also good surgical candidates.

Urethral Stent Temporary (procedure code 53855) is designed for short term use (6 months to 3 years) and is suitable for high-risk patients especially those with urinary retention.

Urethral Stent Permanent (procedure code 52282) is utilized in men ≥ 60 years or < 60 years who are poor surgical candidates' w/ prostate ≥ 2.5 cm long. The procedure is considered for high-risk patients especially with urinary retention.

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9.2.63.2 Prior Authorization and Documentation Requirements

Prior authorization is required for:

- Prostatic Urethral Lift (PUL) add on procedure code 52442 utilizing more than 6 implants.
- Assistant surgeons for holmium laser procedures of the prostate, procedure code 52649, including holmium laser ablation of the prostate (HoLAP), holmium laser enucleation of the prostate (HoLEP), and holmium laser resection of the prostate (HoLRP).

Note: *All other services addressed in this section do not require prior authorization.*

Requests for prior authorization must be received and approvals must be obtained before services are rendered. Requests received after the service date will be denied.

The SMPA form must be submitted, signed, and dated within 60 days before the date of service. Services will not be authorized prior to the ordering provider's signature date.

To facilitate determination of medical necessity and avoid unnecessary denials, the provider must maintain correct and complete information, including documentation for medical necessity for the test requested. The provider must maintain documentation of medical necessity in the client's medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies, and to confirm eligibility criteria are met for the benefit.

Prior authorization requests must be submitted on a SMPA Request Form and must include the following documentation: the client's diagnosis, medical necessity for choosing the procedure, the expected total number of implants required for the procedure, and a brief statement addressing the medical necessity for the number of implants requested.

Medical necessity must be documented for assistant surgeons for holmium laser procedures of the prostate, procedure code 52649, including holmium laser ablation of the prostate (HoLAP), holmium laser enucleation of the prostate (HoLEP), and holmium laser resection of the prostate, (HoLRP).

In addition to documentation requirements outlined in this section, if any, of the following requirements apply: all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

Documentation in the medical record should include a diagnosis of BPH and LUTS that in the opinion of the provider requires a procedure as an intervention for treatment.

Reimbursement is restricted for holmium laser procedure of the prostate, procedure code 52649, including holmium laser ablation of the prostate (HoLAP), holmium laser enucleation of the prostate (HoLEP), and holmium laser resection of the prostate (HOLRP), unless there is an approved prior authorization for an assistant surgeon obtained before the procedure.

Refer to: "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for detailed information about prior authorization requirements.

9.2.63.3 Reimbursement Billing Guidelines

The following procedure codes may be reimbursed for prostate procedures:

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BPH Procedures Reimbursement Information		
Service Category	**Procedure Codes**	**Additional Information**
Minimally Invasive Therapy (MIST) Prostatic Urethral Lift (PUL)	52441, 52442, C9739, C9740	Only Prostatic Urethral Lift (PUL) procedure code 52442 requires prior authorization if more than 6 total implants. Procedure codes 52441, C9739, and C9740 may only be billed once per lifetime.
Minimally Invasive Therapy (MIST)-Other	53850, 53852, 53854	Procedure codes 53850, 53852, and 53854 utilize heat or energy transfer techniques to reduce prostate size by tissue necrosis.
Laser Therapy	52648, 52649	Procedure codes 52648 and 52649 are not covered in an office setting.
Surgical Therapy	52597, 52601, 52630, 52640, 52450	Procedure code 52601 may be billed for the first TURP and may be billed again if the first TURP is staged with modifier 58. Procedure codes 52630 and 52640 may not be billed on the same day of service. Procedure codes 52597, 52601, 52630, 52640, and 52450 are all limited to once per day.
Prostatectomy	55801, 55821, 55831	Suitable for larger prostates and requires hospital admission and services are limited to one service per day.
Urethral Stent	52282, 53855	May be temporary or permanent procedure code 52282, and is limited to men who are 60 years of age or older.

Modifier	Use For
58	Procedure code 52601 if billed a second time in a staged procedure

The Prostatic Urethral Lift (PUL) procedure in an office setting or a hospital outpatient department is billed as procedure code 52441 for the first implant and each subsequent implant is billed separately as procedure code 52442.

If the PUL procedure is billed with procedure code 52442, then procedure code 52441 must also be billed for the same date of service.

The PUL procedure in an ambulatory surgical center setting is billed as procedure code C9739 for the first through third implants and four or more subsequent implants are billed separately as procedure code C9740.

The PUL procedure is limited to one procedure per lifetime. The PUL procedure is billed with only one set of codes, either procedure codes 52441 and 52442 in an office setting or outpatient hospital setting OR procedure codes C9739 and C9740 in an ambulatory surgical center setting. More than 7 implants will require prior authorization. Procedure code 52442 (2 or more implants) will require prior authorization if procedure code 52442 is billed for more than 6 implants.

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A TURP may be billed with procedure code 52597, 52601, 52630, or 52640 and may be reimbursed to the physician performed in a hospital, an outpatient hospital setting, and an ambulatory surgical center with only one service per day.

If a provider submits separate charges for any of the TURP procedure codes listed above and procedure code 52351 or 52354, the charges for procedure codes 52351 and 52354 will be denied as part of the TURP procedure billed as procedure code 52601.

If the first TURP is performed as a staged procedure, the first procedure may be billed as procedure code 52601. The next part of the staged TURP procedure may also be billed as procedure code 52601 but must also include Modifier 58.

A subsequent TURP (not including the staged TURP for procedure code 52601 with modifier 58) may be billed as either procedure code 52630 or procedure code 52640.

A TUMT, procedure code 53850, may be performed in an office as well as hospital setting, and reimbursed to the physician in the outpatient hospital setting as well in an ambulatory surgical center and may be performed only once per day.

A TUNA, procedure code 53852, reimbursed to the physician in the outpatient hospital setting as well in an ambulatory surgical center setting or an office setting and may be performed only once per day.

Transurethral water vapor therapy, procedure, code 53854, may be performed in an office, and reimbursed to the physician in the outpatient hospital setting as well in an ambulatory surgical center.

A TUIP, procedure code 52450, is reimbursed to the physician in the inpatient hospital setting as well in an ambulatory surgical center and may be performed only once per day.

A PVP, procedure code 52648, may be reimbursed to the physician in the inpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

Holmium Laser Procedures of the Prostate (HoLAP), Holmium Laser Enucleation of the Prostate (HoLEP), and Holmium Laser Resection of the Prostate (HoLRP), procedure code 52649, may be reimbursed to the physician in the inpatient and outpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day and may allow for an assistant surgeon.

A permanent urethral stent, procedure code 52282, may be performed in an office and may be reimbursed to the physician in the inpatient or outpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

A temporary urethral stent, procedure code 53855, may be performed in an office and may be reimbursed to the physician in the inpatient or outpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

9.2.64 Radiation Therapy

Radiation treatment management may be reimbursed by Texas Medicaid as defined in the *Current Procedure Terminology* (CPT) manual under the "Radiation Treatment Management" section.

The following radiation therapy services are limited to once per day unless documentation submitted with an appeal supports the need for the service to be provided more frequently:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment

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- Intracavitary radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization
- Radioisotope therapy

Laboratory and diagnostic radiological services provided in the office setting may be reimbursed to physicians as a total component. Radiation treatment centers may also be reimbursed for the total component for these services in the outpatient hospital setting. Injectable medications given during the course of therapy in any setting may be reimbursed separately.

Routine follow-up care by the same physician on the day of any therapeutic radiology service will be denied. Medical services within program limitations may be reimbursed on appeal when documentation supports the medical necessity of the visit due to services unrelated to the radiation treatment or radiation treatment complication.

The professional component and the technical component will be denied when billed with the total component. The total component includes the professional and the technical components.

The professional component may be reimbursed for services rendered in the inpatient hospital setting, radiation treatment center setting, or outpatient hospital setting. Physicians billing client services rendered in the office setting or in a facility recognized by Medicaid as a radiation treatment center may be reimbursed for total components.

9.2.64.1 Brachytherapy

9.2.64.1.1 Prior Authorization for Brachytherapy

Prior authorization is not required for brachytherapy.

9.2.64.1.2 Other Limitations on Brachytherapy

Clinical brachytherapy services include admission to the hospital and daily care. Initial and subsequent hospital care will be denied as part of another service when billed with the same date of service as clinical brachytherapy services.

An office visit will be denied as part of another service when billed with the same date of service by the same provider as clinical treatment planning and clinical brachytherapy.

Normal follow-up care by the same physician will be denied as part of another service when billed with the same dates of service as any therapeutic radiology service. Any other E/M office visit will be denied as part of another service when billed with the same date of service by the same provider as the radiation treatment or radiation treatment complication.

Providers may use modifier 25 to indicate that the additional visit was for a separate, distinct service unrelated to the radiation treatment or radiation treatment complication. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available upon request.

Each service provided using procedure codes 77321 and 77470 are limited to once per two calendar months.

Documentation that supports the provision of special procedures must be maintained in the client's medical record and made available upon request.

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9.2.64.2 Stereotactic Radiosurgery

9.2.64.2.1 Prior Authorization for Stereotactic Radiosurgery

The following procedure codes are a benefit of Texas Medicaid with prior authorization and documentation of medical necessity:

Procedure Codes									
32701	61781	61782	61783	61796	61797	61798	61799	61800	63620
63621	76145	77336	77370	77371	77372	77373	77399	77423	77520
77522	77523	77525	G0339	G0340	G0563	S8030			

Prior authorization requests received after the requested start date of service will be denied for dates of service prior to the date the request was received.

Prior authorization requirements for stereotactic radiosurgery and stereotactic body radiation therapy may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Benign and malignant tumors of the central nervous system
- Vascular malformations
- Soft tissue tumors in chest, abdomen, or pelvis
- Trigeminal neuralgia refractory to medical management
- Pediatric cancers

Stereotactic radiosurgery and stereotactic body radiation therapy are considered investigational and not a benefit of Texas Medicaid for all other indications including, but not limited to, epilepsy, chronic pain, and pancreatic adenocarcinoma.

Prior authorization requirements for proton beam (procedure codes 77520, 77522, 77523, 77525, and S8030) and helium ion radiosurgery (procedure code 77423) may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Melanoma of the uveal tract (iris, choroid, ciliary body)
- Postoperative treatment for chordomas or low-grade chondrosarcomas of the skull or cervical spine
- Prostate cancer
- Pituitary neoplasms
- Other central nervous system tumors located near vital structures
- Pediatric cancers

Proton beam radiation therapy (procedure codes 77520, 77522, 77523, 77525, and S8030) is a benefit of Texas Medicaid for pediatric cancer diagnoses in clients who are 20 years of age or younger with prior authorization.

Prior authorization for neutron beam radiosurgery may be considered for malignant neoplasms of the salivary gland.

Prior authorization requirements for procedure code 77399 include, but are not limited to, diagnosis, documentation of medical necessity, a specific description of the procedure to be performed, and an indication that the procedure would not be covered by a more specific procedure code.

Stereotactic radiosurgery and stereotactic body radiation therapy will not be prior authorized for clients with metastatic disease and a projected life span of less than six months or for clients with widespread cerebral or extracranial metastasis that is not responsive to systemic therapy.

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9.2.64.2.2 Other Limitations on Stereotactic Radiosurgery

In the following table, the procedure codes in Column A may be reimbursed when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

Column A Procedure Code	Column B Procedure Code
61797	61796, 61798
61799	61798
61800	61796, 61798
63621	63620

Procedure codes 61796 and 63620 must not be billed more than once per course of treatment.

Procedure codes 61797 and 61799 must not be billed more than once per lesion, and may only be billed up to four times for the entire course of treatment, regardless of the number of lesions treated.

Procedure code 63621 may only be billed up to two times for the entire course of treatment, regardless of the number of lesions treated.

Procedure codes 77336 and 77370 may be reimbursed to the ordering physician if consultation is performed with a qualified medical physicist for stereotactic radiosurgery, brachytherapy, or any other method of radiation therapy for which medical necessity is determined.

Procedure code 77336 will be limited to once per week of treatment.

Procedure code 77370 will be limited to once per course of treatment. A special medical physics consultation may be reimbursed when the input and complex analysis of a qualified medical physicist are beyond that of a continuing medical physics consultation and are necessary to address a patient-specific reason or scenario.

9.2.65 Radiology Services

In compliance with HHS regulations, physicians (MDs and DOs), group practices, and clinics may not bill for radiology services provided outside their offices. These services must be billed directly by the facility/provider that performs the service.

This restriction does not affect radiology services performed by physicians or under their supervision in their offices. The radiology equipment must be owned by physicians and be located in their office to allow for billing of TOS 4 (complete procedure) or TOS T with modifier TC to Texas Medicaid. If physicians are members of a clinic that owns and operates radiology facilities, they may bill for these services. However, if physicians practice independently and share space in a medical complex where radiology facilities are located, they may not bill for these services even if they own or share ownership of the facility, unless they supervise and are responsible for the operation of the facilities on a daily basis.

Providers billing for three or more of the same radiology procedures on the same day must indicate the time the procedure was performed to indicate that it is not a duplicate service. The use of modifiers 76 and 77 does not remove the requirement of indicating the times services were rendered. The original claim will be denied but can be appealed with the documentation of procedure times.

When billing for services in an inpatient or outpatient hospital setting, the radiologist may only bill the professional interpretation of procedures (modifier 26). This also applies when providing services to a client who is in an inpatient status even if the client is brought to the radiologist's office for the service. The hospital is responsible for all facility services (the technical component) even if the service is supplied by another facility/provider.

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A separate charge for an X-ray interpretation billed by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician's overall work-up and treatment of the patient.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be paid if a radiologist does not bill for the professional component of X-ray procedures.

If duplicate billings are found between radiologists and the other specialties, the radiologist may be paid, and the other provider is denied.

Oral preparations for X-rays are included in the charge for the X-ray procedure when billed by a physician. Separate charges for the oral preparation are denied as part of another procedure on the same day.

Separate charges for injectable radiopharmaceuticals used in the performance of specialized X-ray procedures may be paid. If a procedure code is not indicated, an unlisted code must have a drug name, route of administration, and dosage written on the claim.

9.2.65.1 Diagnosis Requirements

Physicians enrolled and practicing as radiologists are not routinely required to send a diagnosis with their request for payment except when providing the following services:

- Arteriograms
- Venography
- Chest X-rays
- Cardiac blood pool imaging
- Echography

Radiologists are required to identify the referring provider by full name and credentials in Block 17 of the CMS-1500 claim form. Radiology procedures submitted by all other physician specialties must reference a diagnosis with every procedure billed. As with all procedures billed to Texas Medicaid, baseline screening and/or comparison studies are not a benefit.

9.2.65.2 Cardiac Blood Pool Imaging

Cardiac blood pool imaging may be reimbursed with procedure codes 78472, 78473, 78481, 78483, 78494, and 78496. Prior authorization is required for outpatient diagnostic services.

Refer to: Subsection 9.2.26.9, "Myocardial Perfusion Imaging" in this handbook for more information about myocardial perfusion imaging.

Section 4, "Radiological and physiological laboratory services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information and authorization requirements.

9.2.65.3 Chest X-Rays

All providers including radiologists billing for chest X-rays must supply a diagnosis code.

Screening, baseline, or rule-out studies do not qualify for reimbursement.

9.2.65.4 Magnetic Resonance Angiography (MRA)

MRA is an effective diagnostic tool used to detect, diagnose, and aid the treatment of heart disorders, stroke, and blood vessel diseases.

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Refer to: Section 4, "Radiological and physiological laboratory services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information and authorization requirements.

9.2.65.5 Magnetic Resonance Imaging (MRI)

MRIs may be an effective diagnostic tool for detecting defects, diseases, and trauma.

Refer to: Section 4, "Radiological and physiological laboratory services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information and authorization requirements.

9.2.65.6 Technetium TC 99M

Procedure codes A9500 (Sestamibi) and A9502 (Tetrofosmin) are limited to three per day when billed by the same provider.

9.2.66 Magnetoencephalography (MEG)

Magnetoencephalography is a benefit of Texas Medicaid when medically necessary for the presurgical evaluation of clients with intractable epilepsy (i.e., refractory or drug-resistant epilepsy), brain tumors, vascular malformations of the brain, or when one or more conventional measures of localizing the seizure focus have failed to provide sufficient information.

MEG is a noninvasive method of measuring magnetic fields in the brain and is used to precisely localize both the essential functional cortex (i.e., eloquent cortex) and abnormal epileptogenic brain activity as part of a presurgical evaluation. The origin of abnormal MEG brain activity can be precisely localized (source localization) and displayed as a map or image.

The term magnetic source imaging (MSI) refers to an imaging technique that combines a MEG scan with an anatomic magnetic resonance imaging (MRI) image of the brain to map or visualize brain activity.

MEG may assist in guiding the placement of intracranial Electroencephalography (EEG) and, in some patients, avoid an unnecessary intracranial EEG. In the case of pre-surgical mapping of patients with operable lesions, MEG provides non-invasive localization of eloquent cortices (e.g., motor, sensory, language, auditory, or visual).

Physicians must provide MEG services in a comprehensive level IV epilepsy center or a physiological laboratory. A neurologist, epileptologist, or neurosurgeon must order the MEG test.

MEG is not a stand-alone test. Pre-surgical evaluation with MEG testing must include a comprehensive evaluation by the medical team.

Procedure codes 95965, 95966, and 95967 may be reimbursed for MEG services. Procedure code 95967 is an add-on code and must be submitted with procedure code 95966.

Physicians may be reimbursed for the professional component of MEG services.

9.2.66.1 Prior Authorization for MEG

Prior authorization is required for MEG. Prior authorization requests must be submitted using the Special Medical Prior Authorization (SMPA) Request Form. The ordering physician must sign and date the form and submit it to the SMPA department. Requests must include documentation supporting the medical necessity of the study. The ordering physician must maintain all documentation.

Providers must include information about the MEG test facility. This information must be documented on the SMPA form.

Prior authorization requests must include a completed SMPA request form and all of the following documentation:

- Documentation of one of the following conditions: intractable epilepsy, brain tumors, or vascular malformations of the brain

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- The statement of medical necessity from the ordering physician, which must support the need for MEG with identified medical conditions as applicable, including:
  - History of treatment methods used
  - Length of treatment and treatment outcomes
  - Date of onset of supporting diagnoses
  - Types of previous diagnostic testing used or considered and documentation that indicates how these tests have failed to provide the necessary information to address the client's medical needs or when one or more conventional measures of localizing the seizure focus have failed to provide sufficient information

Documentation from the ordering physician outlining how the MEG test will assist in identifying the area to be resected in instances when an MEG test is needed due to a tumor and surgery is the first option.

Documentation that includes the name and number of medications, tried and failed, to control the client's seizure activity when the MEG request is related to intractable epilepsy.

The date of prior MEG, the results of the previous MEG tests, and supporting medical documentation outlining the medical reasons for the repeat MEG requested if the request is for a repeat MEG.

Providers may submit prior authorization requests electronically, through the provider website, fax, or by standard mail.

The provider may complete and submit the required prior authorization documentation through any approved electronic method. The provider must maintain a copy of the prior authorization request as well as all submitted documentation in the client's medical record at the performing provider's place of business, in order to complete the prior authorization process electronically.

The provider may complete and submit the required prior authorization documentation through fax or standard mail and must maintain a copy of the prior authorization request as well as all submitted documentation in the client's medical record at the performing provider's place of business, to complete the prior authorization process by paper.

Providers must include correct and complete information, such as documentation of medical necessity for the service(s) requested, in order to avoid unnecessary denials. Providers must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request.

Requests for prior authorization with documentation supporting the medical necessity for the number of studies requested must be received on, or before, the requested date(s) of service.

Note: *Requests received after the services are performed will be denied for dates of service that occurred before the date the request was received.*

9.2.66.2 Documentation Requirements

In addition to documentation requirements outlined in the "Prior Authorization for MEG" section, the following requirements apply:

- All MEG services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.
- Magnetic Source Imaging procedure code S8035 is not a benefit of Texas Medicaid, but it may be used for informational purposes.

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9.2.66.3 Noncovered Services

The following MEG services are not benefits of Texas Medicaid:

- MEG when used as a stand-alone test for epilepsy
- MEG used as a first-line diagnostic screening
- MEG when used for evaluation of:
  - Alzheimer's disease
  - Autism
  - Cognitive and mental disorders
  - Developmental dyslexia
  - Learning disorders
  - Migraines
  - Multiple sclerosis
  - Parkinson's disease
  - Schizophrenia
  - Stroke rehabilitation
  - Traumatic brain injury

Note: *This list is not all inclusive.*

9.2.67 Reduction Mammaplasties

9.2.67.1 Prior Authorization for Reduction Mammaplasty

Procedure code 19318 is the removal of breast tissue and is a benefit of Texas Medicaid when prior authorized.

For prior authorization of reduction mammaplasty, a completed "Medicaid Certificate of Medical Necessity for Reduction Mammaplasty" form signed and dated by the physician, must be submitted and include at least one of the following criteria:

- Evidence of severe neck and/or back pain with incapacitation from the pain.
- Evidence of ulnar pain or paresthesia from thoracic nerve root compression.
- Submammary dermatological conditions such as intertrigo and acne that are refractory to conventional medication.
- Shoulder grooving with ulceration due to breast size.

In addition to the above criteria, documentation must indicate:

- The minimum weight of tissue expected to be removed from each breast with consideration to height and weight is as follows:

Height and Weight Chart		
Under 5'	<140 lb	300 grams per breast
5'-5'.4"	up to 180 lb	350 grams per breast
5'.4"-5'.7"	up to 220 lb	400 grams per breast
5'.7"- and up	211 lb and up	500 grams per breast

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- The client, if 40 years of age or older, has had a mammogram within the past year that was negative for cancer.

The following services are *not* a benefit of Texas Medicaid:

- Reduction mammaplasty for cosmetic purposes (such as the equalization of breast size)
- Augmentation mammaplasty to increase breast size

The physician is required to maintain the following documentation in the client's clinical records:

- A complete history and physical
- Pulmonary function studies results
- Past treatments, therapies, and outcomes for pain control and weight reduction

The physician is required to maintain preoperative photographs (frontal and lateral views) in the client's clinical records and must be made available to Texas Medicaid upon request.

For reimbursement purposes on a bilateral procedure, the full allowed amount will be paid to the surgeon and assistant surgeon for the first breast reduction and one half the allowed amount will be paid for the second reduction. Facilities are paid for one surgical procedure.

When submitting for prior authorization, requests *must* be sent to TMHP Special Medical Prior Authorization. Sending requests directly to the TMHP Medical Director delays the processing of the request. Providers are to mail prior authorization requests for reduction mammaplasty to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax 1-512-514-4213

9.2.68 Renal Disease

9.2.68.1 Dialysis Patients

Physician reimbursement for supervision of patients on dialysis is based on a monthly capitation payment (MCP) calculated by Medicare. The MCP is a comprehensive payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all POSs except inpatient hospital. The original onset date must be the same date entered on the 2728 form sent to the Social Security office.

9.2.68.1.1 Physician Supervision of Dialysis Patients

Physician supervision of outpatient ESRD services includes services provided 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.

Use the following procedure codes when billing for physician supervision of outpatient ESRD dialysis services:

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

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Procedure Codes									
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970

The procedure codes must be billed as described below:

- In the circumstances where the client is not on home dialysis and has had a complete assessment visit during the calendar month and ESRD-related services are provided for a full month, procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be used, determined by the number of face-to-face visits the physician has had with the client during the month, and the client's age.
- When a full calendar month of ESRD-related services are reported for clients on home dialysis, procedure codes 90963, 90964, 90965, or 90966 must be used, determined by the client's age.
- Report procedure codes 90967, 90968, 90969, and 90970 when ESRD related services are provided for less than a full month, per day, under the following conditions:
  - The client is seen for a partial month and is not on home dialysis and received one or more face-to-face visits but did not receive a complete assessment.
  - The client is on home dialysis and received less than a full month of services.
  - The client is a transient client.
  - The 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.
  - The client received a kidney transplant.
- Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing procedure code 90967, 90968, 90969, or 90970, the date of service must indicate each day that supervision was provided.
- Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed within the same calendar month by any provider as procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966.
- Procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966 are limited to once per calendar month by any provider, and only one service may be reimbursed per calendar month by any provider.

The following services may be provided in conjunction with physician supervision of ESRD dialysis but are considered non-routine and may be billed separately:

- Declotting of shunts when performed by the physician.
- Physician services to inpatient clients. If a client is hospitalized during a calendar month of ESRD related services before a complete assessment is performed, or the client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment, the physician must bill procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision and bill the appropriate hospital evaluation and management code for individual services provided on the hospitalized days. If a client has a complete assessment during a month in which the client is hospitalized, procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be reported for the month of supervision, determined by the number of face-to-face physician visits with the client during the month, and the client's age. The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.

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- Dialysis at an outpatient facility other than the usual dialysis setting for a patient of a physician who bills the MCP. The physician must bill procedure code 90967, 90968, 90969, or 90970 for each date supervision is provided. The physician may not bill for days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the patient's renal condition that cause the number of physician-patient contacts to increase. 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.

Use procedure codes 90935, 90937, 90945, and 90947 for inpatient dialysis services for ESRD or non-ESRD clients when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of the dialysis. These codes are not payable for a cursory visit by the physician; hospital visit codes must be used for a cursory visit.

The hospital procedure codes 90935, 90937, 90945, and 90947 are for complete care of the patient; hospital visits cannot be billed on the same day as these codes. However, if the physician only sees the patient when they are not dialyzing, the physician must bill the appropriate hospital visit code. The inpatient dialysis code must not be submitted for payment.

Only one of procedure code 90935, 90937, 90945, or 90947 may be reimbursed per day, any provider.

Procedure codes 90935, 90937, 90945, and 90947 may also be used for outpatient dialysis services for non-ESRD clients.

Inpatient services provided to hospitalized clients for whom the physician has agreed to bill monthly, may be reimbursed in one of the following three ways:

- The physician may elect to continue monthly billing, in which case she or he may not bill for individual services provided to the hospitalized clients.
- The physician may reduce the monthly bill by 1/30th for each day of hospitalization and charge fees for individual services provided on the hospitalized days.
- The physician may bill for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the clients during the course of the dialysis.

Clients may receive dialysis at an outpatient facility other than his or her usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly billed amount by 1/30th for each day the client is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client's renal condition may be reimbursed on a fee-for-service basis. The physician should provide documentation stating the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the monthly capitation payment for physician supervision rendered to maintenance facility clients.

9.2.68.2 Laboratory Services for Dialysis Patients

Texas Medicaid may reimburse for laboratory services performed for dialysis patients.

Charges for routine laboratory services performed according to established frequencies are included in the facility's composite rate billed to Texas Medicaid regardless of where the tests were performed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by a renal dialysis facility, unless they are inclusive tests.

Nonroutine laboratory services for people dialyzing in a facility and all laboratory work for people on CAPD may be billed separately from the dialysis charge.

Refer to: Subsection 7.2.7, "Laboratory and Radiology Services" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on laboratory services.

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9.2.68.3 Self-Dialysis Patients

Physician reimbursement for supervision of patients on self-dialysis is made after completion of the patient's training. If the training is not completed, payment is proportionate to the amount of time spent in training. Payment for training may be made in addition to payment under the MCP for physician supervision of an in-facility maintenance dialysis patient. Use procedure codes 90989 and 90993 for dialysis training regardless of the type of training performed. These procedure codes must be billed as specified:

- When complete dialysis training is provided, bill procedure code 90989. The date of service indicates the date training was completed, and the quantity is 1.
- When dialysis training is not completed, bill procedure code 90993. The date of service must list each day that a session of training was provided and the quantity must indicate the number of training sessions provided.

The amount of reimbursement of subsequent training is determined by prorating the physician's payment for initial training sessions. The amount of payment for each additional training session does not exceed $20.

9.2.68.3.1 Physician Supervision

All physician services required to create the capacity for self-dialysis must include:

- Direction of and participation in training of dialysis patients.
- Review of family and home status and environment, and counseling and training of family members.
- Review of training progress.

9.2.68.3.2 Dialysis Supervision

The following services are included in the physician charge for supervision of a client on self-dialysis:

- Physician services rendered during a dialysis session including those backup dialyses that occur in outpatient facility settings.
- Office visits for the routine evaluation of patient progress, including the interpretation of diagnostic tests and procedures.
- Physician services rendered by the attending physician in the course of an office visit, the primary purpose of which is routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, which may be appropriately treated without increasing the number of contacts beyond those occurring at regular monitoring sessions or visits for treatment of renal complications.
- General support services (for example, arranging for supplies).

9.2.68.3.3 Subsequent Training

No additional payment is made after the initial self-dialysis training course unless subsequent training is required for one of the following reasons:

- A change from the client's treatment machine to one the client had not been trained to use in the initial training course
- A change in setting
- A change in dialysis partner

The physician must document the reason for additional training sessions on the CMS-1500 paper claim form.

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Dialysis equipment and supplies used by the client who dialyzes in the home are not benefits of Texas Medicaid, including the lease or purchase of dialysis machines and disposable supply kits.

9.2.69 Sacroiliac Joint Fusion

Sacroiliac (SI) joint fusion (procedure code 27278) is a benefit for clients who are 18 years of age or older and requires prior authorization. Requests must be submitted on the Special Medical Prior Authorization (SMPA) Request Form and be signed within 30 days of the start of care date.

Note: *Prior authorization requests must be submitted before the requested start date of service. Any request for dates of service that occur before the date on which the request was received will be denied.*

9.2.69.1 Prior Authorization Criteria

The prior authorization request must be submitted with a provider statement or attestation that the client needs an SI joint fusion and the indications for that determination, including attestation that the following diagnoses have been ruled out:

- Lumbar disc herniation (diagnosis code M5126)
- Lumbar spondylolisthesis (diagnosis code M4316)
- Lumbar spinal stenosis (diagnosis codes M48061 and M48062)
- Lumbar facet degeneration (diagnosis code M4696)
- Lumbar vertebral body fracture (diagnosis code S32009A or S32009D)

The submitted documentation must also include observed evidence of at least three out of five positive test results from SI joint pain provocative tests, such as the following:

- SI joint compression test
- Posterior pelvic pain provocation test—P4 (thigh thrust)
- Patrick's test (Fabere test)
- Sacroiliac distraction test
- Gaenslen's test

Documentation of the following must be included with the prior authorization request:

- Six months of conservative efforts have failed to improve the client's pain by 50–70%.
- The client successfully achieved 50–75% temporary pain reduction with SI joint injections.

9.2.70 Sign Language Interpreting Services

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

Sign language interpreting services are available to Medicaid clients who are deaf or hard of hearing or to a parent or guardian of a Medicaid client if the parent or guardian is deaf or hard of hearing.

Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from Texas Medicaid for providing this service.

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Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels A through H) issued by either the Office of Deaf and Hard of Hearing Services, Board for Evaluation of Interpreters (BEI) or the National Registry of Interpreters for the Deaf (RID).

Certification Levels:

- BEI Level I/Ii and BEI OC: B (Oral Certificate: Basic)
- BEI Basic and RID NIC (National Interpreter Certificate) Certified
- BEI Level II/IIi, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate)
- BEI Level III/IIIi, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter)
- BEI Advanced and RID NIC Advanced
- BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal)
- BEI V/VI
- BEI Master; and RID NIC Master

Interpreting services include the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.

The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the client's medical record and must include the name of the sign language interpreter and the interpreter's certification level. Documentation must be made available if requested by HHSC or its designee.

9.2.71 Skin Therapy

Skin therapy is a benefit of Texas Medicaid and may be reimbursed with the following procedure codes:

Procedure Codes									
15782	15783	15792	15793	17000	17003	17004	17106	17107	17108
17110	17111	17250	17260	17261	17262	17263	17264	17266	17270
17271	17272	17273	17274	17276	17280	17281	17282	17283	17284
17286	17311	17312	17313	17314	17315	17340	17999	11900	11901
96900	96910	96912	96913	96920	96921	96922	96999		

Claims for incision and drainage of acne when the diagnosis states there is infection or pustules may be paid.

Procedure codes 96900, 96910, 96912, 96913, 96920, 96921, and 96922 are covered benefits for the following diagnosis codes:

Diagnosis Codes							
A672	B070	B081	B550	B551	B552	B559	C8401
C8402	C8403	C8404	C8405	C8406	C8407	C8408	C8409
H02731	H02732	H02734	H02735	L100	L101	L102	L103
L104	L105	L1081	L1089	L120	L121	L122	L128

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Diagnosis Codes							
L130	L131	L138	L139	L200	L2081	L2082	L2083
L2084	L2089	L210	L211	L218	L219	L22	L230
L231	L232	L233	L235	L236	L237	L2381	L240
L241	L242	L243	L244	L245	L246	L247	L2481
L24A0	L24A1	L24A2	L24A9	L24B0	L24B1	L24B2	L24B3
L270	L271	L272	L278	L279	L300	L301	L302
L303	L304	L305	L400	L401	L402	L403	L404
L4050	L4051	L4052	L4053	L4054	L4059	L408	L410
L411	L412	L413	L414	L415	L418	L42	L440
L560	L561	L562	L563	L564	L565	L570	L571
L572	L573	L574	L575	L580	L581	L700	L701
L702	L703	L704	L705	L708	L710	L711	L718
L730	L80						

Intralesional injection(s) may be considered for reimbursement in addition to an office visit.

Procedure codes 11900 and 11901 are covered benefits for intralesional injections for the following diagnosis codes:

Diagnosis Codes							
B070	B081	B550	B551	B552	B559	D863	L400
L401	L402	L403	L404	L4050	L4051	L4052	L4053
L4054	L4059	L408	L410	L411	L412	L413	L414
L415	L418	L42	L440	L700	L701	L702	L703
L704	L705	L708	L710	L711	L718	L730	L732
L910	L928	T2000XA	T2000XD	T2000XS	T20011A	T20011D	T20011S
T20012A	T20012D	T20012S	T2002XA	T2002XD	T2002XS	T2003XA	T2003XD
T2003XS	T2004XA	T2004XD	T2004XS	T2005XA	T2005XD	T2005XS	T2006XA
T2006XD	T2006XS	T2007XA	T2007XD	T2007XS	T2009XA	T2009XD	T2009XS
T2010XA	T2010XD	T2010XS	T20111A	T20111D	T20111S	T20112A	T20112D
T20112S	T2012XA	T2012XD	T2012XS	T2013XA	T2013XD	T2013XS	T2014XA
T2014XD	T2014XS	T2015XA	T2015XD	T2015XS	T2016XA	T2016XD	T2016XS
T2017XA	T2017XD	T2017XS	T2019XA	T2019XD	T2019XS	T2020XA	T2020XD
T2020XS	T20211A	T20211D	T20211S	T20212A	T20212D	T20212S	T2022XA
T2022XD	T2022XS	T2023XA	T2023XD	T2023XS	T2024XA	T2024XD	T2024XS
T2025XA	T2025XD	T2025XS	T2026XA	T2026XD	T2026XS	T2027XA	T2027XD
T2027XS	T2029XA	T2029XD	T2029XS	T2030XA	T2030XD	T2030XS	T20311A
T20311D	T20311S	T20312A	T20312D	T20312S	T2032XA	T2032XD	T2032XS
T2033XA	T2033XD	T2033XS	T2034XA	T2034XD	T2034XS	T2035XA	T2035XD
T2035XS	T2036XA	T2036XD	T2036XS	T2037XA	T2037XD	T2037XS	T2039XA
T2039XD	T2039XS	T2040XA	T2040XD	T2040XS	T20411A	T20411D	T20411S
T20412A	T20412D	T20412S	T2042XA	T2042XD	T2042XS	T2043XA	T2043XD

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Diagnosis Codes							
T2043XS	T2044XA	T2044XD	T2044XS	T2045XA	T2045XD	T2045XS	T2046XA
T2046XD	T2046XS	T2047XA	T2047XD	T2047XS	T2049XA	T2049XD	T2049XS
T2050XA	T2050XD	T2050XS	T20511A	T20511D	T20511S	T20512A	T20512D
T20512S	T2052XA	T2052XD	T2052XS	T2053XA	T2053XD	T2053XS	T2054XA
T2054XD	T2054XS	T2055XA	T2055XD	T2055XS	T2056XA	T2056XD	T2056XS
T2057XA	T2057XD	T2057XS	T2059XA	T2059XD	T2059XS	T2060XA	T2060XD
T2060XS	T20611A	T20611D	T20611S	T20612A	T20612D	T20612S	T2062XA
T2062XD	T2062XS	T2063XA	T2063XD	T2063XS	T2064XA	T2064XD	T2064XS
T2065XA	T2065XD	T2065XS	T2066XA	T2066XD	T2066XS	T2067XA	T2067XD
T2067XS	T2069XA	T2069XD	T2069XS	T2070XA	T2070XD	T2070XS	T20711A
T20711D	T20711S	T20712A	T20712D	T20712S	T2072XA	T2072XD	T2072XS
T2073XA	T2073XD	T2073XS	T2074XA	T2074XD	T2074XS	T2075XA	T2075XD
T2075XS	T2076XA	T2076XD	T2076XS	T2077XA	T2077XD	T2077XS	T2079XA
T2079XD	T2079XS	T2100XA	T2100XD	T2100XS	T2101XA	T2101XD	T2101XS
T2102XA	T2102XD	T2102XS	T2103XA	T2103XD	T2103XS	T2104XA	T2104XD
T2104XS	T2106XA	T2106XD	T2106XS	T2107XA	T2107XD	T2107XS	T2110XA
T2110XD	T2110XS	T2111XA	T2111XD	T2111XS	T2112XA	T2112XD	T2112XS
T2113XA	T2113XD	T2113XS	T2114XA	T2114XD	T2114XS	T2116XA	T2116XD
T2116XS	T2117XA	T2117XD	T2117XS	T2119XA	T2119XD	T2119XS	T2120XA
T2120XD	T2120XS	T2121XA	T2121XD	T2121XS	T2122XA	T2122XD	T2122XS
T2123XA	T2123XD	T2123XS	T2124XA	T2124XD	T2124XS	T2126XA	T2126XD
T2126XS	T2127XA	T2127XD	T2127XS	T2130XA	T2130XD	T2130XS	T2131XA
T2131XD	T2131XS	T2132XA	T2132XD	T2132XS	T2133XA	T2133XD	T2133XS
T2134XA	T2134XD	T2134XS	T2136XA	T2136XD	T2136XS	T2137XA	T2137XD
T2137XS	T2140XA	T2140XD	T2140XS	T2141XA	T2141XD	T2141XS	T2142XA
T2142XD	T2142XS	T2143XA	T2143XD	T2143XS	T2144XA	T2144XD	T2144XS
T2146XA	T2146XD	T2146XS	T2147XA	T2147XD	T2147XS	T2150XA	T2150XD
T2150XS	T2151XA	T2151XD	T2151XS	T2152XA	T2152XD	T2152XS	T2153XA
T2153XD	T2153XS	T2154XA	T2154XD	T2154XS	T2156XA	T2156XD	T2156XS
T2157XA	T2157XD	T2157XS	T2159XA	T2159XD	T2159XS	T2160XA	T2160XD
T2160XS	T2161XA	T2161XD	T2161XS	T2162XA	T2162XD	T2162XS	T2163XA
T2163XD	T2163XS	T2164XA	T2164XD	T2164XS	T2166XA	T2166XD	T2166XS
T2167XA	T2167XD	T2167XS	T2170XA	T2170XD	T2170XS	T2171XA	T2171XD
T2171XS	T2172XA	T2172XD	T2172XS	T2173XA	T2173XD	T2173XS	T2174XA
T2174XD	T2174XS	T2176XA	T2176XD	T2176XS	T2177XA	T2177XD	T2177XS
T2200XA	T2200XD	T2200XS	T22011A	T22011D	T22011S	T22012A	T22012D
T22012S	T22021A	T22021D	T22021S	T22022A	T22022D	T22022S	T22031A
T22031D	T22031S	T22032A	T22032D	T22032S	T22041A	T22041D	T22041S
T22042A	T22042D	T22042S	T22049A	T22049D	T22049S	T22051A	T22051D
T22051S	T22052A	T22052D	T22052S	T22061A	T22061D	T22061S	T22062A

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Diagnosis Codes							
T22062D	T22062S	T22091A	T22091D	T22091S	T22092A	T22092D	T22092S
T2210XA	T2210XD	T2210XS	T22111A	T22111D	T22111S	T22112A	T22112D
T22112S	T22121A	T22121D	T22121S	T22122A	T22122D	T22122S	T22131A
T22131D	T22131S	T22132A	T22132D	T22132S	T22141A	T22141D	T22141S
T22142A	T22142D	T22142S	T22151A	T22151D	T22151S	T22152A	T22152D
T22152S	T22161A	T22161D	T22161S	T22162A	T22162D	T22162S	T22191A
T22191D	T22191S	T22192A	T22192D	T22192S	T2220XA	T2220XD	T2220XS
T22211A	T22211D	T22211S	T22212A	T22212D	T22212S	T22221A	T22221D
T22221S	T22222A	T22222D	T22222S	T22231A	T22231D	T22231S	T22232A
T22232D	T22232S	T22239A	T22239D	T22239S	T22241A	T22241D	T22241S
T22242A	T22242D	T22242S	T22249A	T22249D	T22249S	T22251A	T22251D
T22251S	T22252A	T22252D	T22252S	T22261A	T22261D	T22261S	T22262A
T22262D	T22262S	T22291A	T22291D	T22291S	T22292A	T22292D	T22292S
T2230XA	T2230XD	T2230XS	T22311A	T22311D	T22311S	T22312A	T22312D
T22312S	T22321A	T22321D	T22321S	T22322A	T22322D	T22322S	T22331A
T22331D	T22331S	T22332A	T22332D	T22332S	T22341A	T22341D	T22341S
T22342A	T22342D	T22342S	T22351A	T22351D	T22351S	T22352A	T22352D
T22352S	T22361A	T22361D	T22361S	T22362A	T22362D	T22362S	T22369A
T22369D	T22369S	T22391A	T22391D	T22391S	T22392A	T22392D	T22392S
T2240XA	T2240XD	T2240XS	T22411A	T22411D	T22411S	T22412A	T22412D
T22412S	T22421A	T22421D	T22421S	T22422A	T22422D	T22422S	T22431A
T22431D	T22431S	T22432A	T22432D	T22432S	T22441A	T22441D	T22441S
T22442A	T22442D	T22442S	T22451A	T22451D	T22451S	T22452A	T22452D
T22452S	T22461A	T22461D	T22461S	T22462A	T22462D	T22462S	T22491A
T22491D	T22491S	T22492A	T22492D	T22492S	T2250XA	T2250XD	T2250XS
T22511A	T22511D	T22511S	T22512A	T22512D	T22512S	T22521A	T22521D
T22521S	T22522A	T22522D	T22522S	T22531A	T22531D	T22531S	T22532A
T22532D	T22532S	T22541A	T22541D	T22541S	T22542A	T22542D	T22542S
T22551A	T22551D	T22551S	T22552A	T22552D	T22552S	T22561A	T22561D
T22561S	T22562A	T22562D	T22562S	T22591A	T22591D	T22591S	T22592A
T22592D	T22592S	T2260XA	T2260XD	T2260XS	T22611A	T22611D	T22611S
T22612A	T22612D	T22612S	T22621A	T22621D	T22621S	T22622A	T22622D
T22622S	T22631A	T22631D	T22631S	T22632A	T22632D	T22632S	T22641A
T22641D	T22641S	T22642A	T22642D	T22642S	T22649A	T22649D	T22649S
T22651A	T22651D	T22651S	T22652A	T22652D	T22652S	T22661A	T22661D
T22661S	T22662A	T22662D	T22662S	T22691A	T22691D	T22691S	T22692A
T22692D	T22692S	T2270XA	T2270XD	T2270XS	T22711A	T22711D	T22711S
T22712A	T22712D	T22712S	T22721A	T22721D	T22721S	T22722A	T22722D
T22722S	T22731A	T22731D	T22731S	T22732A	T22732D	T22732S	T22741A
T22741D	T22741S	T22742A	T22742D	T22742S	T22751A	T22751D	T22751S

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Diagnosis Codes							
T22752A	T22752D	T22752S	T22761A	T22761D	T22761S	T22762A	T22762D
T22762S	T22791A	T22791D	T22791S	T22792A	T22792D	T22792S	T23001A
T23001D	T23001S	T23002A	T23002D	T23002S	T23011A	T23011D	T23011S
T23012A	T23012D	T23012S	T23021A	T23021D	T23021S	T23022A	T23022D
T23022S	T23031A	T23031D	T23031S	T23032A	T23032D	T23032S	T23041A
T23041D	T23041S	T23042A	T23042D	T23042S	T23051A	T23051D	T23051S
T23052A	T23052D	T23052S	T23061A	T23061D	T23061S	T23062A	T23062D
T23062S	T23071A	T23071D	T23071S	T23072A	T23072D	T23072S	T23091A
T23091D	T23091S	T23092A	T23092D	T23092S	T23101A	T23101D	T23101S
T23102A	T23102D	T23102S	T23111A	T23111D	T23111S	T23112A	T23112D
T23112S	T23121A	T23121D	T23121S	T23122A	T23122D	T23122S	T23131A
T23131D	T23131S	T23132A	T23132D	T23132S	T23141A	T23141D	T23141S
T23142A	T23142D	T23142S	T23151A	T23151D	T23151S	T23152A	T23152D
T23152S	T23161A	T23161D	T23161S	T23162A	T23162D	T23162S	T23171A
T23171D	T23171S	T23172A	T23172D	T23172S	T23191A	T23191D	T23191S
T23192A	T23192D	T23192S	T23201A	T23201D	T23201S	T23202A	T23202D
T23202S	T23211A	T23211D	T23211S	T23212A	T23212D	T23212S	T23221A
T23221D	T23221S	T23222A	T23222D	T23222S	T23231A	T23231D	T23231S
T23232A	T23232D	T23232S	T23241A	T23241D	T23241S	T23242A	T23242D
T23242S	T23251A	T23251D	T23251S	T23252A	T23252D	T23252S	T23261A
T23261D	T23261S	T23262A	T23262D	T23262S	T23271A	T23271D	T23271S
T23272A	T23272D	T23272S	T23291A	T23291D	T23291S	T23292A	T23292D
T23292S	T23301A	T23301D	T23301S	T23302A	T23302D	T23302S	T23311A
T23311D	T23311S	T23312A	T23312D	T23312S	T23321A	T23321D	T23321S
T23322A	T23322D	T23322S	T23331A	T23331D	T23331S	T23332A	T23332D
T23332S	T23341A	T23341D	T23341S	T23342A	T23342D	T23342S	T23351A
T23351D	T23351S	T23352A	T23352D	T23352S	T23361A	T23361D	T23361S
T23362A	T23362D	T23362S	T23371A	T23371D	T23371S	T23372A	T23372D
T23372S	T23391A	T23391D	T23391S	T23392A	T23392D	T23392S	T23401A
T23401D	T23401S	T23402A	T23402D	T23402S	T23411A	T23411D	T23411S
T23412A	T23412D	T23412S	T23421A	T23421D	T23421S	T23422A	T23422D
T23422S	T23431A	T23431D	T23431S	T23432A	T23432D	T23432S	T23441A
T23441D	T23441S	T23442A	T23442D	T23442S	T23451A	T23451D	T23451S
T23452A	T23452D	T23452S	T23461A	T23461D	T23461S	T23462A	T23462D
T23462S	T23471A	T23471D	T23471S	T23472A	T23472D	T23472S	T23491A
T23491D	T23491S	T23492A	T23492D	T23492S	T23501A	T23501D	T23501S
T23502A	T23502D	T23502S	T23511A	T23511D	T23511S	T23512A	T23512D
T23512S	T23521A	T23521D	T23521S	T23522A	T23522D	T23522S	T23531A
T23531D	T23531S	T23532A	T23532D	T23532S	T23541A	T23541D	T23541S
T23542A	T23542D	T23542S	T23551A	T23551D	T23551S	T23552A	T23552D

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Diagnosis Codes							
T23552S	T23561A	T23561D	T23561S	T23562A	T23562D	T23562S	T23571A
T23571D	T23571S	T23572A	T23572D	T23572S	T23591A	T23591D	T23591S
T23592A	T23592D	T23592S	T23601A	T23601D	T23601S	T23602A	T23602D
T23602S	T23611A	T23611D	T23611S	T23612A	T23612D	T23612S	T23621A
T23621D	T23621S	T23622A	T23622D	T23622S	T23631A	T23631D	T23631S
T23632A	T23632D	T23632S	T23641A	T23641D	T23641S	T23642A	T23642D
T23642S	T23651A	T23651D	T23651S	T23652A	T23652D	T23652S	T23661A
T23661D	T23661S	T23662A	T23662D	T23662S	T23671A	T23671D	T23671S
T23672A	T23672D	T23672S	T23691A	T23691D	T23691S	T23692A	T23692D
T23692S	T23701A	T23701D	T23701S	T23702A	T23702D	T23702S	T23711A
T23711D	T23711S	T23712A	T23712D	T23712S	T23721A	T23721D	T23721S
T23722A	T23722D	T23722S	T23731A	T23731D	T23731S	T23732A	T23732D
T23732S	T23741A	T23741D	T23741S	T23742A	T23742D	T23742S	T23751A
T23751D	T23751S	T23752A	T23752D	T23752S	T23761A	T23761D	T23761S
T23762A	T23762D	T23762S	T23771A	T23771D	T23771S	T23772A	T23772D
T23772S	T23791A	T23791D	T23791S	T23792A	T23792D	T23792S	T24001A
T24001D	T24001S	T24002A	T24002D	T24002S	T24011A	T24011D	T24011S
T24012A	T24012D	T24012S	T24021A	T24021D	T24021S	T24022A	T24022D
T24022S	T24031A	T24031D	T24031S	T24032A	T24032D	T24032S	T24091A
T24091D	T24091S	T24092A	T24092D	T24092S	T24101A	T24101D	T24101S
T24102A	T24102D	T24102S	T24111A	T24111D	T24111S	T24112A	T24112D
T24112S	T24121A	T24121D	T24121S	T24122A	T24122D	T24122S	T24131A
T24131D	T24131S	T24132A	T24132D	T24132S	T24191A	T24191D	T24191S
T24192A	T24192D	T24192S	T24201A	T24201D	T24201S	T24202A	T24202D
T24202S	T24211A	T24211D	T24211S	T24212A	T24212D	T24212S	T24221A
T24221D	T24221S	T24222A	T24222D	T24222S	T24229A	T24229D	T24229S
T24231A	T24231D	T24231S	T24232A	T24232D	T24232S	T24291A	T24291D
T24291S	T24292A	T24292D	T24292S	T24301A	T24301D	T24301S	T24302A
T24302D	T24302S	T24311A	T24311D	T24311S	T24312A	T24312D	T24312S
T24321A	T24321D	T24321S	T24322A	T24322D	T24322S	T24331A	T24331D
T24331S	T24332A	T24332D	T24332S	T24391A	T24391D	T24391S	T24392A
T24392D	T24392S	T24401A	T24401D	T24401S	T24402A	T24402D	T24402S
T24411A	T24411D	T24411S	T24412A	T24412D	T24412S	T24421A	T24421D
T24421S	T24422A	T24422D	T24422S	T24431A	T24431D	T24431S	T24432A
T24432D	T24432S	T24491A	T24491D	T24491S	T24492A	T24492D	T24492S
T24501A	T24501D	T24501S	T24502A	T24502D	T24502S	T24511A	T24511D
T24511S	T24512A	T24512D	T24512S	T24521A	T24521D	T24521S	T24522A
T24522D	T24522S	T24531A	T24531D	T24531S	T24532A	T24532D	T24532S
T24591A	T24591D	T24591S	T24592A	T24592D	T24592S	T24601A	T24601D
T24601S	T24602A	T24602D	T24602S	T24611A	T24611D	T24611S	T24612A

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Diagnosis Codes							
T24612D	T24612S	T24621A	T24621D	T24621S	T24622A	T24622D	T24622S
T24631A	T24631D	T24631S	T24632A	T24632D	T24632S	T24691A	T24691D
T24691S	T24692A	T24692D	T24692S	T24701A	T24701D	T24701S	T24702A
T24702D	T24702S	T24711A	T24711D	T24711S	T24712A	T24712D	T24712S
T24721A	T24721D	T24721S	T24722A	T24722D	T24722S	T24731A	T24731D
T24731S	T24732A	T24732D	T24732S	T24791A	T24791D	T24791S	T24792A
T24792D	T24792S	T25011A	T25011D	T25011S	T25012A	T25012D	T25012S
T25021A	T25021D	T25021S	T25022A	T25022D	T25022S	T25031A	T25031D
T25031S	T25032A	T25032D	T25032S	T25091A	T25091D	T25091S	T25092A
T25092D	T25092S	T25111A	T25111D	T25111S	T25112A	T25112D	T25112S
T25121A	T25121D	T25121S	T25122A	T25122D	T25122S	T25131A	T25131D
T25131S	T25132A	T25132D	T25132S	T25191A	T25191D	T25191S	T25192A
T25192D	T25192S	T25211A	T25211D	T25211S	T25212A	T25212D	T25212S
T25221A	T25221D	T25221S	T25222A	T25222D	T25222S	T25231A	T25231D
T25231S	T25232A	T25232D	T25232S	T25291A	T25291D	T25291S	T25292A
T25292D	T25292S	T25311A	T25311D	T25311S	T25312A	T25312D	T25312S
T25321A	T25321D	T25321S	T25322A	T25322D	T25322S	T25331A	T25331D
T25331S	T25332A	T25332D	T25332S	T25391A	T25391D	T25391S	T25392A
T25392D	T25392S	T25411A	T25411D	T25411S	T25412A	T25412D	T25412S
T25421A	T25421D	T25421S	T25422A	T25422D	T25422S	T25431A	T25431D
T25431S	T25432A	T25432D	T25432S	T25491A	T25491D	T25491S	T25492A
T25492D	T25492S	T25511A	T25511D	T25511S	T25512A	T25512D	T25512S
T25521A	T25521D	T25521S	T25522A	T25522D	T25522S	T25531A	T25531D
T25531S	T25532A	T25532D	T25532S	T25591A	T25591D	T25591S	T25592A
T25592D	T25592S	T25611A	T25611D	T25611S	T25612A	T25612D	T25612S
T25621A	T25621D	T25621S	T25622A	T25622D	T25622S	T25631A	T25631D
T25631S	T25632A	T25632D	T25632S	T25711A	T25711D	T25711S	T25712A
T25712D	T25712S	T25721A	T25721D	T25721S	T25722A	T25722D	T25722S
T25731A	T25731D	T25731S	T25732A	T25732D	T25732S	T25791A	T25791D
T25791S	T25792A	T25792D	T25792S	T2601XA	T2601XD	T2601XS	T2602XA
T2602XD	T2602XS	T2611XA	T2611XD	T2611XS	T2612XA	T2612XD	T2612XS
T2621XA	T2621XD	T2621XS	T2622XA	T2622XD	T2622XS	T2631XA	T2631XD
T2631XS	T2632XA	T2632XD	T2632XS	T2641XA	T2641XD	T2641XS	T2642XA
T2642XD	T2642XS	T2651XA	T2651XD	T2651XS	T2652XA	T2652XD	T2652XS
T2661XA	T2661XD	T2661XS	T2662XA	T2662XD	T2662XS	T2671XA	T2671XD
T2671XS	T2672XA	T2672XD	T2672XS	T2681XA	T2681XD	T2681XS	T2682XA
T2682XD	T2682XS	T2691XA	T2691XD	T2691XS	T2692XA	T2692XD	T2692XS
T271XXA	T271XXD	T271XXS	T275XXA	T275XXD	T275XXS	T280XXA	T280XXD
T280XXS	T281XXA	T281XXD	T281XXS	T282XXA	T282XXD	T282XXS	T283XXA
T283XXD	T283XXS	T2840XA	T2840XD	T2840XS	T28411A	T28411D	T28411S

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Diagnosis Codes							
T28412A	T28412D	T28412S	T2849XA	T2849XD	T2849XS	T285XXA	T285XXD
T285XXS	T286XXA	T286XXD	T286XXS	T287XXA	T287XXD	T287XXS	T288XXA
T288XXD	T288XXS	T2890XA	T2890XD	T2890XS	T28911A	T28911D	T28911S
T28912A	T28912D	T28912S	T2899XA	T2899XD	T2899XS	T300	T304
T310	T3110	T3111	T3120	T3121	T3122	T3130	T3131
T3132	T3133	T3140	T3141	T3142	T3143	T3144	T3150
T3151	T3152	T3153	T3154	T3155	T3160	T3161	T3162
T3163	T3164	T3165	T3166	T3170	T3171	T3172	T3173
T3174	T3175	T3176	T3177	T3180	T3181	T3182	T3183
T3184	T3185	T3186	T3187	T3188	T3190	T3191	T3192
T3193	T3194	T3195	T3196	T3197	T3198	T3199	T320
T3210	T3211	T3220	T3221	T3222	T3230	T3231	T3232
T3233	T3240	T3241	T3242	T3243	T3244	T3250	T3251
T3252	T3253	T3254	T3255	T3260	T3261	T3262	T3263
T3264	T3265	T3266	T3270	T3271	T3272	T3273	T3274
T3275	T3276	T3277	T3280	T3281	T3282	T3283	T3284
T3285	T3286	T3287	T3288	T3290	T3291	T3292	T3293
T3294	T3295	T3296	T3297	T3298	T3299		

Procedure codes 15782, 15783, 15792, 15793, and 17999 require prior authorization. Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the anticipated procedure. This documentation must remain in the client's medical record and is subject to retrospective review. To avoid unnecessary denials, the physician must provide correct and complete information.

Dermabrasion procedures (procedure codes 15782 and 15783) and chemical peel procedures (procedure codes 15792 and 15793) may be prior authorized with documentation that the client meets all of the following criteria:

- A diagnosis of actinic keratosis with more than three lesions.
- Failed conservative treatment or documentation that conservative treatment is contraindicated.

Prior authorization requests for procedure code 17999 must include the following documentation:

- A clear, concise description of the procedure to be performed.
- Reason for recommending the particular procedure.
- Documentation that a specific procedure code is not available for the procedure requested.
- The client's diagnosis.
- Medical records indicating prior treatment for the diagnosis and the medical necessity of the requested procedure.
- Place of service the procedure is to be performed.
- Documentation that the procedure is not investigational or experimental.
- The physician's intended fee for the procedure including a comparable procedure code.

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9.2.72 Sleep Studies

Sleep study procedure code 95806 is not a benefit of Texas Medicaid.

9.2.72.1 Actigraphy

Actigraphy (procedure code 95803) may be reimbursed in the office or outpatient hospital setting with a limit of one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Actigraphy can be performed as a stand-alone procedure or as an adjunct to polysomnography or multiple sleep latency test (MSLT).

Actigraphy (procedure code 95803) must be billed with one of the following diagnosis codes:

Diagnosis Codes							
F5104	F5105	F5113	G2581	G4700	G4701	G4709	G4710
G4711	G4712	G4713	G4714	G4719	G4720	G4721	G4722
G4723	G4724	G4725	G4726	G4727	G4729	G4761	

If the primary care physician performs the actigraphy, the technical component must be billed (procedure code 95803 with modifier TC).

Documentation of actigraphy must include a hard-copy printout or electronic file. Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's professional interpretation and report must include inspection of the entire recording and integration of the information gathered from other professionals' analysis and observations. Documentation of the interpretation must be maintained by the interpreting physician.

Under the following conditions, actigraphy may be a useful adjunct to a detailed history, examination, and subjective sleep diary for the diagnosis and treatment of insomnia, circadian-rhythm disorders, and excessive sleepiness:

- When demonstration of multiday rest-activity patterns is necessary to diagnose, document severity, and guide the proper treatment.
- When more objective information regarding the day-to-day timing or the amount or patterns of a client's sleep is necessary for optimal clinical decision-making.
- When the severity of a sleep disturbance reported by the client or caretaker seems inconsistent with clinical impressions or laboratory findings.
- To clarify the effects of, and under some instances, compliance with pharmacologic, behavioral, phototherapeutic, or chronotherapeutic treatment.
- In symptomatic clients for whom an accurate history cannot be obtained and at least one of the following is true:
    - A polysomnographic study has already been conducted.
    - A polysomnographic study is considered unlikely to be of much diagnostic benefit.
    - A polysomnographic study is not yet clearly indicated (because of the absence of accurate historical data).
    - A polysomnographic study is not immediately available.

Actigraphy may be useful in the assessment of specific aspects of the following disorders:

- Insomnia. Assessment of sleep variability, measurement of treatment effects, and detection of sleep phase alterations in insomnia secondary to circadian rhythm disturbance.

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- Restless legs syndrome or periodic limb movement disorder. Assessment of treatment effects.

9.2.72.2 Pneumocardiograms

Pneumocardiograms (procedure code 95807) are limited to clients who are birth through 12 months of age.

Pneumocardiograms are limited to one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Procedure code 95807 must be billed with one of the following diagnosis codes:

Diagnosis Codes							
G4731	G4733	G4734	G4735	G4736	G4737	P282	P2830
P2831	P2832	P2833	P2839	P2840	P2841	P2842	P2843
P2849	P285	P2911	P2912	R063	R0681	R0902	R230
R6813							

Documentation of the complete readings associated with the pneumocardiogram and the physician's interpretation must be maintained in the client's medical record in a hard-copy printout or electronic file at the facility where the procedure is performed.

The physician's interpretation and report must include inspection and integration of the information gathered from all physiological systems and other professionals' analysis and observations.

9.2.72.3 Polysomnography

Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is a benefit of Texas Medicaid.

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a 1-to 4- lead electroencephalogram (EEG), electro-oculogram (EOG), and a limb or submental electro-myogram (EMG).

Additional parameters of sleep that are evaluated in polysomnography include, but are not limited to, the following:

- ECG
- Airflow (by thermistor or intra-nasal pressure monitoring)
- Respiratory effort
- Adequacy of oxygenation by oximetry or transcutaneous monitoring
- Extremity movement or motor activity
- EEG monitoring for sleep staging
- Nocturnal penile tumescence
- Esophageal pH or intraluminal pressure monitoring
- Continuous blood pressure monitoring
- Snoring
- Body positions
- Adequacy of ventilation by end-tidal or transcutaneous CO2 monitoring

For a sleep study to be reported as a polysomnography, sleep must be recorded and staged. Use the following procedure codes to bill for polysomnography studies: 95782, 95783, 95808, 95810, and 95811.

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Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is limited to one per day and two per rolling year by any provider and is allowed for the following diagnosis codes:

Diagnosis Codes							
E6601	E662	F10182	F10282	F10982	F11182	F11282	F11982
F13182	F13282	F13982	F14182	F14282	F14982	F15182	F15282
F15982	F19182	F19282	F19982	F5101	F5102	F5103	F5104
F5105	F5109	F5111	F5112	F5113	F5119	F513	F514
F515	F518	F519	G120	G121	G1221	G128	G2581
G373	G4700	G4701	G4710	G4711	G4712	G4713	G4719
G4720	G4721	G4722	G4723	G4724	G4725	G4726	G4727
G4729	G4730	G4731	G4732	G4733	G4734	G4735	G4736
G4737	G4739	G47411	G47419	G47421	G47429	G4750	G4751
G4752	G4753	G4754	G4759	G4761	G4762	G4763	G4769
G478	G479	G7100	G7101	G7102	G7109	G7120	G7121
G71220	G71228	G7129	G809	G8250	G901	G931	J353
J9610	J9611	J9612	N5201	N5202	N5203	N521	N5235
N5236	N5237	Q040	Q041	Q042	Q078	Q308	Q311
Q312	Q313	Q315	Q318	Q320	Q321	Q322	Q323
Q324	Q672	Q673	Q674	Q75001	Q75002	Q75009	Q7501
Q75021	Q75022	Q75029	Q7503	Q75041	Q75042	Q75049	Q75051
Q75052	Q75058	Q7508	Q751	Q752	Q753	Q754	Q755
Q758	Q759	Q770	Q771	Q773	Q774	Q775	Q777
Q778	Q779	Q781	Q789	Q870	R0681	R0902	

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of the polysomnography testing must be maintained in the client's medical record at the sleep facility and include approximately 1,000 pages or the electronically-stored equivalent of data during a single nighttime recording. Each record must be for sleep-wake states and stages, cardiac arrhythmias, respiratory events, motor activity, oxygen desaturations, and behavioral observations.

Documentation must also include the technologist's analysis and report, the patient's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's professional interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

9.2.72.4 Multiple Sleep Latency Test (MSLT)

Multiple sleep latency test (procedure code 95805) is limited to one per day and two per rolling year by any provider, and is restricted to the following diagnosis codes:

Diagnosis Codes							
E662	F5104	F5105	G2581	G4700	G4701	G4709	G4730
G47411	G47419	G47421	G47429	G4753	G4761		

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Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client's medical record at the sleep facility and include a hard copy or electronic copy of four to five 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG
- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist's analysis and report, the client's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95782, 95783, 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.72.5 Home Sleep Study Test

Home sleep study tests are unattended studies that are performed in the client's home using a portable monitoring device. The portable monitoring device must meet American Academy of Sleep Medicine (AASM) practice parameters and clinical guidelines.

Home sleep study testing is a benefit of Texas Medicaid only when performed in conjunction with a comprehensive sleep evaluation that has been performed by a physician who is board-certified or board-eligible, as outlined in the AASM guidelines. Documentation of the comprehensive sleep evaluation must be kept in the client's medical record. The evaluation must indicate probability of moderate to severe obstructive sleep apnea to support medical necessity for home sleep study testing.

Procedure code 95800 applies to a device that measures three or more channels, including pulse oximetry, actigraphy, and peripheral arterial tone (PAT).

Procedure codes 95800, G0398, G0399, and G0400 are a benefit for Texas Medicaid clients who are 18 years of age or older with suspected or proven simple, uncomplicated obstructive sleep apnea. Procedure codes G0398, G0399, and G0400 are restricted to diagnosis code G4733.

Home sleep study tests are payable to physicians in the office setting. Procedure codes 95800, G0398, G0399, and G0400 are limited to one per day and a combined total of two tests per rolling year, with any provider. If a client needs more than two tests in a rolling year, subsequent tests must be performed in a sleep facility.

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9.2.72.6 Sleep Facility Restrictions for Polysomnography and Multiple Sleep Latency Testing

Sleep facilities that perform services for Medicaid clients must be accredited with the AASM or the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). Sleep facilities must maintain documentation with proof that the facility is accredited. Documentation is subject to retrospective review. Sleep facilities that perform services for Texas Medicaid clients must also follow current AASM practice parameters and clinical guidelines.

Physicians who provide supervision in sleep facilities must be board-certified or board-eligible, as outlined in the AASM guidelines.

Sleep facility technicians, technologists, and trainees must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

Polysomnographic technologists, technicians, and trainees must meet the following supervision requirements:

- A polysomnographic trainee provides basic polysomnographic testing and associated interventions under the direct supervision of a polysomnographic technician, polysomnographic technologist, or a physician.

  Note: *Direct supervision means that the supervising licensed/certified professional must be present in the office suite or building and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the supervising professional must be present in the room while the service is provided.*

- A polysomnographic technologist provides comprehensive evaluation and treatment of sleep disorders under the general supervision of the clinical director (MD or DO).
- A polysomnographic technician provides comprehensive polysomnographic testing and analysis and associated interventions under the general supervision of a polysomnographic technologist or clinical director (MD or DO).
- The supervising physician must be readily available to the performing technologist throughout the duration of the study, but is not required to be in the building.

The sleep facility must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualifications of the nonphysician staff who use the equipment.

Services provided without the required level of supervision are not considered medically appropriate and will be recouped upon retrospective record review.

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client's medical record at the sleep facility and include a hard copy or electronic copy of four to five, 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG

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- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist's analysis and report, the client's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.73 Speech Therapy (ST) Services

Speech therapy (ST) is a payable benefit to physicians.

Refer to: Section 4, "Therapy Services Overview" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about speech therapy services provided by a physician.

9.2.74 Surgery Billing Guidelines

9.2.74.1 Primary Surgeon

A primary surgeon may be reimbursed for services provided in the inpatient hospital, outpatient hospital setting, and ASC/HASC Center.

A surgeon billing for a surgery and an assistant surgery fee on the same day may be reimbursed if two separate procedures are performed.

Refer to: Subsection 9.2.74.7, "Multiple Surgeries" in this handbook.

9.2.74.2 Anesthesia Administered by Surgeon

If the physician bills for a surgical procedure and anesthesia for the same procedure, the surgery is paid and the anesthesia is denied as part of the surgical procedure. The exception to this policy is an epidural during labor and delivery.

Refer to: Subsection 9.2.7, "Anesthesia" in this handbook.

9.2.74.3 Assistant Surgeon

Assistant surgeons may be reimbursed 16 percent of the TMRM fee for the surgical procedures performed.

Medicaid follows the TEFRA regulations for assistant surgeons in teaching hospitals. TEFRA states that an assistant surgeon will not be paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician's specialty. Medicaid may consider reimbursement for an assistant surgeon at a teaching hospital classified by Medicare as a teaching facility with approved graduate training program if one of the following situations is present and documented on the claim:

- No qualified resident was available. (Modifier 82 may be used to document this exception.)
- There were exceptional medical circumstances such as an emergency or life-threatening situation requiring immediate attention (modifiers 80 and KX).
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of a patient (modifiers 80 and KX).

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- The surgical procedure was complex and required a team of physicians (modifiers 80 and KX).

Use of these modifiers is not required but expedites claims processing. Therefore, it is *recommended* that these modifiers be used in conjunction with the procedure code rather than a narrative statement when these specific circumstances exist.

All claims for assistant surgeon services must include in Block 32 of the CMS-1500 paper claim form the name, address, and NPI of the hospital in which the surgery was performed. If the physician seeks an exception to this TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or attached to the claim form:

> "I understand that section 1842(b)(6)(D) of the Social Security Act generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP."

Surgical procedures that do not ordinarily require the services of an assistant, as identified by Medicare, are denied when billed as an assistant surgery. One assistant surgeon is reimbursed for surgical procedures when appropriate.

Use modifier AS when the physician assistant is not enrolled as an individual provider and provides assistance at surgery. The claim must include the PA's name and license number. Only procedures currently allowed for assistant surgeons are payable.

PAs actively enrolled as a Medicaid provider with an assigned NPI may bill assistant surgery services on a separate claim form using the PA's individual NPI and modifiers U7 and 80.

9.2.74.4 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of 1 for each code. For all procedures, use modifiers LT (left) and RT (right) as appropriate. For example, bilateral application of short leg cast is billed as follows:

Procedure Code	Modifier
29405	LT
29405	RT

9.2.74.5 Cosurgery

Cosurgery (two surgeons) may be reimbursed when the skills of two surgeons (usually with different skills) are required in the management of a specific surgical procedure. Cosurgery is for a surgery where the two surgeons' separate contributions to the successful outcome of the procedure are considered to be of equal importance.

> ***Note:*** *No additional reimbursement will be made for an assistant surgeon.*

Cosurgeons may be reimbursed for surgical procedure codes that are billed with modifier 62 if the CMS fee schedule indicates that the procedure allows for cosurgeons. Claims will not suspend for manual review of the documentation of medical necessity. Reimbursement will be calculated at 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure's fee.

No cosurgery payment is made for claims submitted without modifier 62. In instances where the surgeons do not use modifier 62, the first claim received at TMHP for the service is considered that of the primary surgeon, and the subsequent claim is denied as a previously paid service.

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9.2.74.6 Global Fees

Texas Medicaid uses global surgical periods to determine reimbursement for services that are related to surgical procedures. The following services are included in the global surgical period:

- Preoperative care, including history and physical
- Hospital admission work-up
- Anesthesia (when administered and monitored by the primary surgeon)
- Surgical procedure (intraoperative)
- Postoperative follow-up and related services
- Complications following the surgical procedure that do not require return trips to the operating room

Texas Medicaid adheres to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows:

- 0-day Global Period-Reimbursement includes the surgical procedure and all associated services that are provided on the same day.
- 10-day Global Period-Reimbursement includes the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 10 days following the date of the surgical procedure.
- 90-day Global Period-Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 90 days following the date of the surgical procedure.

Procedure codes that are designated as "Carrier Discretion" will have their global periods determined by HHSC.

Note: *All unlisted surgical procedure codes have a 42 day global period assigned by Texas Medicaid.*

The global surgical fee period applies to both emergency and nonemergency surgical procedures. Physicians who are in the same group practice and specialty must bill, and are reimbursed, as if they were a single provider.

Modifiers

For services that are rendered in the preoperative, intraoperative, or postoperative period to be correctly reimbursed, providers must use the appropriate modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

Modifiers Related to Surgical Fees					
24	25	54	55	56	57
58	62	76	77	78	79

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the physician who provides preoperative or postoperative care. Reimbursement for claims associated with modifier 54, 55, or 56 is limited to the same total amount as would have been paid if only one physician provided all of the care, regardless of the number of physicians who actually provide the care.

If a physician provided all of the preoperative, intraoperative, and postoperative care, claims may be considered for reimbursement when they are submitted without a modifier.

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Documentation Requirements

For services that are billed with any of the listed modifiers to be considered for reimbursement, providers must maintain documentation in the client's medical record that supports the medical necessity of the services. Acceptable documentation includes, but is not limited to, progress notes, operative reports, laboratory reports, and hospital records.

On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed.

Note: *Retrospective review may be performed to ensure that the submitted documentation supports the medical necessity of the surgical procedure and any modifier used to bill the claim.*

Preoperative Services

Preoperative physician E/M services (such as office or hospital visits) that are directly related to the planned surgical procedure and provided during the preoperative limitation period will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a significant, separately identifiable service may be billed with modifier 25 if they are provided on the same day by the same provider as the surgical procedure.

Modifier 25 is not used to report an E/M service that results in a decision to perform a surgical procedure. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request. If the decision to perform a minor procedure is made during an E/M visit immediately before the surgical procedure, the E/M visit is considered a routine preoperative service and is not separately billable.

Physicians who provide only preoperative services for surgical procedures with a 10- or 90-day global period may submit claims using the surgical procedure code with the identifying modifier 56. Reimbursement will be limited to a percentage of the fee for the surgical procedure.

E/M services that are provided during the preoperative period (one day before or the same day) of a major surgical procedure (90-day global period) and result in the initial decision to perform the surgical procedure may be considered for reimbursement when billed with modifier 57. The client's medical record must clearly indicate when the initial decision to perform the procedure was made.

Intraoperative Services

Physicians who perform a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with modifier 54. Modifier 54 indicates that the surgeon provided the surgical care only. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

Postoperative services

Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not reimbursed separately. Postoperative services include, but are not limited to, all of the following:

- Postoperative follow-up visits (any place of service)
- Postoperative pain management
- Miscellaneous services, including:
  - Dressing changes
  - Local incision care

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- Platelet gel
- Removal of operative packs
- Removal of cutaneous sutures, staples, lines, wires, drains, casts, or splints
- Replacement of vascular access lines
- Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes
- Changes or removal of tracheostomy tubes

Note: *Removal of postoperative dressings or anesthetic devices is not eligible for separate reimbursement as the removal is considered part of the allowance for the primary surgical procedure.*

If the surgeon provides the surgery and only the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

- The surgical procedure, date of the surgery, and modifier 54, which indicates that he or she was the surgeon.
- The surgical procedure, date of service, and modifier 55 to denote the postoperative care.

Note: *Providers must not submit a claim for the postoperative care until after the client has been seen during a face-to-face follow-up visit.*

When a transfer of care occurs for postoperative care for procedures that have a 10- or 90-day global period, the following conditions apply:

- When transfer of care occurs immediately after surgery, the surgeon or other provider assuming in-hospital postoperative care must bill subsequent care procedure code 99231, 99232, or 99233.
- When the transfer of care occurs after hospital discharge, the surgeon or other provider who provides postdischarge care must bill the appropriate surgical code with modifier 55. Reimbursement will be limited to a percentage of the allowable fee for the surgical procedure.
- Documentation in the medical record must include all of the following:
  - A copy of the written transfer agreement.
  - The dates the care was assumed and relinquished.
- The claim must indicate in the comments field of the claim form the dates on which care was assumed and relinquished, and the units field must reflect the total number of postoperative care days provided. Claims that are submitted on the CMS-1500 paper claim form must include the date of surgery in Block 14 and the dates on which care was assumed and relinquished in Block 19.

Staged or related surgical procedures or services that are performed during the postoperative period may be reimbursed when they are billed with modifier 58. A postoperative period will be assigned to the subsequent procedure. Documentation must indicate that the subsequent procedure or service was not the result of a complication and any of the following:

- It was planned at the time of the initial surgical procedure.
- It is more extensive than the initial surgical procedure.
- It is for therapy following an invasive diagnostic surgical procedure.

Note: *Modifier 58 does not apply to procedure codes that are already defined as staged or sessioned services in the Current Procedural Terminology (CPT) Manual (e.g., 65855 or 66821).*

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Hospital visits by the surgeon during the same hospitalization as the surgery are considered to be related to the surgery and, as a result, not separately billable; however, separate payment for such visits can be allowed if any of the following conditions apply:

- Immunotherapy management is provided by the transplant surgeon. Immunosuppressant therapy following transplant surgery is covered separately from other postoperative services, so postoperative immunosuppressant therapy is not part of the global fee allowance for the transplant surgery. This coverage applies regardless of the setting.
- Critical care is provided by the surgeon for a burn or trauma patient.
- The hospital visit is for a diagnosis that is unrelated to the original surgery.

E/M services that are provided by the same provider for reasons that are unrelated to the operative surgical procedure may be considered for reimbursement if they are billed with modifier 24. The submitted documentation must substantiate the reasons for providing E/M services.

- Modifier 24 may be billed with modifier 25 if a significant, separately identifiable E/M service that was performed on the day of a procedure falls within the postoperative period of another unrelated procedure.
- Modifier 24 may be billed with modifier 57 if an E/M service that was performed within the postoperative period of another unrelated procedure results in the decision to perform major surgery.

Return Trips to the Operating Room

Return trips to the operating room for a repeat surgical procedure on the same part of the body may be considered for reimbursement when billed with modifiers 76 and 77. Billing with modifier 76 or 77 initiates the beginning of a new global period. Medical record documentation must support the need for a repeat procedure.

All surgical procedure codes with a predefined limitation (e.g., once per lifetime, one every 5 years) must not be submitted with modifier 76 or 77.

For modifiers 76 and 77, the repeated procedure must be the same as the initial surgical procedure. The repeat procedure must be billed with the appropriate modifier. The reason for the repeat surgical procedure should be entered in the narrative field on the claim form.

Return trips to the operating room for surgical procedures that are related to the initial surgery (i.e., complications) may be considered for reimbursement when they are billed with modifier 78 by the same provider.

- When a surgical procedure has a 0-day global period, the full value of the surgical procedure will be reimbursed; when the procedure has a 10- or 90-day global period only the intraoperative portion will be reimbursed.
- When an unlisted procedure is billed because no code exists to describe the treatment for the complications, reimbursement is a maximum of 50 percent of the value of the intraoperative services that were originally performed.

Reimbursement for the postoperative period of the first surgical procedure includes follow-up services from both surgical procedures, and no additional postoperative reimbursement is allotted. The global period will be based on the first surgical procedure.

Billing with modifier 78 does not begin a new global period.

Surgical procedures that are performed by the same provider during the postoperative period may be considered for reimbursement when they are billed with modifier 79 for any of the following:

- When the same procedure is performed with a different diagnosis.

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- When the same procedure is performed on the left and right side of the body in different operative sessions and that procedure is billed with the RT or LT modifier.
- When a different procedure is performed with the same diagnosis.
- When a different procedure is performed with a different diagnosis.

Billing with modifier 79 initiates a new global surgical period.

9.2.74.7 Multiple Surgeries

Medicaid payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day at the same operative session, the primary procedure (such as the higher paying procedure) is paid at the full TMRM allowance. Secondary procedures performed on the same day are paid at half of the TMRM allowance when medically justified.
- Surgical procedures performed at different operative sessions on the same day are paid at the full TMRM allowance for each primary procedure at each session.
- Vaginal deliveries followed by tubal ligations are considered different operative sessions and are paid at full allowance for each primary procedure at a different session (i.e., both vaginal delivery and tubal ligation are paid at full allowance).
- Procedure code 58611 performed in conjunction with a Cesarean section is reimbursed at full allowance in cases where the allowance already represents half of the primary procedure.
- When a surgical procedure and a biopsy on the same organ or structure is done on the same day, the charges will be reviewed and reimbursement will be made only for the service with the higher of the allowed amounts.

9.2.74.8 Office Procedures

CMS has identified certain surgical procedures that are more appropriately performed in the office setting rather than as outpatient hospital, ASC/HASC procedures. The following list of surgical procedure codes should be billed in POS 1 (physician's office). The medical necessity and/or special circumstances that dictate that these surgical procedures be performed in a POS other than the office must be documented on the claim. These surgical procedures are evaluated on a retrospective basis that may cause recoupment and/or adjustment of the original claim payment. This list is not all inclusive.

Procedure Codes		
Excision benign lesions	**Excision malignant lesions**	**Manipulation (urethral)**
11400	11600	53600
11401	11601	53601
11402	11602	53620
11403	11603	53621
11404	11604	53660
11420	11620	53661
11421	11621	
11422	11622	
11423	11623	
11440	11624	
11441	11640	
11442	11641	

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Procedure Codes		
11443	11642	
11444	11643	
	11644	
Simple repairs	**Endoscopy**	**Biopsy (tongue)**
28010	31505	41100
28011		
Lesions (penile)	**Lesions (eyelid)**	
54060	67801	

9.2.74.9 Orthopedic Hardware

Reimbursement for the orthopedic hardware (e.g., buried wire, pin, screw, metal band, nail, rod, or plate) is part of the surgeon's global fee or the facility's payment group. The hardware is not reimbursed separately to either the surgeon or the facility.

The removal of orthopedic hardware is not payable to the same provider who inserted it, if removed within the global operative care period of the original insertion.

Services for removal of orthopedic hardware may be reimbursed separately after the global post operative care period.

9.2.74.10 Second Opinions

Texas Medicaid benefits include payment to physicians when eligible clients request second opinions about specific problems. The claim must be coded with the appropriate office or hospital visit codes, and the notation "Client Initiated Second Opinion" should be identified in Block 24D of the CMS-1500 paper claim form.

Refer to: Subsection 9.2.60.4.4, "Office and Outpatient Consultation Services" in this handbook.

9.2.74.11 Supplies, Trays, and Drugs

Payment to physicians for supplies is not allowed under Texas Medicaid. All supplies, including anesthetizing agents, inhalants, surgical trays, or dressings are included in the surgical payment on the day of surgery when the surgery is performed in the office or home setting.

Reimbursement for office visits includes overhead for supplies. If any of these items are submitted separately, they are denied as included in the surgical fee. If the supplies are submitted with a place of service (POS) other than the office, these supplies are denied as services that must be billed by the hospital, or as services that are included in nursing facility charges.

Silver nitrate applicators, used to treat granulated tissue around gastrostomy tubes and tracheostomies, are considered part of the office/hospital visit. Silver nitrate applicators are not a benefit for home use.

9.2.75 Telemedicine Services

Telemedicine services are a benefit of Texas Medicaid.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for information about telemedicine services.

9.2.76 * Therapeutic Apheresis

The following conditions must be met for therapeutic apheresis:

- To perform the medical services, including all nonphysician services, and to respond to medical emergencies at all times during client care, direct supervision by a physician is required.

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- Each client must be under the care of a physician.

Procedure codes 36511, 36512, 36513, 36514, and 36516 are limited to the following diagnosis codes:

[Revised] Diagnosis Codes							
C8800	C8801	C8820	C8821	C8830	C8831	C8880	C8881
C9000	C9002	C9010	C9011	C9012	C9020	C9021	C9022
C9030	C9031	C9032	C9100	C9101	C9102	C9110	C9111
C9112	C9130	C9131	C9132	C9140	C9141	C9142	C9150
C9151	C9152	C9160	C9161	C9162	C9190	C9191	C9192
C91A0	C91A1	C91A2	C91Z0	C91Z1	C91Z2	C9200	C9201
C9202	C9210	C9211	C9212	C9220	C9221	C9222	C9230
C9231	C9232	C9240	C9241	C9242	C9250	C9251	C9252
C9260	C9261	C9262	C9290	C9291	C9292	C92A0	C92A1
C92A2	C92Z0	C92Z1	C92Z2	C9300	C9301	C9302	C9310
C9311	C9312	C9330	C9331	C9332	C9391	C9392	C93Z0
C93Z1	C93Z2	C9400	C9401	C9402	C9420	C9421	C9422
C9430	C9431	C9432	C9440	C9441	C9442	C9480	C9481
C9482	C9500	C9501	C9502	C9510	C9511	C9512	C9590
C9591	C9592	D45	D472	D473	D474	D47Z2	D5700
D5701	D5702	D5703	D5704	D5709	D571	D5720	D57211
D57212	D57213	D57214	D57218	D57219	D57412	D57413	D57414
D57418	D5742	D57431	D57432	D57433	D57434	D57438	D57439
D5744	D57451	D57452	D57453	D57454	D57458	D57459	D5780
D57811	D57812	D57813	D57814	D57818	D57819	D588	D589
D590	D5910	D5911	D5912	D5913	D5919	D592	D5930
D5931	D5932	D5939	D594	D599	D6182	D65	D682
D68311	D6851	D6852	D6859	D6861	D6862	D6869	D688
D690	D692	D693	D6941	D6942	D6949	D696	D698
D699	D72828	D732	D740	D748	D749	D750	D751
D7589	D759	D761	D762	D763	D77	D890	D892
D8940	D8941	D8942	D8943	D8949	E0842	E0942	E1042
E1142	E7800	E78010	E78011	E78019	E7841	E7849	G603
G610	G6181	G6182	G6189	G620	G621	G622	G6281
G6282	G63	G64	G650	G7000	G7001	G731	I00
I010	I012	I018	I019	I773	I776	I7789	K716
K7200	K7201	K7581	K759	K760	K762	K767	K7689
K77	K8041	K8043	K8045	K8047	K8061	K8063	K8065
K8081	L100	L101	L102	L103	L104	L105	L1081
L1089	L109	L900	L940	L941	L943	M05011	M05012
M05021	M05022	M05031	M05032	M05041	M05042	M05051	M05052
M05061	M05062	M05071	M05072	M0509	M05411	M05412	M05421
M05422	M05431	M05432	M05441	M05442	M05451	M05452	M05461

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[Revised] Diagnosis Codes							
M05462	M05471	M05472	M0549	M05611	M05612	M05621	M05622
M05631	M05632	M05641	M05642	M05651	M05652	M05661	M05662
M05671	M05672	M0569	M069	M08011	M08012	M08021	M08022
M08031	M08032	M08041	M08042	M08051	M08052	M08061	M08062
M08071	M08072	M0809	M080A	M083	M08411	M08412	M08421
M08422	M08431	M08432	M08441	M08442	M08451	M08452	M08461
M08462	M08471	M08472	M0848	M084A	M08832	M08841	M08842
M08851	M08852	M08861	M08931	M08932	M08941	M08942	M08951
M08952	M08961	M08962	M089A	M310	M3110	M3111	M3119
M320	M3210	M3219	M328	M3300	M3301	M3302	M3309
M3310	M3311	M3312	M3319	M3320	M3321	M3322	M3329
M3390	M3391	M3392	M3399	M340	M341	M342	M3481
M3482	M3483	M3489	N000	N001	N002	N003	N004
N005	N006	N007	N008	N00A	N00B1	N00B2	N010
N011	N012	N013	N014	N015	N016	N017	N018
N01A	N02B1	N02B2	N02B3	N02B4	N02B5	N02B6	N02B9
N032	N034	N035	N037	N03A	N040	N0420	N0421
N0422	N0429	N044	N045	N047	N048	N049	N04A
N04B1	N04B2	N052	N054	N055	N058	N059	N05A
N08	N171	N172	T8690	T8691	T8692	T8693	T8699

Procedure code 36516 may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as Liposorber LA 15) or the protein A immunoadsorption (such as Prosorba) columns.

The protein A immunoadsorption column is indicated for use in either of the following cases:

- Clients who have a platelet count of less than 100,000 mm3.
- Adult clients who have signs and symptoms of moderate to severe rheumatoid arthritis with long-standing disease who have failed, or are intolerant to, DMARDs.

The LDL apheresis column is indicated for use in clients who have severe familial hypercholesterolemia whose cholesterol levels remain elevated despite a strict diet and ineffective or untolerated maximum drug therapy. Coverage is considered for the following high-risk population, for whom diet has been ineffective and maximum drug therapy has either been ineffective or not tolerated:

- Functional hypercholesterolemia homozygotes with LDL-C > 500 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 300 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 200 mg/dL and documented coronary heart disease.

Baseline LDL-C levels are to be obtained after the client has had, at a minimum, a six-month trial on an American Heart Association (AHA) Step II diet or equivalent and maximum tolerated combination drug therapy designed to reduce LDL-C. Baseline lipid levels are to be obtained during a two- to four-week period and should be within 10 percent of each other, indicating a stable condition.

Therapeutic apheresis using the LDL apheresis column may be reimbursed for diagnosis code E780.

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Apheresis is denied for all other diagnosis codes. Other diagnosis codes can be reviewed by the TMHP Medical Director or designee on appeal with documentation of medical necessity.

Laboratory work before and during the apheresis procedure is covered when apheresis is performed in the outpatient setting (POS 5). Laboratory work billed in conjunction with apheresis performed in the inpatient setting (POS 3) is included in the DRG reimbursement and is not paid separately.

9.2.77 Therapeutic Phlebotomy

Therapeutic phlebotomy is a treatment whereby a prescribed amount of blood is withdrawn for medical reasons. Conditions that cause an elevation of the red blood cell volume or disorders that cause the body to accumulate too much iron may be treated by therapeutic phlebotomy.

Therapeutic phlebotomy is a benefit of Texas Medicaid and may be billed using procedure code 99195. This procedure code should be used only for the therapeutic form of phlebotomy and not for diagnostic reasons.

Reimbursement of therapeutic phlebotomy is limited to the following diagnosis codes:

Diagnosis Codes							
D45	D649	D750	D751	E800	E801	E8020	E8021
E8029	E8310	E83110	E83118	E8319	P611		

Therapeutic phlebotomy will be automatically denied for all other diagnosis codes.

9.2.78 Therapeutic Radiopharmaceuticals

Therapeutic radiopharmaceuticals, when used for therapeutic treatment, are a benefit of Texas Medicaid.

The following procedure codes may be submitted for therapeutic radiopharmaceuticals:

Procedure Codes								
79403	A9513	A9542	A9543	A9563	A9564	A9590	A9600	A9699

9.2.78.1 Prior Authorization for Therapeutic Radiopharmaceuticals

Prior authorization is required for ibritumomab tiuxetan procedure codes A9542 and A9543.

Only one ibritumomab tiuxetan (procedure codes A9542 and A9543) may be prior authorized and reimbursed once per lifetime, any provider with one of the following diagnosis codes:

Diagnosis Codes							
C8259	C8399	C8499	C84A9	C84Z9	C8519	C8529	C8589
C8599							

Ibritumomab tiuxetan may be prior authorized when all of the following criteria are met:

- Client has a diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy and the following is documented:
  - Marrow involvement is less than 26 percent.
  - Platelet count is 100,000 cell/mm3 or greater.
  - Neutrophil count is 1,500 cell/mm3 or greater.
- Client has failed a trial of rituximab.

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Prior authorization must be submitted through Special Medical Prior Authorization department.

Prior authorization is required for lutetium lu 177 dotatate (Lutathera) procedure code A9513.

Lutetium lu 177 dotatate (Lutathera) procedure code A9513 will be considered with documentation that meets all of the following criteria:

- The client has a diagnosis of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (one of the following diagnosis codes must be submitted on the prior authorization request: C7A00, C7A010, C7A011, C7A012, C7A019, C7A020, C7A021, C7A022, C7A023, C7A024, C7A025,C7A026,C7A029, C7A092, C7A094, C7A095, C7A096).
- The client is 18 years of age or older.
- The client is not pregnant or breastfeeding.
- The official pathology report documents a GEP-NET with Ki67 index less than 20 percent.
- The disease is metastatic, or locally advanced and unresectable as indicated by one of the following:
  - Positive somatostatin receptor scintigraphy with correlative magnetic resonance imaging (MRI)
  - Computed tomography (CT) imaging of metastatic measurable disease
  - 68-Ga-Dotate positron emission tomography (PET) scan positive for metastatic disease
- The client experienced disease progression while on a long-acting somatostatin analog (e.g. octreotide, lanreotide).
- The client has not had prior treatment with Peptide Receptor Radionuclide Therapy (PRRT), and has not had prior external radiation therapy to more than 25 percent of the bone marrow.
- The documentation includes an oncologist's or nuclear medicine specialist's complete written order and prescription for Lutetium lu 177 dotatate intravenous infusion.
- A treatment plan that includes all of the following documentation:
  - Lutetium lu 177 dotatate 7.4 GBq (200 mCi) every 60 days for a total of 4 doses that is administered in a facility under the control of a physician who is licensed and authorized to administer radiopharmaceuticals
  - The recommended use of premedication and concomitant medications of somatostatin analogs, antiemetics, and specialized amino acid solution
  - The restrictions and usage of long- and short-acting octreotide agents before, during, and after lutetium lu 177 dotatate intravenous infusions
  - Details of withholding the treatments for contraindicated circumstances including, but not limited to:
    - Thrombocytopenia
    - Anemia neutropenia
    - Renal toxicity
    - Hepatotoxicity
    - Other non-hematologic toxicities

Prior authorization requests must be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

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Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

An SMPA Request Form must be completed, signed, and dated by the prescribing provider. The SMPA form will not be accepted after 90 days from the date of the prescribing provider's signature.

The completed SMPA Request Form must be maintained by the prescribing provider in the client's medical record and is subject to retrospective review.

Section C of the SMPA Request Form under Statement of Medical Necessity must contain the following:

- Documentation of the client's dosage
- The administration schedule
- The number of injections to be administered during the prior authorization period
- The requested units/millicuries per injection
- The dosage calculation

To facilitate the determination of medical necessity and avoid unnecessary denials, the prescribing provider must submit correct and complete information, including documentation of medical necessity for the equipment or supplies requested, the procedure codes, and the numerical quantities for services requested. The provider must maintain documentation of medical necessity in the client's medical record.

Prior authorization must be requested through the Special Medical Prior Authorization (SMPA) department with appropriate documentation.

Requests can be mailed or faxed to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

9.2.78.1.1 Reimbursement Limitations for Ibritumomab tiuxetan and Lutetium lu 177 dotatate

Ibritumomab tiuxetan is indicated for the treatment of clients that have failed rituximab and have CD20 antigen-expressing relapsed or refractory, low grade, follicular, or transformed non-Hodgkin's lymphoma or refractory non-Hodgkin's lymphoma.

Ibritumomab tiuxetan may only be considered once per lifetime, any provider, and only one of the agents.

Lutetiem Lu 177 dotatate (Lutathera) intravenous injection (procedure code A9513) is indicated for the treatment of adult clients who are 18 years of age or older with a diagnosis of somastatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors. For all other indications, Lutetiem Lu 177 dotatate (Lutathera) injection for intravenous use is not proven to be medically effective and is considered experimental. Lutetium lu 177 dotatate (Lutathera) must be administered under the control of an oncologist or a nuclear medicine specialist who is licensed and authorized to administer radiopharmaceuticals and must be administered in an outpatient setting.

Lutetium lu 177 dotatate (Lutathera) procedure code A9513 is limited to one service every 60 days for a total of four services per lifetime, any provider.

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9.2.78.2 Other Limitations on Therapeutic Radiopharmaceuticals

Strontium-89 chloride (procedure code A9600) may be reimbursed when submitted with diagnosis code C7951 or C7952.

Strontium-89 chloride is limited to a total of 10 mci intravenously injected every 90 days, any provider.

Sodium phosphate P-32, therapeutic (procedure code A9563) may be reimbursed when submitted with the following diagnosis codes:

Diagnosis Codes							
C7951	C7952	C9110	C9112	C9192	C91Z2	C9292	C92Z2
C9512	C9592	D45					

Chromic phosphate P-32 suspension (procedure code A9564) may be reimbursed when submitted with diagnosis codes C782 and C786.

An appropriate modifier may be used when billing for services more than once per day, same provider.

Iodine i-131 iobenguane procedure code A9590 is a benefit for clients who are 12 years of age and older.

Iodine i-131 iobenguane is a radiopharmaceutical indicated for the treatment of adult and pediatric clients who are 12 years of age and older with iobenguane scan positive, unresectable, locally advanced or metastatic pheochromocytoma or paraganglioma who require systemic anticancer therapy. Iodine i-131 iobenguane should be handled with appropriate safety measures to minimize radiation exposure and should be administered by or under the control of physicians who are licensed and authorized to administer radiopharmaceuticals.

Procedure code A9590 is limited to the following diagnosis codes:

Diagnosis Codes						
C7410	C7411	C7412	C755	C7A1	C7A8	D447

9.2.79 Urethral Dilation

If urethral dilation (procedure code 53600, 53601, 53605, 53620, 53621, 53660, 53661, or 53665) is billed on the same date of service by the same provider as procedure code 52000, the charges will be combined and processed as procedure code 52281.

Urethral dilation will be denied when billed on the same date of service by the same provider as any other cystoscopy.

9.2.80 Ventilation Assist and Management for the Inpatient

Use the following procedure codes and guidelines for reimbursement of ventilation assist and management: 94002 and 94003. Procedure codes 94002 and 94003 may be reimbursed only when the client is in observation or inpatient status. Respiratory care billed in any other POS will be denied.

Use the ventilation assist and management subsequent code (procedure code 94003) when respiratory support must be established for a patient in the postoperative period in the hospital (POS 3). Subsequent days of ventilation assistance are payable when documentation indicates a respiratory problem.

When the use of a ventilator is required as part of a major surgery, initial ventilation assist and management will be denied. It should be billed as ventilation assist and management subsequent procedure code 94003.

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Procedure codes 94002 and 94003 apply only to hospital care for critically ill patients. They do not apply to routine recovery room ventilation services. Separate support service charges billed on the same day as ventilatory support are denied (for example, arterial or venous punctures; interpretations of arterial blood gases; or pulmonary function tests and management of the hemodynamic functions of the patient).

Use ventilation assist and management and initiation of pressure or volume preset ventilators for assisted or controlled breathing–first day (procedure coed 94002) when respiratory support must be established for a patient. It is a one-time charge per hospitalization that may be paid when the claim documents that a respiratory problem exists (for example, respiratory distress, asphyxia). After the first day, use subsequent days (procedure code 94003).

9.2.81 Wearable Cardiac Defibrillator (WCD)

A WCD (procedure codes 93292, 93745, and K0606) are a benefit of Texas Medicaid.

The rental of a WCD (procedure code K0606) is limited to once per month and must be submitted with modifier RR.

Modifier 25 may be used to identify a significant separately identifiable evaluation and management service performed (for example, different diagnosis) on the same day as the initial set up of a WCD by the same provider for the same client. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Procedure code 93292 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

Procedure codes 93000, 93005, 93010, 93040, 93041, and 93042 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

9.2.81.1 Prior Authorization for WCD

Prior authorization is required for the rental of WCD (procedure code K0606).

The WCD may be prior authorized for clients at high-risk of sudden cardiac arrest who meets one of the following criteria:

- Has completed electrophysiologic studies to determine the type of arrhythmia present and confirm that a wearable cardiac defibrillator is the best course of treatment.
- Is contraindicated for an implantable cardiac defibrillator (ICD) at the current time, such as with a systemic infection.
- Is waiting for ICD implantation.
- Is waiting for ICD implantation and is undergoing treatment for a systemic infection.
- Has had an ICD explantation due to pocket infection.
- Is waiting for heart transplantation.
- Has self-limiting arrhythmias from iatrogenic (drug loading with potentially pro-arrhythmic medications) or other causes.
- Has a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome or hypertrophic cardiomyopathy.
- Has had either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction (LVEF) less than or equal to 35 percent.
- Has received a documented diagnosis of any one of the following conditions:

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- Clinically inducible hemodynamically significant ventricular tachycardia (HSVT) or ventricular fibrillation (VF), where drug treatment has been ineffective, or the side effects of the medication used to treat the arrhythmia are intolerable.
- Inducible VT or VF despite endocardial ablation or surgical excision when drug therapy has failed.
- VF or syncopal ventricular tachycardia.
- Specific ST-T wave changes, borderline CPK-MB isoenzymes, and dangerous ventricular arrhythmias are exhibited in a postmyocardial infarction patient.
- VT caused by ischemic heart disease not associated with an acute myocardial infarction, and where drug therapy or surgical therapy has failed.
- Recurrent syncope of undetermined etiology in a patient with HSVT or VF induced by EPS in whom no effective or tolerated drug is available or appropriate. Symptoms must be linked to HSVT or VF.
- Recurrent syncope of undetermined etiology with positive EPS studies where ventricular arrhythmia is documented as the cause.
- Palliative treatment for VT or VF in clients awaiting heart transplant.

The WCD is contraindicated in clients with an active ICD and should not be used in clients who meet the following criteria:

- Have a vision or hearing problem that may interfere with the perception of alarms or messages from the WCD.
- Is taking medications that would interfere with responding to the alarms or message from the WCD by depressing buttons.
- Is unwilling or unable to wear the device continuously, except when bathing or showering.
- Is pregnant or breastfeeding.
- Is of childbearing age and is not attempting to prevent pregnancy.

The WCD is considered investigational and not medically necessary for all other indications, including but not limited to, the following:

- Clients with drug-refractory class IV congestive heart failure who is not candidates for heart transplantation.
- Clients who have a history of psychiatric disorders that interfere with the necessary care and follow-up.
- Clients in whom a reversible triggering factor for VT/VF can be definitely identified, such as ventricular tachyarrhythmias in evolving acute myocardial infarction or electrolyte abnormalities.
- Clients with terminal illnesses.

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form requesting the DME and/or supplies must be signed and dated by a physician familiar with the client before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

Note: *A physician assistant (PA), certified nurse practitioner (CNP), or clinical nurse specialist (CNS) is not allowed to sign the Title XIX form to lease a WCD.*

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The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department at 1-512-514-4209 or in writing to the following address:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977

When a WCD is not covered as a home health service, it may be considered for reimbursement through the CCP for clients who are 20 years of age and younger. All of the following criteria must be met for CCP reimbursement for a WCD:

- The client is eligible for CCP benefits.
- The documentation submitted with the request supports the determination of medical necessity based on the criteria listed in the policy.
- Federal financial participation is available.
- The client's cardiac status would be compromised without the requested equipment.
- The requested equipment is safe in the home setting.

Note: *For clients who are 21 years of age or older, requests for a WCD that does not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Rental of an automatic external defibrillator, with integrated electrocardiogram analysis, garment type (procedure code K0606) may be prior authorized (initially for up to three months) with documentation supporting the medical necessity and appropriateness of the device.

The provider may be reimbursed only for the length of time the device is used even though the authorization for the rental may be for a longer period of time.

The rental of the device includes the monitor, electrode belt (four sensors or electrodes and three treatment pads), garment, two rechargeable batteries, a battery charger and modem.

The purchase of a replacement battery (procedure code K0607), the purchase of a garment (procedure code K0608), and electrodes (procedure code K0609) will be considered part of the rental.

Prior authorization extensions for WCDs beyond the initial three-month rental may be considered by the medical director when documentation supports continued medical necessity for the device. Providers must submit new documentation to support continued medical necessity for an extension of the rental to be considered.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the device and is subject to retrospective review. The physician must maintain documentation of medical necessity in the client's medical record. The requesting DME provider may be asked for additional information to clarify or complete a request for the WCD.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when billing the claim.

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9.2.82 Wound Care Management

Wound care management includes the care of acute and chronic wounds, which include, but are not limited to, open ulcers (venous pressure or diabetic ulcers), fistulas, or erosion of skin related to cancer. Acute and chronic wounds are defined as the following:

- Acute wounds: Wounds taking less than or up to 30 days for complete healing
- Chronic wounds: Wounds taking more than 30 days for complete healing

Wound care includes the following:

- Optimization of nutritional status
- Debridement by any means to remove devitalized tissue
- Maintenance of a clean, moist bed of granulation tissue
- Necessary treatment to resolve any infection that may be present
- Education of the client or their caregiver on how to clean and properly dress their wound

For clients with an ulcer, wound care may include the following:

- Frequent repositioning of a client who has a pressure ulcer
- Off-loading pressure and good glucose control for a client who has a diabetic ulcer
- Establishment of adequate circulation for a client who has an arterial ulcer
- Use of a compression system for clients who have a venous ulcer

Wound care management includes first- and second-line therapies. First-line wound care is used for acute wounds. If the wound does not improve with first-line treatment, adjunctive second-line therapy may be used. Measurable signs of improved healing can be used as outcome measures in a wound care treatment plan and include the following:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate
- A decrease in amount of necrotic tissue

Wound care must be performed by a licensed health professional who is qualified to safely and effectively provide the medically necessary care. Providers are expected to exercise their clinical judgment to render the most appropriate care in accordance with their scope of practice as designated by their regulatory and governing boards. Education of the client or their caregiver during wound care interventions is a standard of care. Clients or their caregivers should be able to explain why each intervention is being performed for their specific type of wound.

All wound care services require documentation of the wound, and a comprehensive treatment plan is required to be maintained in the client's medical record as outlined in the documentation requirements section. Providers will document progress with each client encounter and use the measurable signs of healing to determine the degree of improvement.

The following services are not a benefit of Texas Medicaid:

- Infrared therapy
- Ultraviolet therapy
- Topical hyperbaric oxygen therapy
- Low-energy ultrasound wound cleanser (MIST therapy)

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- Services that are submitted as debridement but do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.
- Electrical stimulation and electromagnetic therapy

9.2.82.1 First-Line Wound Care Therapy

First-line wound care therapy includes the following:

- Cleansing, antibiotics, and pressure off-loading
- Compression
- Debridement
- Dressing
- Whirlpool for burns

9.2.82.1.1 Cleansing, Antibiotics, and Pressure Off-loading

Wound cleansing helps to create an optimal healing environment and decreases the potential for infection by loosening and removing cellular debris and residual topical agents from previous dressings.

Wound cleansing agents may include normal saline, commercial wound cleansers, providone iodine, hydrogen peroxide, or sodium hydrochlorite. Cleansing solutions and methods vary based on effectiveness and individual client needs.

Systemic or topical antibiotics may be used to prevent or treat wound infections and to aid in the healing of wounds.

Pressure off-loading devices, such as pillows, boots, mattresses, and protectors, may also be used as part of first-line wound care therapy to prevent or relieve pressure on the wound.

Procedure code 29445 may be reimbursed for pressure off-loading performed as part of wound care management.

9.2.82.1.2 Compression

Compression performed as a part of wound care management is a benefit and may be reimbursed when billed with procedure code 29580 or 29581.

9.2.82.1.3 Debridement

Wound debridement includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the client on the date of service.

Selective debridement consists of the following:

- Conservative sharp debridement
- High-pressure lavage to selected areas

Non-selective debridement consists of the following:

- Autolytic debridement
- Blunt debridement
- Enzymatic debridement
- Hydrotherapy and wound immersion rossr
- Mechanical debridement

The following procedure codes may be reimbursed for wound debridement:

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Procedure Codes									
11000	11001	11042	11043	11044	11045	11046	11047	97597	97598
97602									

Professional services for selective wound debridement (procedure codes 97597 and 97598) may be reimbursed to a licensed physical therapist, when it is determined to be within the provider's scope of practice, and the service is prescribed by a Medicaid-enrolled supervising physician or qualified non-physician provider.

Procedure codes 16020, 16025, and 16030 may be reimbursed for debridement of partial-thickness burns.

Prior authorization is not required for debridement of partial-thickness burns (procedure codes 16020, 16025, or 16030).

Prior authorization is required for wound debridement procedure codes 11042, 11043, and 11044. A request for prior authorization must be submitted to TMHP with the Special Medical Prior Authorization (SMPA) Request Form before the procedure is performed. Providers must retain a copy of the signed and dated form in the client's medical record at the provider's place of business. The requesting provider may be asked for additional information to clarify or complete a request for the equipment/supply requested.

Requests for prior authorization for wound debridement procedure codes 11042, 11043, and 11044 must include the following documentation:

- Location of the wound
- Characteristics of the wound, which include all of the following:
  - Dimensions (diameter and depth)
  - Drainage (amount and type)
  - Related signs and symptoms (swelling, pain, inflammation)
  - Presence of necrotic tissue/slough

When submitting an initial prior authorization request, the treating provider (registered nurse, physician, physical therapist) must submit a signed and dated wound care treatment plan or letter of medical necessity that includes all the following documentation:

- Planned interventions for the problem identified
- Treatment goals
- Expected outcomes

The treatment plan or letter of medical necessity is considered current when it is signed and dated within 30 calendar days prior to or on the date the procedure is performed. Otherwise, a new treatment plan must be submitted.

Retroactive authorization requests for wound debridement performed on an urgent or emergent basis (procedure code 11042, 11043, or 11044) will be denied if not submitted within 14 calendar days, beginning the day after the procedure is performed.

For wound debridement retroactive authorization to be considered, the treatment plan or letter of medical necessity must be signed and dated within 14 calendar days beginning the day after the procedure is performed. If the treatment plan is not signed and dated within the 14-calendar-day period, the request will be denied.

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For procedure codes 11043 and 11044, at least one of the following conditions must be present and documented:

- Stage III or IV wounds
- Venous or arterial insufficiency ulcers
- Dehisced wounds or wounds with exposed hardware or bone
- Neuropathic ulcers
- Complications of surgically created or traumatic wound where accelerated granulation therapy is necessary but cannot be achieved by other available topical wound treatment

Wound debridement procedure codes 11042, 11043, and 11044 are not appropriate and will not be approved for the following:

- Washing bacteria or fungal debris from the feet
- Paring or cutting of corns or calluses
- Incision and drainage of an abscess
- Trimming or debridement of nails, or avulsion of nail plates
- Acne surgery
- Destruction of warts
- Burn debridement

Prior authorization requests must be submitted by the provider within 30 calendar days prior to, or on the date the procedure is performed. If the prior authorization request is not submitted within 30 calendar days prior to, or on the date the procedure is performed, the request will be denied. The SMPA Request Form must be signed by the requesting provider on or within 30 days prior to the requested start of service. All dates of service prior to the prescribing providers signature date will be denied.

The physician's signature on the SMPA Request Form is considered current when signed and dated within 30 calendar days prior to, or on the date the procedure is performed. If the physician's signature is not signed and dated within the 30-calendar-day period prior to or on the date the procedure is performed, the request will be denied.

Prior authorization requests for procedure codes 11042, 11043, and 11044 will be considered for three calendar months, beginning on the requested procedure date.

Retroactive authorization is required for wound debridement procedure codes 11042, 11043, and 11044 that are performed on an urgent or emergent basis. The provider must submit a request for retroactive authorization within 14 calendar days, beginning the day after the procedure is performed.

For wound debridement retroactive authorization requests, the physician's signature on the SMPA Request Form is considered current when signed and dated within 14 calendar days, beginning the day after the procedure is performed. Requests with the physician's signature not signed and dated within the 14-calendar-day period will be denied.

Prior authorization requests for subsequent debridement will be considered on a case-by-case basis with documentation of medical necessity. These requests will be reviewed by the Medical Director.

The wound debridement procedure code submitted on the prior authorization or retroactive authorization request must reflect the level of debrided tissue, e.g., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle, and/or bone, and not the extent, depth, or grade of the ulcer or wound.

9.2.82.1.4 Dressings and Metabolically Active Skin Equivalents

Wound dressings may include wet and dry dressings.

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All dressings applied to the wound during a wound debridement procedure are considered part of the service for wound debridement.

9.2.82.1.5 Whirlpool for Burns

Whirlpool is a benefit when used as first-line wound care therapy for the treatment of burn wounds.

9.2.82.2 Second-Line Wound Care Therapy

Second-line wound care therapy is limited to chronic Stage III or IV wounds and may be covered only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing. First-line wound care therapy may continue as appropriate, with the addition of second line wound care measures as indicated by the client's medial condition.

Second-line wound care therapy includes the following:

- Whirlpool
- Irrigation, including pulsatile jet irrigation
- Application of metabolically active skin equivalents/skin substitutes

9.2.82.2.1 Pulsatile-Jet Irrigation

Pulsatile-jet irrigation is a benefit for the treatment of Stage III or IV wounds when other forms of treatment have failed. Removal of devitalized tissue using pulsatile-jet irrigation may be reimbursed when claims are submitted for procedure code 97597 or 97598.

9.2.82.2.2 Negative Pressure Wound Therapy (NPWT)

Negative pressure wound therapy (NPWT) procedure codes 97605, 97606, 97607, and 97608 are a benefit of Texas Medicaid for clients who are 18 years of age or older.

NPWT may be provided utilizing durable medical equipment (DME), or nondurable medical equipment to treat acute and chronic wounds that include diabetic foot ulcers, venous leg ulcers, pressure ulcer wounds, non-healing surgical wounds, non-adhering skin grafts. NPWT may consist of using a traditional computerized electric vacuum pump, or a disposable single use mechanical device which includes the collection canister and the hydrocolloid dressing with the integrated nozzle and tubing.

NPWT may promote tissue granulation and wound healing by providing a warm moist wound bed while removing excessive secretions or bacterial material from the wound and should be considered only when other treatments are not effective.

Procedure codes 97605 and 97606 include management of the exudate collection system, topical application, wound assessment, and instructions for ongoing care services.

DME and supplies are not included for procedure codes 97605 and 97606 and may be reimbursed separately.

Procedure codes 97607 and 97608 include management of the exudate collection system, topical application, wound assessment, instructions for ongoing care services, and the disposable device.

The disposable device is included with procedure codes 97607 and 97608 and is not separately reimbursed.

NWPT is contraindicated for any of the following wound types and conditions:

- Necrotic tissue with eschar present
- Untreated osteomyelitis
- Fistulas
- Wounds containing malignancy

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- Exposed vasculature, nerves, anastomotic site, or organs
- Actively bleeding wounds

Prior authorization is not required for the initial 90 days of NPWT. A maximum of 36 NPWT treatments will be allowed in any 90-day period per rolling year, which will begin on the first day of the first NPWT treatment.

Prior authorization is required for more than 36 NPWT treatments within or after the initial 90 days and will be considered on a case-by-case basis with documentation of medical necessity. A request submitted to TMHP may be considered for services beyond the initial 90 days for an additional 30-day treatment period. These requests will be reviewed by the medical director.

Claims for procedure codes 97605, 97606, 97607, and 97608 must include the authorization number on the claim at the time of claim submission.

9.2.82.2.3 Skin Substitutes and Surgical Wound Preparation

The application of skin substitutes is a benefit for the treatment of chronic Stage 3 or 4 wounds that have failed to respond to standard wound care treatment after 30 days. A failed response is defined as a wound that has increased in size or depth, or has not changed in baseline size or depth, and shows no measurable signs of healing improvements after 30 days of appropriate wound-care measures.

Use of the appropriate specific skin substitute product(s) for the episode of each documented wound is expected. Compliance with the Food and Drug Administration (FDA) assessments and submitted guidelines for the specific skin substitute product(s) used is expected. Skin substitute products not used within the scope of the FDA's intended use and indications are considered experimental and/or investigational. All wound care services require documentation of the wound, and a comprehensive treatment plan is required to be maintained in the client's medical record.

The following procedure codes may be reimbursed for the application of skin substitute grafts:

Procedure Codes									
15271	15272	15273	15274	15275	15276	15277	15278		

Approved skin substitute products used in wound care services that are provided in an office-based setting will be considered for separate reimbursement when submitted with an appropriate application procedure code from the table above.

The approved skin substitute product(s) must have a published average sales price, must be FDA cleared/approved or be designated as 361 HCT/P exempt, and should be used in accordance with each product's individualized labeling and application guidelines. The approved list of skin substitute products are reviewed and updated biannually. Providers should refer to the Center for Medicare & Medicaid Services (CMS) Medicare Part B Drug Average Sales Price web page at www.cms.gov for updates to the list of approved skin substitute products.

All skin substitute products used in wound care services that are provided in a facility setting are considered part of the application services (procedure codes listed in the table above) and are not separately reimbursed.

Surgical Wound Preparation

Appropriate surgical wound preparation is expected at least once at the initiation of care, prior to placement of the skin substitute graft. Repeated use of surgical preparation services in conjunction with skin substitute application codes will be considered not reasonable or necessary and will not be reimbursed.

The following procedure codes may be reimbursed for surgical wound preparation:

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Procedure Codes							
15002	15003	15004	15005	15040	15050	15271	15272
15273	15274	15275	15276	15277	15278	G0681	G0682
G0683	G0684						

Note: *Procedure code 15005 is not a benefit for ambulatory surgical center providers.*

Limitations

The treatment of any chronic skin wound will typically last no more than 12 weeks.

Skin substitute applications and grafts are limited to 10 per episode of care in a 12-week period, per rolling year beginning on the first day of the first skin substitute application. If more than one specific product is used or a product change occurs during the 12-week period of care, the expectation remains that the cumulative number of applications will not exceed 10.

More than 10 skin substitute applications in a 12-week period will be considered on a case-by-case basis with documentation of medical necessity. These requests will be reviewed by the Medical Director.

Re-Treatment of Healed, Stage 3, or Stage 4 Chronic Wounds

Retreating healed skin wounds showing greater than 75 percent in size reduction and smaller than 0.5 square cm is not considered medically reasonable or necessary and will not be reimbursed.

Retreating a venous stasis ulcer or diabetic neuropathic foot ulcer with any skin substitute product(s) within one year of previous treatment is considered treatment failure. This unsuccessful treatment does not meet reasonable and necessary criteria for re-treatment and will not be reimbursed.

Unsuccessful treatment is defined as an increase in size or depth of an ulcer, or no change in baseline size or depth and no sign of improvement or indication that improvement is likely (such as granulation, epithelialization, or progress towards closing) for a period of 4 weeks past the start of therapy.

Contraindications

Skin substitute grafts are contraindicated for the following:

- Clients with known hypersensitivity to any component of the specific skin substitute graft (e.g., allergy to avian, bovine, porcine, or equine products).
- Skin substitute grafts will not be considered reasonable and necessary for clients with inadequate control of underlying conditions or exacerbating factors, such as the following:
- Clients with uncontrolled diabetes
- Clients with active infection
- Clients with active Charcot arthropathy of the ulcer extremity
- Clients with vasculitis
- Clients who continue smoking tobacco and have not received smoking cessation guidance from their physician

9.2.82.3 Specialized Wound Care Education

Specialized wound care education with prior authorization may be reimbursed when provided by a wound care services provider.

In addition to the education included in the standard of care, specialized wound care education can be provided by a wound care services provider (with modifier U1) for additional reimbursement. These client interactions are denoted by the addition of the modifier U1 to the Healthcare Common Procedure

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Coding System (HCPCS) procedure code or other applicable HCPCS code billed for the wound care procedure performed. When the modifier U1 is used, documentation (client chart records) should be filed with the claim.

To evaluate progress and determine the degree of improvement, the wound care provider performing the specialized education must document in the client's chart each client encounter including the education provided and a description of the client's wound using measurable signs of healing.

The documentation must include:

- A record of teaching specific to the knowledge and skills necessary for independent care of the client's wound provided to the client or their caregiver.
- An affirmative statement that the client or their caregiver has received the education.

9.2.82.3.1 Limitations of Wound Care Education

Specialized wound care education is limited to the following:

- Two claims with a wound care procedure code submitted with modifier U1 per wound occurrence in an office setting or facility
- Four claims with modifier U1 per wound occurrence in an ambulatory surgical center

Each wound occurrence is defined as a three-month rolling time period. Additional prior authorization requests for more than the limitation number of claims submitted for wound occurrence will be considered on a case-by-case basis with documentation of medical necessity. These requests will go to a clinical review for consideration.

9.2.82.3.2 Reimbursement

Specialized wound care education will be limited to four wound care education services per 90 days by the same provider for services rendered in the ambulatory surgical center and may be reimbursed with the following procedure codes with modifier U1:

Procedure Codes						
11000	11042	11043	11044	15002	15004	15040
15050	15271	15273	15275	15277	16020	16025
16030	29445	29580	29581			

Specialized wound care education will be limited to two wound care education services per 90 days by the same provider for services rendered in the office, home, or facility setting and may be reimbursed with the following procedure codes with modifier U1:

Procedure Codes						
97597	97598	97602	97605	97606	97607	97608

9.2.82.4 Documentation Requirements

For all wound care management services, documentation that supports the medical necessity of the service must be maintained in the client's medical records, which includes but is not limited to the following information:

- Accurate diagnostic information that pertains to the underlying diagnosis and condition as well as any other medical diagnoses and conditions, which include the client's overall health status.
- Appropriate medical history related to the current wound, including the following:
- Wound location

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- Wound measurements, which includes length, width, and depth, any tunneling and/or undermining
- Wound color, drainage (type and amount), and odor, if present
- The prescribed wound care regimen, which includes frequency, duration, and supplies needed
- Treatment for infection, if present
- All previous wound care therapy regimens, if appropriate
- The client's use of a pressure reducing support surface, mattress, and/or cushion, when appropriate

Documentation maintained in the client's medical record must support the level of debridement service provided.

Fewer than five surgical debridements that involve removal of muscle or bone are typically required for management of most wounds. Documentation that is maintained in the client's medical record must support the number of debridements involving muscle or bone that are performed.

Wound care services providers must document the specialized education covered and the client's progress in the client's wound care education treatment plan with each billed encounter using the U1 modifier.

The measurable signs of healing described will be used as outcome measures to determine the degree of improvement as a result of such education.

9.2.82.4.1 Skin Substitutes

Documentation maintained in the client's medical record must support the need for skin substitute applications and the product used.

Documentation for all wound care treatments involving the application of skin substitute products must include, but is not limited to, the following:

- Wound treatments are accompanied by the appropriate adjunctive measures, and identify the specific adjunctive therapies being provided to the client as part of the wound treatment regimen.
- Clients who use tobacco must satisfy one of the following documentation requirements:
  - The client will have ceased smoking or have refrained from systemic tobacco intake for at least 4 weeks prior to beginning skin substitute applications and during the conservative wound care.
  - Smoking history, cessation counseling on the effects of smoking on surgical outcomes, treatment for smoking cessation (if applicable), and the outcome of counseling must be recorded in the client's medical record.
- Adequate circulation/oxygenation to support tissue growth/wound healing must be present as evidenced by physical examination (e.g., Ankle-Brachial Index [ABI] of no less than 0.60, toe pressure greater than 30 millimeters of mercury [mmHg]).
- The wound has a skin deficit at least 1.0 square centimeter in size.
- For diabetic foot ulcers, the client's medical record reflects a diagnosis of Type 1 or Type 2 diabetes.
- Partial or full thickness ulcers must have a clean granular base without tendon and or muscle involvement, bone exposure, or sinus tracts.
- Documentation of the wound's response to the treatment is required at least every 30 days for each treatment episode. The documentation requirements must include measurements of the initial wound, measurements at the completion of appropriate wound care every 30 days, and measurements immediately prior to placement and with each subsequent placement of the skin substitute.

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- Wound care services that include the use of skin substitutes must be FDA cleared/approved or be designated as 361 HCT/P exempt and should be used in accordance with each product's individualized labeling and application guidelines. Skin substitute products not used within the scope of the FDA's intended use and indications are considered experimental, investigational, or both.

9.2.82.5 Exclusions

The following services are not a benefit of Texas Medicaid:

- Separately billed, repeated use of a skin substitute product after 12 weeks for a single wound or episode
- Skin substitute grafting for partial thickness loss with the retention of epithelial appendages is not covered, as epithelium will repopulate the deficit from the appendages, negating the benefit of over grafting

9.3 Collaborative Care Model (CoCM)

The Collaborative Care Model (CoCM) is a systematic approach to the treatment of behavioral health conditions (mental health or substance use) in primary care settings. The model integrates the services of behavioral health care managers (BHCMs) and psychiatric consultants with primary care provider oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.

CoCM services are benefits for persons of all ages who are enrolled in Texas Medicaid and who have a mental health or substance use condition to include a pre-existing or suspected mental health or substance use condition, when provided by a physician, physician assistant, nurse practitioner, clinic or group practices, federally qualified health center (FQHC), or rural health clinic (RHC) (henceforth, referred to as the Primary Care Provider).

Prior to delivering CoCM services, the primary care provider must attest in the Provider Enrollment and Management System (PEMS) that their practice location has an established CoCM program as described in this section. To ensure continued adherence to the CoCM core principles and the specific functional requirements of the model, the primary care provider must also re-attest in PEMS at the time of enrollment revalidation.

CoCM services must be provided under the direction of the primary care provider and are benefits when provided in an office, outpatient hospital, inpatient hospital, skilled nursing facility or intermediate care facility, extended care facility or other locations.

An episode of care of CoCM services begins when the person receiving services is referred by the primary care provider to the BHCM for CoCM services and ends after 12 calendar months (initial calendar month plus 11 subsequent calendar months) of services or earlier if treatment goals are met. A new episode of care must be initiated when either:

- The person receiving services is referred to a behavioral health provider for ongoing treatment of the behavioral health condition.
- There is a break in services, which is defined as no CoCM services provided for six consecutive calendar months.

CoCM services are individually delivered, time-based, monthly services that include outreach and engagement, completing an initial assessment, developing an individualized and person-centered plan of care, monitoring and tracking a person's progress using a registry, providing brief interventions and other focused treatments, and conducting weekly caseload reviews with the psychiatric consultant. For more information on registry requirements refer to The Advancing Integrated Mental Health Solutions (AIMS) Center, University of Washington, Psychiatry and Behavioral Sciences Division of Population Health.

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Initial CoCM services (procedure code 99492) are those BHCM activities provided to the person receiving services in the first calendar month of services. Initial CoCM services, using procedure code 99492, must include the following elements and be documented in the electronic medical record (EMR) or electronic health record (EHR) for reimbursement:

- Conducting outreach to and engagement of the person needing services, directed by the primary care provider
- Completing an initial assessment to include administration of a validated rating scale
- Developing a person-centered plan of care that is reviewed and modified, as needed, by the psychiatric consultant
- Monitoring progress and updating the person-centered plan of care, as needed
- Entering information into the registry and tracking follow-up activities and progress through the registry with appropriate documentation
- Participating in weekly caseload consultation meetings with the psychiatric consultant
- Providing evidenced-based brief interventions, such as motivational interviewing or other focused strategies

Subsequent CoCM services (procedure code 99493) are those BHCM activities provided to the person receiving services in the months following the first calendar month of services.

Initial or subsequent CoCM services (procedure code G2214) are those BHCM activities provided to the person receiving services in the first calendar month or subsequent calendar months of services.

Procedure codes 99493 and G2214 must include the following elements and be documented in the EMR or EHR for reimbursement:

- Tracking follow-up activities and progress of the person receiving services through the registry with appropriate documentation
- Participating in weekly caseload consultation meetings with the psychiatric consultant
- Collaborating with and coordinating of the person's care and treatment with the primary care provider or other treating behavioral health providers
- Reviewing progress and recommendations from the psychiatric consultant for changes in treatment to include modifications to the medication regimen
- Providing evidenced-based brief interventions
- Monitoring clinical outcomes using a validated rating scale
- Planning for relapse prevention as the person receiving services prepares for discharge from services

9.3.1 CoCM Team Member Qualifications and Responsibilities

The primary care provider must be a physician (including specialists, such as a cardiologist or oncologist), physician assistant, or nurse practitioner that has an established CoCM program.

The primary care provider must:

- Direct the BHCM and other clinical staff.
- Oversee the care of the person receiving services to include prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.
- Remain actively involved in the care and treatment of the person receiving services through continuous oversight, management, collaboration, and reassessment.
- Comply with all applicable licensure board rules.

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The BHCM must be credentialed as a Qualified Mental Health Professional-Community Services (QMHP-CS), as defined in Title 1 Texas Administrative Code (TAC) §353.1415. The BHCM works under the oversight and direction of the primary care provider and, in consultation with the psychiatric consultant, provides care management services, including:

- Completing an initial assessment
- Administrating a validated rating scale
- Developing a person-centered plan of care
- Providing evidenced-based brief interventions
- Collaborating with the primary care provider
- Maintaining the registry

The BHCM must:

- Be available to provide CoCM services in person when needed.
- Maintain a continuous relationship with the person receiving CoCM services.
- Be able to engage the person receiving CoCM services outside of regular office hours, as needed, to perform CoCM duties.

Note: *BHCM activities may be provided in person or by synchronous audio-visual or audio only (telephone) technology, if clinically appropriate, safe, and agreed to by the person receiving CoCM services. Providers must defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth.

The psychiatric consultant must be a medical professional who is trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant must engage, at a minimum, in weekly caseload reviews with the BHCM that may be conducted in person or by synchronous audio-visual or audio only (telephone) technology. Caseload reviews typically focus on persons who are new to CoCM services or who are not improving as expected under their current person-centered plan of care. The psychiatric consultant advises and makes recommendations, either directly to the primary care provider or through the BHCM, regarding psychiatric and other medical care to include:

- Psychiatric and other medical diagnoses
- Treatment strategies to include appropriate therapies, medication management, and medical management of complications associated with treatment of psychiatric disorders
- Referral for specialty services

The psychiatric consultant typically does not meet with the person receiving services but must be able to do so either in person or by synchronous audio-visual technology if clinically indicated. The psychiatric consultant must also facilitate referrals to a behavioral health provider when clinically appropriate.

9.3.2 Prior Authorization Requirements

Prior authorization is not required for the first six calendar months (initial month and five subsequent months) of CoCM services.

Prior authorization is required for an additional six calendar months (beyond the first six calendar months) of CoCM services.

Note: *Prior authorization is a condition of reimbursement, not a guarantee of payment.*

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Prior authorization requests are considered on a case-by-case basis with documentation supporting medical necessity for an additional six calendar months of CoCM services. Requests must be received prior to the last day of the sixth calendar month of services. The documentation must demonstrate the person receiving services continues to meet eligibility criteria, as outlined in the section above, and include the following:

- The current person-centered recovery plan that includes goals and objectives
- Progress made relative to the goals and objectives outlined in the person-centered recovery plan

Requests must be submitted by the primary care provider to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form. The form must be signed and dated within 30 calendar days prior to the start of an additional six calendar months of CoCM services, and must include the following information:

- Identifying information for the person receiving services
- Provider information
- Service and procedure code information
- Expected dates of service
- Diagnosis or diagnoses
- Medical necessity information

Note: *A nurse practitioner and physician assistant may sign all documentation related to the provision of CoCM services on behalf of the physician when the physician delegates this authority to the nurse practitioner or physician assistant.*

Primary care providers are required to adhere to prior authorization requirements.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department through 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 EMR or 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 person'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 request must also attest that the 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, responsible adults of persons receiving services, and persons receiving services may sign prior 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 to the TMHP Prior Authorization Department and retain a copy of the signed and dated prior authorization form in the client's medical record.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated prior authorization form in the person'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 services requested. The physician must maintain documentation of medical necessity in the person's medical record.

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The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services.

9.3.3 Documentation Requirements

Prior to receiving CoCM services, the primary care provider must obtain verbal or written consent from the person being referred for CoCM services to consult with the psychiatric consultant and other relevant specialists. A new consent is not required for each subsequent calendar month of services or annually unless the person receiving services changes primary care providers. If the person receiving services changes primary care providers, then a new verbal or written consent must be obtained and documented by the new primary care provider prior to the provision of CoCM services. Informed consent must be documented in the EMR or EHR.

Primary care providers must use a registry that is used jointly with the EMR or EHR of the practice to track clinical outcomes.

All elements for the procedure code being billed (99492, 99493 or G2214), as described in this section must be documented in the registry for reimbursement. In addition, documentation must also include the following:

- The initial assessment and any subsequent assessments
- The validated rating scale, or scales, used to include results
- All versions of the individualized, person-centered plan of care.
- The person-centered plan of care must:
    - Identify the goals of treatment
    - Indicate progress of the person receiving services towards their goals
    - Include any modifications to care and treatment.

All services outlined in this section are subject to retrospective review to ensure that the documentation in the person's medical record supports the medical necessity of the services provided.

9.3.4 Claims Reimbursement

CoCM services are time-based and reported as the total amount of time the BHCM spends engaging in clinical activities over the course of a calendar month.

Only the primary care provider may submit claims for CoCM services. The BHCM and psychiatric consultant are reimbursed by the primary care provider through a contract, employment, or other arrangement. If a contract or other arrangement is pursued, it must be as a billing agent, such as billing service or accounting firm, that furnishes statements and receives payments in the name of the provider; a facility under which the service is provided; or a foundation plan or similar organization under which the organization submits the claim, in accordance with 42 CFR 447.10.

To be reimbursed for CoCM services, the primary care provider must meet the following core components:

- Provide active treatment and care management for an identified population
- Use a registry to monitor treatment and outcomes, and to conduct psychiatric caseload reviews

The primary care provider must use procedure codes 99492, 99493, 99494, or G2214 to bill for monthly CoCM services in all settings. The primary care provider must also use the place of service code for the location where services would normally be provided for in-person care and treatment.

CoCM services begin after the referral is made by the primary care provider and the BHCM starts engaging in reimbursable clinical activities, as described in this section.

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The primary care provider must use procedure code 99492 for the first 70 minutes accrued during the initial calendar month of BHCM activities, in consultation with the psychiatric consultant.

The primary care provider must use procedure code 99493 for the first 60 minutes accrued during each subsequent calendar month of BHCM activities, in consultation with the psychiatric consultant.

The primary care provider must use add-on procedure code 99494 for each additional 30 minutes accrued during the initial calendar month or subsequent calendar months of BHCM activities, in consultation with the psychiatric consultant. The add-on procedure code must be billed with the appropriate primary procedure code 99492 or 99493.

The primary care provider must use procedure code G2214 for no more than 30 minutes accrued during an initial calendar month or subsequent calendar months of BHCM activities, in consultation with the psychiatric consultant.

The primary care provider may not bill both procedure codes 99492 and G2214 during the initial calendar month of services or procedure codes 99493 and G2214 during any subsequent calendar month of services for the same person, same provider. See the CoCM procedure codes table for information about time thresholds.

The primary care provider must use the appropriate evaluation and management (E/M) code for the initial presenting visit with the person.

All required elements of the procedure codes, as described in this section, must be performed and documented, and time thresholds met, to be reimbursed for services.

The BHCM may provide other outpatient mental health services, if eligible for reimbursement, in the same calendar month as CoCM services but those services are separate and distinct from CoCM services and do not count toward the time thresholds for CoCM services. Therefore, the BHCM must report separately those other mental health services that are delivered in the same calendar month as CoCM services.

The psychiatric consultant may provide E/M services and other outpatient mental health services, if eligible for reimbursement, in the same calendar month as CoCM consultation services but those services are separate and distinct from CoCM services and do not count toward the time thresholds for CoCM services. Therefore, the psychiatric consultant must report separately E/M or other mental health services that are delivered in the same calendar month as CoCM services.

Refer to: The "Behavioral Health and Case Management Services Handbook" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about outpatient mental health services, and Section 9.2.60, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about physician evaluation and management (E/M) services.

FQHCs and RHCs should submit claims using the CoCM standard procedure codes only, which will be reimbursed at the fee-for-service rate outside the FQHC or RHC encounter rate.

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The following procedure codes may be reimbursed for CoCM services based on the time thresholds listed:

Procedure Code	Additional Information
99492	Billable at 36 minutes. Time threshold is 36 to 85 minutes. Administrative and clerical duties do not count towards the time threshold. May only be billed by the primary care provider during the initial calendar month of an episode of care. Limited to one per initial calendar month, same person, same provider. May not be billed in subsequent months of services.
99493	Billable at 31 minutes. Time threshold is 31 to 75 minutes. Administrative and clerical duties do not count towards the time threshold. May only be billed by the primary care provider during subsequent calendar months of an episode of care. Limited to one per subsequent calendar month, same person, same provider. May not be billed in the initial calendar month of services.
99494	Billable at 16 minutes, beyond total time, to 30 minutes. Administrative and clerical duties do not count towards the time threshold. May only be billed by the primary care provider during any calendar month (initial or subsequent) of an episode of care. Limited to two per calendar month (initial or subsequent), same person, same provider. Add-on code must be billed with primary procedure code 99492 or 99493. May not be submitted with procedure code G2214.
G2214	Billable at 16 minutes. Time threshold is 16 to 30 minutes. Administrative and clerical duties do not count towards the time threshold. May only be billed by the primary care provider during any calendar month (initial or subsequent) of an episode of care. Limited to one per calendar month (initial or subsequent), same person, same provider. The primary care provider may not bill both procedure codes 99492 and G2214 during the initial calendar month of services or procedure codes 99493 and G2214 during any subsequent calendar month of services for the same person, same provider.

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Procedure code 99492 is limited to one occurrence or unit in the initial calendar month of CoCM services, same person, same provider during an episode of care. Procedure code 99492 will be denied if billed during any subsequent calendar month of CoCM services.

Procedure code 99493 is limited to one occurrence or unit per calendar month for all subsequent calendar months of CoCM services, same client, same provider during an episode of care. Procedure code 99493 will be denied if billed during the initial calendar month of CoCM services.

Procedure code 99494 is limited to two occurrences or units per calendar month (initial or subsequent) of CoCM services, same person, same provider during an episode of care. Procedure code 99494 will be denied if billed without primary procedure code 99492 or 99493 for the same person, same provider.

Procedure code G2214 is limited to one occurrence or unit per calendar month (initial or subsequent) of CoCM services, same person, same provider during an episode of care.

Procedure codes 99492, 99493, and G2214 will be denied if billed in the same calendar month of CoCM services, same person, same provider.

9.3.5 Exclusions

Administrative and clerical duties, except for entering information in the registry which is a required element of the procedure codes are not a covered benefit of Texas Medicaid.

9.4 Doctor of Dentistry Practicing as a Limited Physician

This section outlines the guidelines for the Doctor of Dentistry practicing as a limited physician. The THSteps dental program is not addressed in these guidelines.

Services by a dentist (DDS or DMD) are covered by Texas Medicaid in accordance with the Omnibus Budget Reconciliation Act (OBRA) of 1987 §4103 and Title 2 *Texas Human Resources Code* §32.054, if the services are furnished within the dentist's scope of practice as defined by Texas state law and would be covered under Texas Medicaid when provided by a licensed physician (MD or DO).

Dentist (DDS or DMD) who want to participate as a dentist-physician in Texas Medicaid must be separately enrolled as a Doctor of Dentistry practicing as a limited physician even if they are enrolled in the THSteps Dental Program.

Dual licensure (MD, DO, and DDS) is not required for a dentist to enroll as a limited physician. Medicare enrollment is required for a dentist to enroll as a limited physician.

9.4.1 Prior Authorization for General Dental Services Due to Life-Threatening Medical Condition

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

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

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

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

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

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

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

9.4.1.1 Guidelines for Requesting Mandatory Prior Authorization

The limited physician dentist must request the mandatory prior authorization, and the request must include:

- A treatment plan that clearly outlines the dental condition as related to the life-threatening medical condition.
- Narrative describing the current medical problem, client status, and medical need for requested services.
- The client name and Medicaid number.
- The limited physician dentist's NPI.
- The name and address of the facility.
- CPT procedure codes.
- The history and physical.
- The limited physician dentist's signature.

Note: *The "limited physician" dentist who will perform the procedure(s) must submit the request for prior authorization.*

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

9.4.2 Benefits and Limitations

Dental procedure codes and their corresponding CPT procedures may not be billed on the same date of service by any provider.

Cosmetic procedures are not a benefit of Texas Medicaid. Certain procedure codes, including, but not limited to, the procedure codes in the following table, may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury for the purpose of:

- Reconstructing tissues/body structures.
- Repairing damaged tissues.

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Procedure Codes									
11950	11951	11952	11954	11970	15780	15781	15786	15787	15788
15789	15838	15876	21089	21497	41820	41821	41828	61501	Q3031

9.4.2.1 * Additional Payable Procedure Codes

The following procedure codes are a benefit when prior authorized and the dentist is qualified and licensed to perform the procedures:

[Revised] Procedure Codes									
Surgery									
10004	10005	10006	10007	10008	10009	10010	10011	10012	10021
10060	10061	10120	10121	10140	10160	10180	11000	11001	11010
11011	11012	11042	11043	11044	11045	11046	11047	11102	11103
11104	11105	11106	11107	11200	11201	11305	11306	11307	11308
11310	11311	11312	11313	11420	11421	11422	11423	11424	11426
11440	11441	11442	11443	11444	11446	11620	11621	11622	11623
11624	11626	11640	11641	11642	11643	11644	11646	11900	11901
11950	11951	11952	11954	11960	11970	11971	12001	12002	12004
12005	12006	12007	12011	12013	12014	12015	12016	12017	12018
12020	12021	12031	12032	12034	12035	12036	12037	12051	12052
12053	12054	12055	12056	12057	13120	13121	13122	13131	13132
13133	13151	13152	13153	13160	14020	14021	14040	14041	14060
14061	14301	14302	15004	15005	15115	15116	15120	15121	15135
15136	15155	15156	15157	15240	15241	15260	15261	15275	15276
15277	15278	15574	15576	15620	15630	15730	15733	15740	15750
15756	15757	15758	15760	15769	15770	15780	15781	15782	15783
15786	15787	15788	15789	15792	15793	15820	15821	15822	15823
15838	15851	15852	15876	16020	16025	16030	17000	17003	17004
17106	17107	17108	17110	17111	17250	17270	17271	17272	17273
17274	17276	17280	17281	17282	17283	17284	17286	20100	20200
20205	20220	20240	20520	20525	20550	20551	20552	20600	20604
20605	20606	20615	20650	20660	20661	20670	20680	20690	20692
20693	20694	20696	20697	20900	20902	20910	20912	20920	20922
20955	20956	20957	20962	20969	20970	20972	20973	20999	21010
21011	21012	21013	21014	21015	21016	21025	21026	21029	21030
21031	21032	21034	21040	21044	21045	21046	21047	21048	21049
21050	21060	21070	21073	21076	21079	21080	21081	21082	21083
21085	21087	21088	21089	21100	21110	21116	21120	21121	21122
21123	21125	21127	21137	21138	21139	21141	21142	21143	21145
21146	21147	21150	21151	21154	21155	21159	21160	21172	21175
21179	21180	21181	21182	21183	21184	21188	21193	21194	21195
21196	21198	21199	21206	21208	21209	21210	21215	21230	21235

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[Revised] Procedure Codes									
21240	21242	21243	21244	21245	21246	21247	21255	21256	21260
21261	21263	21267	21268	21270	21275	21280	21282	21295	21296
21299	21315	21320	21325	21330	21335	21336	21337	21338	21339
21340	21343	21344	21345	21346	21347	21348	21355	21356	21360
21365	21366	21385	21386	21387	21390	21395	21400	21401	21406
21407	21408	21421	21422	21423	21431	21432	21433	21435	21436
21440	21445	21450	21451	21452	21453	21454	21461	21462	21465
21470	21480	21485	21490	21497	21499	21501	21550	21552	21554
21555	21556	21558	21685	29800	29804	29999	30000	30020	30120
30124	30125	30150	30160	30200	30300	30310	30400	30410	30420
30430	30435	30450	30460	30462	30465	30520	30580	30600	30620
30630	30801	30802	30901	30903	30905	30906	30930	30999	31020
31030	31032	31080	31081	31084	31085	31086	31087	31225	31230
31600	31603	31605	31830	40490	40500	40510	40520	40525	40527
40530	40650	40652	40654	40700	40701	40702	40720	40761	40799
40800	40801	40804	40805	40806	40808	40810	40812	40814	40816
40818	40819	40820	40830	40831	40840	40842	40843	40844	40845
40899	41000	41005	41006	41007	41008	41009	41010	41015	41016
41017	41018	41100	41105	41108	41110	41112	41113	41114	41115
41116	41120	41130	41135	41140	41145	41150	41153	41155	41250
41251	41252	41510	41520	41599	41800	41805	41806	41820	41821
41822	41823	41825	41826	41827	41828	41830	41850	41870	41872
41874	41899	42000	42100	42104	42106	42107	42120	42140	42145
42160	42180	42182	42200	42205	42210	42215	42220	42225	42226
42227	42235	42260	42280	42281	42299	42300	42305	42310	42320
42330	42335	42340	42400	42405	42408	42409	42410	42415	42420
42425	42426	42440	42450	42500	42505	42507	42509	42510	42550
42600	42650	42660	42665	42699	42700	42720	42725	42800	42804
42806	42808	42809	42810	42815	42842	42844	42845	42890	42892
42894	42900	42950	42960	42961	42962	42970	42999	61501	61559
61575	61576	61580	61581	61584	61586	61590	61592	62147	64400
64600	64612	64722	64736	64738	64740	67900	67914	67915	67916
67917	67921	67922	67923	67924	67930	67935	67950	67961	92511
96360	96361	96369	96370	96372	96374				
Injections/Medications									
90284	J0121	J0162	J0168	J0169	J0280	J0290	J0295	J0330	J0360
J0475	J0525	J0558	J0561	J0670	J0690	J0692	J0694	J0696	J0697
J0698	J0702	J0720	J0744	J0780	J1010	J1100	J1165	J1171	J1200
J1364	J1459	J1555	J1557	J1559	J1561	J1566	J1568	J1569	J1572
J1576	J1580	J1630	J1631	J1720	J1790	J1800	J1885	J1920	J1921

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[Revised] Procedure Codes									
J1938	J2010	J2060	J2175	J2249	J2291	J2305	J2360	J2371	J2372
J2401	J2402	J2410	J2540	J2550	J2560	J2690	J2700	J2765	J2800
J2865	J2919	J2970	J3000	J3010	J3260	J3301	J3303	J3360	J3373
J3410	J3430	J3480	J3485	J3490					
Pathology									
88305	88331	88332							

9.4.2.2 Radiographs by a Doctor of Dentistry Practicing as a Limited Physician

When a Doctor of Dentistry Practicing as a Limited Physician uses appropriate radiograph equipment to produce required radiographs, the following procedure codes are eligible for reimbursement:

Procedure Codes									
70100	70110	70120	70130	70140	70150	70160	70190	70200	70250
70260	70300	70310	70320	70328	70332	70336	70350	70355	70370
70371	70380	70390	73100	70450	70460	70470	70480	70481	70482
70486	70487	70488	70490	70491	70492				

9.4.2.3 Dental Anesthesia by a Doctor of Dentistry Practicing as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician who is licensed by the Texas State Board of Dental Examiners (TSBDE) practicing in Texas, who has obtained an Anesthesia Permit from the TSBDE in accordance with Title 22 TAC §§110.1 through 110.15, may be reimbursed for anesthesia services on clients having dental/oral and maxillofacial surgical procedures in the dental office or hospital in accordance with all applicable rules for physician administration and supervision of anesthesia services.

Dentists providing sedation/anesthesia services must have the appropriate permit from TSBDE for the level of sedation/anesthesia provided.

The following anesthesia services are payable to dentists as physician services:

Procedure Codes									
00100	00102	00160	00162	00164	00170	00190	00192	00300	99100
99116	99135	99140							

9.5 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including physician services. Physician services are subject to retrospective review and recoupment if documentation does not support the service billed.

9.6 Claims Filing and Reimbursement

9.6.1 Claims Information

Claims for physician and doctor services 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 them.

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 and itemized statements are not accepted as claim supplements.

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Physicians who submit a claim using the physician's own NPI for services provided by an NP, CNS, PA, or CNM must submit one of the following modifiers on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit:

- SA – Services were provided by an NP or CNS
- U7 – Services were provided by a physician assistant
- SB – Services were provided by a CNM

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

9.6.2 National Drug Codes (NDC)

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

9.6.3 Reimbursement

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an NP, CNS, PA, or CNM if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. The 92 percent reimbursement rate will not apply to laboratory services, X-ray services, and injections provided by an NP, CNS, PA, or CNM.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare/Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.

Reimbursement for these services will be 60 percent of the Texas Medicaid rate for the service furnished in the physician's office. The following table identifies the services applicable to the 60-percent limitation when furnished in outpatient hospital settings:

Procedure Codes									
99202	99203	99204	99205	99211	99212	99213	99214	99215	99281
99282	99283								

These procedures are designated with note code "1" in the current physician fee schedule, which is available at www.tmhp.com. The following list shows the services excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs).

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- Surgical services that are covered ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC) services.
- Anesthesiology and radiology services.
- Prenatal services when billed with modifier TH and the appropriate E/M procedure code to the highest level of specificity.
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client's health.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.

Because of TEFRA, Texas Medicaid reimbursement for a payable nonemergency office service that is performed in the outpatient department of a hospital is limited to 60 percent of Texas Medicaid rate for that service. If the condition qualifies as an emergency or if the client is critically ill or critically injured, the 60 percent professional service reimbursement limit does not apply.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about conditions that are excluded from the 60-percent limitation.

Subsection 9.2.7, "Anesthesia" in this handbook for information on anesthesia services that are reimbursed according to relative value units (RVUs).

9.6.3.1 Affordable Care Act of 2010 (ACA) Rate Increase for Primary Care Services

To qualify for the Affordable Care Act of 2010 (ACA) rate increase for primary care services, a physician must have a specialty designated of general internal medicine, family practice, or pediatrics and must attest to one of the following:

- The provider has a certification recognized by the American Board of Allergy and Immunology (ABAI), American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), or American Osteopathic Association (AOA) and meets the requirements as required by federal and state regulation to receive the increased payment.
- The provider does not have a certification recognized by the ABAI, ABMS, ABPS, or AOA, but at least 60 percent of the provider's Medicaid billings for the previous calendar year (or for the previous calendar month if the provider has been enrolled in Medicaid for less than one year) were for the evaluation and management (E/M) and vaccine administration procedure codes as published in the final federal and state regulations and the provider meets the requirement to receive payment.

  Note: *New providers with no history of Medicaid billings can attest that 60 percent of their Medicaid billing will be for primary care services.*

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Providers can attest using the Texas Medicaid Attestation for ACA Primary Care Services Rate Increases form. ABAI-certified allergists must indicate "ABAI-allergy" in the "List subspecialties" field of the attestation form.

Important: *By signing the form, providers attest that they qualify for the rate increase, and that the increase will be applied to paid claims for primary care services on or after the effective date. Payment of the rate increase may be subject to retrospective review and recoupment if it is determined at a later time that the provider did not qualify for the ACA primary care services rate increase. Federal regulations require states to conduct an annual audit of provider attestations.*

Non-physician practitioners who are under the supervision of a provider who has self-attested, are not required to submit a separate provider attestation form. Increased payment may be available to the supervising physician when the following conditions are met:

- The non-physician practitioner renders services under the personal supervision of a provider who has self-attested to meeting the requirements.
- Services are billed under the qualifying provider's provider identification number.

10 Physician Assistant

10.1 Enrollment

To enroll in Texas Medicaid, a PA must be licensed and recognized as a PA by the Texas Physician Assistant Board. Texas Medicaid accepts a signed letter of certification from the Texas Physician Assistant Board as acceptable documentation of appropriate licensure and certification for enrollment. The PA must identify their supervising physician in the appropriate field of the enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days.

Enrollment as an individual provider is optional. PAs currently treating clients and billing under the supervising physician's NPI may continue this billing arrangement.

All PA services must be delivered according to protocols developed jointly within the scope of practice and state law governing PAs.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA are not reimbursed for laboratory services.

PAs may enroll as providers of THSteps medical checkups.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about enrolling as a THSteps provider.

PAs may be included as primary care providers in the provider network for Medicaid and CHIP programs (both fee-for-service and managed care), regardless of whether the physician supervising the PA is enrolled in Medicaid or in the provider network.

10.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by PAs are covered if the services meet the following criteria:

- Are within the scope of practice for PAs, as defined by Texas state law

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- Are consistent with rules and regulations promulgated by the Texas Medical Board or other appropriate state licensing authority
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO)
- Are reasonable and medically necessary as determined by HHSC or its designee

Services provided to Medicaid clients must be documented in the client's medical record to include the following:

- Services provided
- Date of service
- Pertinent information about the client's condition supporting the need for service
- The individual practitioner of the service

PAs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician's own NPI for services provided by a PA must submit modifier U7 on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and claims must be received within 95 days from the date of service.

Note: *Payment to providers for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.*

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 9, "Physician" in this handbook.

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 9.3, "Collaborative Care Model (CoCM)" in this handbook for information about CoCM services.

10.2.1 Prior Authorization

Services performed by a PA are subject to the same prior authorization guidelines as services performed by other provider types.

10.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including PA services. PA services are subject to retrospective review and recoupment if documentation does not support the service billed.

10.4 Claims Filing and Reimbursement

10.4.1 Claims Information

Claims for PA services must include modifier U7 on the claim details to indicate that the client was treated by a PA.

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

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When completing a CMS-1500 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.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

10.4.2 Reimbursement

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

Note: *PA providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps NPI as the billing provider.*

PAs who bill Medicaid directly for services they perform must use their individual NPI. If the services were performed by the PA but billed by a physician or physician group, the billing provider is the physician or physician group. Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by a PA if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, or injections provided by a PA.

Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on how to obtain electronic fee schedules from the TMHP website.

11 Claims Resources

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

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Resource	Location
Family Planning Claim Form Examples	Section 10, "Claim Form Examples" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

12 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

13 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Abortion Certification Statements Form
Attestation Form for the Collaborative Care Model (CoCM) in Texas Medicaid
DME Certification and Receipt Form
Hospital Report (Newborn Child or Children) (Form 7484)
Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information
Medicaid Certificate of Medical Necessity for Reduction Mammaplasty
Non-emergency Ambulance Exception Form
Non-emergency Ambulance Prior Authorization Request
Obstetric Ultrasound Prior Authorization Request Instructions
Obstetric Ultrasound Prior Authorization Request
Special Medical Prior Authorization (SMPA) Request Form
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)
THSteps Dental Mandatory Prior Authorization Request Form
Criteria for Dental Therapy Under General Anesthesia

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14 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Anesthesia
Certified Nurse-Midwife (CNM)
Certified Registered Nurse Anesthetist (CRNA)
Chiropractic Services
Dental (Doctor of Dentistry)
Dialysis Training
Genetics
Radiation Therapy
Surgery

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MEDICAL TRANSPORTATION PROGRAM HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human Services

MEDICAL TRANSPORTATION PROGRAM HANDBOOK

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1 General Information

The Medical Transportation Program (MTP), under the direction of the Texas Health and Human Services Commission (HHSC), arranges nonemergency medical transportation services and travel-related services for eligible fee-for-service (FFS) Medicaid, Children with Special Health Care Needs (CSHCN) Services Program, and Transportation for Indigent Cancer Patients (TICP) clients who have no other means of transportation. MTP is responsible for the prior authorization of all FFS MTP services. Medicaid managed care organizations (MCOs) are responsible for approval of managed care nonemergency medical transportation services. This handbook does not apply to managed care.

MTP provides for the following general services:

- Mass transit (intercity and intracity): Passes or tickets for client transport within a city and from city to city. Air travel is also an allowable service.
- Demand response transportation: Common carriers such as taxi, wheelchair van, and other transportation according to contractual requirements.
- Mileage reimbursement for registered individual transportation participant (ITP): The registered ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals: Eligible for clients birth through 20 years of age and their guardian or responsible adult.
- Lodging: Eligible overnight stays for clients birth through 20 years of age and their guardian or responsible adult.
- Advanced funds: Financial services travel-related expenses for clients birth through 20 years of age.

Under the contract between Texas Medicaid & Healthcare Partnership (TMHP) and HHSC, TMHP is responsible for enrollment of Demand Response Transportation Service (DRTS) providers, including Transportation Network Companies (TNC), registration of ITPs, and processing of certain MTP claims.

MTP contracts with various provider types to arrange transportation and travel-related services for eligible MTP clients and their attendants.

There are two MTP provider types that enroll directly with TMHP:

- DRTS
- TNC

Note: *ITPs register with TMHP but do not enroll as Medicaid providers.*

1.1 Contacting MTP

If health-care providers have MTP-eligible clients who express difficulty accessing health-care services, advise the clients or their advocates to call the statewide MTP toll-free number at 1-877-633-8747 to request transportation services. Clients or their advocates must call the MTP office at least 2 business days before the scheduled appointment. For clients who need to travel beyond the county where they live, clients or their advocates must call the MTP office at least 5 business days before the scheduled appointment. Appointments are available with less than 48-hour notice if they involve:

- Discharge of a client from a health care facility.
- Obtaining pharmacy services and prescription drugs.
- Receipt of urgent care.

The client must provide the following information to the intake operator at the time of the call:

- Client name, address, and, if available, the telephone number

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- Medicaid, TICP or CSHCN Services Program client identification number (if applicable) or Social Security number, and date of birth
- Name, address, and telephone number of health-care provider and/or referring health-care provider
- Purpose and date of trip and time of appointment
- Affirmation that other means of transportation are unavailable
- Special needs, including wheelchair lift or attendant(s)
- Medical necessity verified by the Health Care Provider's Statement of Need, if applicable
- Affirmation that advance funds are needed in order for the recipient to access health-care services

Note: *Clients must reimburse the department for any advance funds, and any portion thereof, that are not used for the specific prior authorized service.*

2 Individual Transportation Participants (ITP)

ITPs are individuals who use their personal vehicle to drive themselves, a friend, or a family member safely to the doctor, dentist, or drug store.

2.1 Registration for ITPs

To initiate the registration process, the MTP client must contact MTP to request a ride from an individual who is a potential ITP. This request is the first step in the registration process for the ITP.

After the client's call, MTP sends the potential ITP's information to TMHP, and TMHP mails the potential ITP a registration package. The ITP must fill out the Individual Transportation Participant Application and mail it to TMHP with all requested documentation.

The participant must identify the MTP clients they will be transporting and whether they are related to the client. The application packet also includes an Electronic Funds Transfer (EFT) Agreement form that authorizes TMHP to deposit payments directly into a bank account, which results in faster payments.

After the ITP application has been processed, the ITP will receive a letter from TMHP that includes the Atypical Provider Identifier (API) and the Taxonomy Code to be used when the ITP submits claim forms for mileage reimbursement.

2.2 Prior Authorization for ITPs

Once an ITP is registered with TMHP and a client calls MTP to request a ride, MTP will mail a preprinted ITP Service Record (Form H3017) to the MTP client. The H3017 is the form the ITP must mail to TMHP to be reimbursed for the ride.

Important: *Only claims that are authorized by MTP will be considered for payment. All claims must be prior authorized to be paid.*

Refer to: Subsection 3, "Prior Authorization" in this handbook.

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2.3 Claims Filing for ITPs

To file a claim, the ITP must complete the H3017 form that was sent to the Medicaid client and mail it to TMHP at the following address:

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

The H3017 includes the following transportation details:

- Date of the ride
- Number of miles authorized
- MTP Authorization Number
- MTP client's name
- ITP's name
- API
- Taxonomy code

The H3017 claim form must be signed by the doctor, dentist, or drug store representative that rendered services to the MTP client. This signature stands as proof that the ride authorized by MTP was taken. The ITP must also sign the claim form and include the API and taxonomy code that was assigned to them by TMHP. If any of this required information is missing, the claim will be denied.

The ITP must mail the completed claim form to TMHP after the client's authorized ride, but no later than 95 days from the date of the ride. Any claims received by TMHP more than 95 days after the date of the ride will be denied.

An ITP may not charge an MTP client a fee for completing claim forms or for denied claims or additional fees above the rate approved. TMHP also cannot be charged for the filing of claim forms.

3 Prior Authorization

All MTP services must be prior authorized by MTP, which issues all prior authorizations for transportation services. The eligible MTP client must contact MTP to obtain an authorization. Claims that are submitted without proper prior authorization will be denied.

3.1 Retention of Prior Authorization Documents

MTP prior authorization documents relating to Medicaid services or benefits provided to clients who are 20 years of age and younger must not be destroyed until the provider receives notice from HHSC. Examples of such documents include but are not limited to:

- Correspondence with HHSC/MTP;
- Invoices
- Receipts
- Contacts with clients who are class members

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3.2 Definition of Prior Authorization Documents

The term "prior authorization document" is broad and includes, but is not limited to, the following:

- Paper records
- Electronic files in any format
- Database entries
- The original and any drafts or non-identical copies of any document
- Exhibits or attachments to documents
- Handwritten documents
- Emails
- Drawings, graphs, charts
- Electronic or videotape recordings
- Computer disks
- Other forms of computer memory storage

3.3 Copies of Prior Authorization Documents

Providers are not required to retain multiple exact copies of a document. For example:

- An exact electronic copy (e.g., scanned computer image, microfiche) may be retained instead of a paper copy.
- If the last in a chain of emails is retained, it is not necessary to retain each of the individual emails included in the chain, as long as the email that is retained reflects all of the earlier emails.

However, a document containing any substantive editorial comment, margin notes, underlining, etc., is not an exact copy and becomes a new original that must be retained.

3.4 Storage of Prior Authorization Document Storage

Relevant information and documents should be stored in a way that is protected from unintentional disclosure or destruction.

4 Claims Filing

This section contains instructions for completion of Medicaid-required claim forms. When filing a claim, providers should review the instructions carefully and complete all requested information. A correctly completed claim form is processed faster.

Texas Medicaid cannot make payments to clients, so the provider who performs the service must file an assigned claim. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms or for denied claims or additional fees above the rate approved. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business. Providers cannot bill Texas Medicaid or Medicaid clients for missed appointments or failure to keep an appointment. Only claims for services rendered are considered for payment.

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Medicaid providers are also required to complete and sign authorized medical transportation forms (e.g., Form H3017, Individual Transportation Participant (ITP)) Service Record, or Form 3111, Verification of Travel to Healthcare Services by Mass Transit) or provide an equivalent (e.g., provider statement on official letterhead) to attest that services were provided to a client on a specific date. The client presents these forms to the provider.

Providers are not allowed to bill clients or Texas Medicaid for completing these forms.

Medicaid claims are subject to the following procedures:

- TMHP verifies all required information is present.
- Claims filed under the same provider identifier and program and ready for disposition at the end of each week are paid to the provider with an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) Report, which may be received as a downloadable portable document format (PDF) version or on paper. A Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 transaction file is also available for those providers who wish to import claim dispositions into a financial system.

An R&S Report is generated for providers that have weekly claim or financial activity with or without payment. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist during the time period, an R&S Report is not generated for the week.

Providers can participate in the most efficient and effective method of submitting claims to TMHP by submitting claims through the TMHP Electronic Data Interchange (EDI) claims processing system using TexMedConnect or a third party vendor. Claims must contain the provider's complete name, address, and provider identifier to avoid unnecessary delays in processing and payment.

4.1 Claims Filing Deadlines

All claims for services rendered to eligible MTP clients are subject to a filing deadline from the date of service (DOS) of:

- 95 days for in-state providers
- 365 days for out-of-state providers

Claims submitted by newly-enrolled MTP providers must be received within 95 days of the date the national provider identifier or the atypical provider identifier (API) is issued, and within 365 days of the DOS. Providers with a pending application should submit any claims that are nearing the 365-day deadline from the DOS. TMHP will reject all claims until an API is issued. MTP providers can use the TMHP rejection report or Return to Provider (RTP) letters as proof of meeting the 365 day deadline and submit an appeal.

4.2 Auditing of Claims

Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

HHSC and TMHP routinely perform retrospective reviews of all providers. HHSC ultimately is responsible for Texas Medicaid utilization review activities. This review includes comparing services billed to the client's clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client's medical record subjects the associated services to recoupment.

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4.3 Important Codes for All MTP Providers

MTP providers must use the following codes when submitting claims:

- Benefit Code = MTP
- Provider Type = MT
- Diagnosis Code = Z753
- Place of Service = 09 for paper claims, 99 for TexMedConnect claims
- Type of Service = 9
- Taxonomy Code = 347C00000X

The following table shows additional codes that TMHP recommends for filing MTP claims. The codes are based on transportation provider type:

MTP Provider Description	Provider Specialty	Taxonomy Code	Recommended Procedure Code	Modifier Codes
Individual Transportation Participant (ITP)	T4	347C00000X	S0215	
Demand Response Transportation Service Provider (DRTS)	TS	343800000X	T2003	U1
				U2
				U3
DRTS Transportation Network Company	TS	347C00000X	T2003	U1
				U2
				U3

4.4 Delegation of Signature Authority

A provider that delegate signatory authority to a member of the office staff or to a billing service remains responsible for the accuracy of all information on a claim submitted for payment. A provider's employees or a billing service and its employees are equally responsible for any false billings in which they participated or directed.

If the claim is prepared by a billing service or printed by data processing equipment, it is permissible to print "Signature on File" in place of the provider's signature. When claims are prepared by a billing service, the billing service must obtain and keep a letter on file that is signed by the provider authorizing claim submission.

4.5 Electronic Claims

4.5.1 TMHP Electronic Data Interchange (EDI)

Providers are encouraged to submit claims using electronic methods. Providers can participate in the most efficient and effective method of submitting requests to TMHP by submitting through the TMHP EDI Gateway. TMHP uses the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 5010 file format through a Secure File Transfer Protocol (SFTP) connection for maximum security. Providers can access TMHP's electronic services through the TMHP website at www.tmhp.com, TexMedConnect, vendor software, and billing agents. Providers may also submit claims using paper forms. Version 2001 0805 3 MTP Claim Filing.

Note: *This option is not applicable to ITPs.*

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4.5.2 TexMedConnect

TexMedConnect is a free, web-based, claims submission application provided by TMHP. Technical support and training for TexMedConnect are also available free from TMHP. DRTS/TNC Providers can submit claims, eligibility requests, claim status inquiries, appeals, and download ER&S Reports (in either PDF or ANSI 835 formats) using TexMedConnect. TexMedConnect can interactively submit individual claims that are processed in seconds. To use TexMedConnect, providers must have:

- An internet service provider (ISP)

One of the following:

- Microsoft Edge®
- Google Chrome®
- Mozilla Firefox®

A broadband connection is recommended but not required. Providers that use TexMedConnect can find the online instruction manual on the home page and on the EDI page of the TMHP website at www.tmhp.com.

Note: *This option is not applicable to ITPs.*

4.5.3 Vendor Software

Providers that do not use TexMedConnect may use vendor software to create, submit, and retrieve data files. Providers can use software from any vendor listed on the EDI Submitter List, which is located on the EDI Vendor Testing web page of the TMHP website at www.tmhp.com. There are hundreds of software vendors that have a wide assortment of services and that have been approved to submit electronic files to TMHP. Providers that plan to access TMHP's electronic services with vendor software should contact the vendor for details on software requirements. TMHP does not make vendor recommendations or provide any assistance for vendor software. Not all vendor software offers the same features or levels of support. Providers are encouraged to research their software thoroughly to make certain that it meets their needs and that it has completed testing with TMHP.

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

Providers that download the ANSI 835 file through TexMedConnect and providers that use vendor software must request a submitter ID. A submitter ID is necessary for vendor software to access TMHP's electronic services. It serves as an electronic mailbox for the provider and TMHP to exchange data files. To order a submitter ID, providers must call the EDI Help Desk at 1-888-863-3638. Providers that use a billing agent do not need a submitter ID.

Providers may receive an ER&S Report by completing the Electronic Remittance and Status (ER&S) Agreement and submitting it to the EDI Help Desk after setting up access to the TMHP EDI Gateway. 4 Version 2001 0805 MTP Claim Filing.

Note: *This option is not applicable to ITPs.*

4.5.4 Third Party Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before access to the production server is allowed. Vendors that wish to begin testing may call the EDI Help Desk at 1-888-863-3638, Option 3. After the successful submission of a Trading Partner Agreement, vendors must then complete end-to-end testing on the TMHP test server. Software vendors and billing agents must be partnered with at least one Texas provider before a test submitter ID can be issued. When end-to-end testing has been completed, the software vendor or billing agent will be added to the EDI Submitter List.

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Providers and billing agents may then order production submitter IDs for use with the vendor's software. Companion guides and vendor specifications are available in the EDI section of the TMHP website at www.tmhp.com.

Note: *This option is not applicable to ITPs.*

4.6 Paper Claims

MTP providers can also file claims using the CMS-1500 paper claim form. Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice. ITPs are required to submit H3017 claim form; TMHP does not supply them.

Providers must submit paper claims to TMHP at the following address:

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

4.6.1 Tips on Expediting Paper Claims

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

4.6.1.1 General requirements

- Use original claim forms. Don't use copies of claim forms.
- Detach claims at perforated lines before mailing.
- Use 10 x 13 inch envelopes to mail claims. Don't fold claim forms, appeals, or correspondence.
- Don't use labels, stickers, or stamps on the claim form.
- Don't send duplicate copies of information.
- Use 8 ½ x 11 inch paper. Don't use paper smaller or larger than 8 ½ x 11 inches.
- Don't mail claims with correspondence for other departments. Version 2001 0805 5 MTP Claim Filing

4.6.1.2 Data Fields

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

4.6.1.3 Attachments

- Use paper clips on claims or appeals if they include attachments. Don't use glue, tape, or staples.
- Place the claim form on top when sending new claims, followed by any medical records or other attachments.
- Number the pages when sending when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).

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- Don't total the billed amount on each claim form when submitting multi-page claims for the same client.

  Note: *It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send.*

- All paper claims must be submitted with an API or NPI.
- Modifiers describe and qualify the services provided by Texas Medicaid. A modifier is placed after the five-digit procedure code.

4.6.1.4 Attachments to Claims

To expedite claims processing, providers and ITPs must supply all information on the claim form itself and limit attachments to those required by TMHP or necessary to supply information to properly adjudicate the claim.

4.6.2 CMS-1500 Instruction Table

The table below describes what information must be entered in each of the block numbers of the CMS-1500 claim form. Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice; TMHP does not supply them.

Block numbers not referenced in the table may be left blank. They are not required for TMHP to process MTP claims.

CMS 1500 - Required MTP Information		
Block No	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the patient's MPCN (10-digit) patient number from the MTP authorization form.
2	Patient's name	Enter the patients last name, first name, and middle initial as printed on the MTP authorization form.
		If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.
21	Diagnosis or nature of illness or injury	The ICD-10-CM diagnosis codes recommended for MTP claims are Z753.
23	Prior authorization number	Enter the Prior Authorization Number issued by MTP.
24a	Date(s) of service	Enter the date of service for each MTP authorization provided in a MM/ DD/YYYY format.
24b	Place of service	The recommended POS code for MTP paper claims is 09. For electronic filing using TexMedConnect, the POS code is 99.
24d	Fully describe procedures, medical services, or supplies furnished for each date given	The recommended procedure code for DRTS claim is T2003.
24e	Diagnosis pointer	The recommended diagnosis codes are Z753 for all MTP claims.
24f	Charges	Indicate the charges for the service listed
24g	Days or units	Enter the number of services performed (such as the quantity billed) per MTP.
27	Accept assignment	Required
		All providers of the Texas Medicaid must accept assignment to receive payment by checking Yes.

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CMS 1500 - Required MTP Information		
Block No	Description	Guidelines
28	Total charge	Enter the total charges.
31	Signature of physician or supplier	An authorized representative must sign and date the claim.
		Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
33	Billing provider info & PH #	Enter the billing provider's name, street, city, state, ZIP+4 code, and telephone number.
33A	NPI	DRTS providers enter your NPI or API ITPs and TNCs enter your API
33B	Other ID #	Enter your taxonomy code

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OUTPATIENT DRUG SERVICES HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human
Services

OUTPATIENT DRUG SERVICES HANDBOOK

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1 General Information

The information in this handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to outpatient drugs.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers may also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

1.1 About the Vendor Drug Program

The Texas Vendor Drug Program (VDP) provides statewide access to prescription drugs as authorized by a prescribing provider for clients enrolled in:

- Medicaid (fee-for-service and managed care).
- Children's Health Insurance Program (CHIP).
- Children with Special Health Care Needs (CSHCN) Services Program.
- Healthy Texas Women (HTW) Program.
- Kidney Health Care (KHC) Program.

VDP manages the Medicaid and CHIP drug formularies and Medicaid Preferred Drug List (PDL).

Note: *Pharmacy services for clients in Medicaid managed care are administered by a client's managed care organization (MCO).*

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care prescription drug and pharmacy benefits.

1.2 Pharmacy Enrollment

VDP enrolls any eligible, in-state pharmacy licensed as Class A or C by the Texas State Board of Pharmacy.

Any out-of-state pharmacies or pharmacies holding any other class of pharmacy license are considered for inclusion in the program on a case-by-case basis. Consideration is relative to the benefits made available to the client eligible for pharmacy benefits. Enrollment is not granted unless additional benefits are established.

Pharmacy providers must enroll with Texas Medicaid through the Provider Enrollment and Management System (PEMS) before providing outpatient prescription services and prior to participating in any Medicaid managed care network. To participate in the Medicaid or CHIP managed care networks, the pharmacy must contact the health plan.

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Pharmacy providers enrolled with HHSC should refer to the VDP Pharmacy Provider Procedure Manual for policies and procedures pertaining to fee-for-service outpatient pharmacy claims, including drug benefit guidance, pharmacy prior authorization, coordination of benefits, drug pricing, and reimbursement.

Refer to: The *VDP Pharmacy Provider Procedure Manual* on the VDP website.

Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about procedures for enrolling as a Medicaid provider.

Subsection 2.2, "Provider Enrollment and Responsibilities" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

1.3 Program Contact Information

Vendor Drug Program	Contact
Pharmacy Benefits Access: for questions about outpatient drug and billing (the 800 number is for pharmacy use only and can be used to reach any area within VDP).	1-800-435-4165
Program Policy and Management	vdp-policy@hhs.texas.gov
Drug formulary (Texas listing of national drug codes)	vdp-formulary@hhs.texas.gov
Texas Pharmacy Prior Authorization Center	1-877-728-3927
Texas Pharmacy Third Party Call Center	1-866-389-5594
CAD information	vdp-cad@hhs.texas.gov
Texas Drug Utilization Review Board	vdp-advisory@hhs.texas.gov

1.4 Education

HHSC and TMHP provide several provider education and training opportunities.

1.4.1 Continuing Education

Texas Health Steps offers more than 40 continuing education courses accredited by the Accreditation Council of Pharmacy Education (ACPE). Pharmacy-related continuing education modules.

The Pharmacy module equips pharmacists and pharmacy providers in delivering outpatient pharmacy services to clients enrolled in Texas Medicaid, Children's Health Insurance Program, Children with Special Health Care Needs Services Program, Healthy Texas Women Program, and Kidney Health Care Program.

1.4.2 Texas Health Steps Quick Course

Quick courses are short, targeted training modules available to anyone. Most take 15 minutes or less to complete and do not offer continuing education credit. Outpatient drug-related quick-courses include the following:

- Prescriber's Guide to Medicaid Prior Authorizations
- Texas Medicaid Mosquito Repellent Benefit: What Pharmacy Providers Need to Know

1.4.3 * TMHP Learning Management System

The TMHP Learning Management System is an education portal. To access the LMS, providers must register and obtain a username. Refer to the LMS Registration and Navigation Job Aid to learn more about creating an account and navigating the LMS.

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- [Revised] TMHP LMS
- [Revised] LMS Registration and Navigation Job Aid

Pharmacy-related computer-based training (CBT) modules include the following:

- Durable Medical Equipment
  - The Pharmacy DME CBT provides DME and pharmacy DME providers information and resources necessary to enroll in Texas Medicaid as a DME provider and provide DME and supplies to Texas Medicaid clients.
- NDC Requirements for the Submission of Clinician-Administered Drug Claims
  - Provides information about national drug code (NDC) and healthcare common procedure coding system (HCPCS) requirements on clinician-administered drug (CAD) claims.

2 Clinician-Administered Drugs

2.1 Services, Benefits, Limitations, and Prior Authorization

Clinician-administered drugs or biologicals (CADs), also known as physician-administered drugs, are injectable medications given in an office or outpatient clinic setting when oral medications are not appropriate and may be reimbursable as a medical benefit through Texas Medicaid and CHIP.

Newly released HCPCS codes for CADs and biologicals are reviewed by Texas Medicaid throughout the year. If the CADs are determined to be appropriate benefits for Medicaid, then the HCPCS codes are presented at a rate hearing as part of the process to become a benefit. An application to initiate this review process is not necessary. HHSC's review of any new CAD does not guarantee that the new CAD will become a benefit. If a manufacturer is interested in having a CAD included on the Texas Vendor Drug Program (VDP) formulary list it is necessary to contact VDP for an application.

If a HCPCS code that already is a benefit of Texas Medicaid has a new NDC that needs to be added to the Texas NDC-to-HCPCs crosswalk, contact the Texas Vendor Drug Program. A new NDC for a currently payable HCPCs code generally does not require a new rate hearing.

Refer to: Subsection 10, "Pharmacy Benefit" in this handbook for more information.

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for information about the managed care prescription drug and pharmacy benefits.

2.1.1 Clinician-administered Drug Search

The VDP clinician-administered drug search is an online tool available to health-care providers to help clients get access to medications.

Users can search by either brand or generic name of the drug or product, the 11-digit national drug code (NDC), the HCPCS code, or the HCPCS description for products.

Refer to: The VDP CAD Search for more information.

2.1.2 Prior Authorization Requests

Prior authorization requests for CADs must be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal.

To facilitate determination of medical necessity and avoid unnecessary denials, the prescribing provider must submit correct and complete information, including documentation for medical necessity for the equipment or supplies requested, procedure codes, and numerical quantities for services requested. The provider must maintain documentation of medical necessity in the client's medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

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To complete the prior authorization process by paper, the provider must fax or mail the completed Special Medical Prior Authorization (SMPA) Request form to the Special Medical Prior Authorization (SMPA) unit.

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

A SMPA Request Form must be completed, signed, and dated by the prescribing provider. The SMPA form will not be accepted beyond 90 days from the date of the prescribing provider's signature.

The completed SMPA Request Form must be maintained by the prescribing provider in the client's medical record and is subject to retrospective review.

Documentation of the client's dosage, administration schedule, number of injections to be administered during the prior authorization period, requested units per injection, and the dosage calculation must be submitted in Section C of the Special Medical Prior Authorization (SMPA) Request Form under Statement of Medical Necessity.

2.1.3 Electronic Signatures in Prior Authorizations

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

3 Reimbursement

Clinician-administered drugs, vaccines, and biologicals are reimbursed under Texas Medicaid in accordance with 1 TAC rule §355.8085. Reimbursement for clinician-administered drugs, vaccines, and biologicals are based on the lesser of the billed amount, a percentage of the Medicare rate, or one of the following methodologies:

- If the drug or biological is considered a new drug or biological (that is, approved for marketing by the Food and Drug Administration within 12 months of implementation as a benefit of HHSC-administered programs), it may be reimbursed at an amount equal to 89.5 percent of average wholesale price (AWP).
- If the drug or biological does not meet the definition of a new drug or biological, it may be reimbursed at an amount equal to 85 percent of AWP.
- Vaccines may be reimbursed at an amount equal to 89.5 percent of AWP.
- Infusion drugs furnished through an item of implanted durable medical equipment may be reimbursed at an amount equal to 89.5 percent of AWP.
- Drugs, other than vaccines and infusion drugs, may be reimbursed at a percentage of the Medicare rate.

HHSC may use other data sources or methodologies to establish its fees for physician-administered drugs, vaccines, and biologicals when HHSC determines that the above methodologies are unreasonable or insufficient.

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Texas Medicaid reimburses providers using several different reimbursement methodologies, including fee schedules, reasonable cost with interim rates, hospital reimbursement methodology, provider-specific encounter rates, reasonable charge payment methodology, and manual pricing. Each Texas Medicaid service describes the appropriate reimbursement for each service area.

Note: *If a client is covered by a Medicaid managed care organizations (MCO) or dental plan, providers must contact the client's MCO or dental plan for reimbursement information. The MCOs and dental plans are not required to follow the Texas Medicaid fee schedules, so there may be some differences in reimbursement based on decisions made by the individual health and dental plans.*

When services or products do not have an established reimbursement amount, the detail or claim is manually reviewed to determine an appropriate reimbursement.

Texas Medicaid (FFS and MCO) providers can bill and receive reimbursement for the unused portion of weight-based or variable dosing CADs that are only manufactured in single-dose vials. A multi-dose vial is a vial of liquid medication that is intended for parenteral administration (injection or infusion), contains more than one dose of medication, and may be used for more than one patient preparation or administration. Multi-dose vials are excluded from reimbursement under Texas Medicaid for any unused or discarded portions.

Claims will only be considered for reimbursement if an HHSC review has determined that the medication has a weight-based, variable dosing schedule or that it requires dosing adjustments for pharmacokinetic or pharmacodynamic considerations. The administration of the medication for the recommended dosing must result in a patient dose portion plus a discarded portion of a drug vial. The provider may be eligible for reimbursement up to the amount of drug or biological in accordance with the drug label.

Claims submitted for the unused portion and discarded portion of weight-based or variable dosing clinician-administered drugs (CADs) manufactured only in single-dose vials must include the modifier JW for consideration of reimbursement.

This only applies to medical claims for weight-based or variable dosing CADs billed with Healthcare Common Procedure Coding System (HCPCS) procedure codes, manufactured only in single-dose vials, and provided in a professional or outpatient setting.

Providers must use the modifier JW to identify the unused portion of the vial contents and the discarded amount of the drug or biological. Medicaid and CHIP providers must bill the JW on a separate line.

Example: *A single use vial labeled to contain 100 units of a drug has 95 units administered to the client and 5 units discarded. The 95-unit dose is billed on one line, while the discarded 5 units are billed on another line by using the JW modifier. Both line items are reviewed for reimbursement. The provider must record the discarded amounts of drugs and biologicals in the client's medical record.*

Refer to: Subsection 9.1, "JW Modifier Claims Filing Instructions" in this handbook for further instructions about the JW modifier.

4 Injectable Medications as a Pharmacy Benefit

Some injectable drugs or biologicals are available by prescription and are reimbursable as a pharmacy benefit through the Vendor Drug Program (VDP) under Texas Medicaid.

Refer to: Subsection 10, "Pharmacy Benefit" in this handbook for more information.

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Oral medications that are given in the hospital or physician's office are considered part of the hospital or office visit and cannot be reimbursed separately. Take-home and self-administered drugs may be a pharmacy benefit when they are provided to eligible Texas Medicaid fee-for-service clients through VDP with a valid prescription.

Providers may utilize the "white-bagging" delivery method, in which the treating provider submits prescriptions to pharmacies and the prescription is shipped or mailed to the provider's office.

Refer to: Subsection 11.5.1, "Pharmacy Delivery Method for Clinician-Administered Drugs" in this handbook for additional information on the "white-bagging" delivery method.

Providers must use oral medication in preference to injectable medication in the office and outpatient hospital. If an oral medication cannot be used, the KX modifier must be submitted on the claim. The following situations are acceptable reasons for the use of administering an injectable medication instead of administering an oral medication.

Claim Form	Reason for Injection
Modifier KX	• No acceptable oral equivalent is available. • Injectable medication is the standard treatment of choice. • The oral route is contraindicated. • The client has a temperature over 102 degrees Fahrenheit (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly. • The client has demonstrated noncompliance with orally prescribed medication (must be documented on the claim and in the medical record). • Previously attempted oral medication regimens have proven ineffective (must be supported by documentation in the medical record). • Situation is emergent.

The claim and the client's medical record must include documentation of medical necessity to support the need for the service. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service and any modifier used when billing the claim.

5 National Drug Code (NDC)

The NDC is an 11-digit number on the package or container from which the medication is administered.

Some packages may display less than 11 digits. In those cases, leading zeros can be assumed and are required for billing. For example, 5678-0123-01 becomes 05678-0123-01. In another example, 78513-677-2 becomes 78513-0677-02.

Note: *The NDCs in the examples show hyphens between the segments for easier visualization. NDCs submitted on claims should not include hyphens or spaces between the segments.*

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information on NDC requirements as well as drug rebates.

5.1 Calculating Billable HCPCS and NDC Units

All drug claims must include HCPCS billing units as well as NDC billing units. HCPCS billing units are calculated by dividing the amount administered by the units found in the procedure code description. The calculated HCPCS billing unit is also needed to determine the correct NDC billing unit. NDC billing units are calculated by multiplying the HCPCS billing unit by the conversion factor. The conversion

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factor is calculated by dividing the HCPCS unit (found in the code description) by the NDC unit (found on the box or packaging). See calculation examples in the following sections. Conversion factors are already computed and included on the Texas NDC-to-HCPCS Crosswalk. The NDC billing unit also requires a unit of measurement. For example, if the NDC is for a liquid medication the submitted units must be in milliliters (ML). If the NDC is for a powder form then the submitted units are Unit (UN). Other allowable NDC units are GR for gram, F2 for international unit, and ME for milligram. For all claims, the HCPCS and NDC billing units are required, along with the specific NDC and HCPCS procedure code. Claims submitted with incorrect unit calculations may cause delayed or incorrect payment.

5.1.1 Single-Dose Vials Calculation Examples

Below are three examples of how to calculate the HCPCS and NDC billing units using single-dose vials.

1) A patient receives 4 mg Zofran IV in the physician's office. The NDC of the product used is 00173-0442-02 (Zofran 2 mg/ml in solution form). There are 2 milliliters per vial. The provider should bill J2405 for ondansetron hydrochloride with 4 HCPCS units and the NDC units submitted should be 2 ML.
2) A patient receives 8mg of Avastin IV in the physician's office. The NDC of the product used is 50242-060-01 (Avastin 25mg/ml). The provider should bill J9035 for bevacizumab with 0.8 HCPCS unit. The NDC unit is 0.32 ML.
3) A patient receives 1 gm Rocephin IM in the physician's office. The NDC of the product used is 00004-1963-02 (Rocephin 500 mg vial in a powder form that is reconstituted prior to the injection). The provider should bill J0696 for ceftriaxone sodium with 4 HCPCS units. The NDC units are 2 UN because this NDC is in powder form.

	Zofran	Avastin	Rocephin
Dose Administered to Patient	4 mg	8mg	1gm = 1000mg
HCPCS Code and Unit found in description	J2405 Per 1 mg	J9035 Per 10 mg	J0696 Per 250 mg
HCPCS CODE BILLING UNIT(s) = Dose divided by units found in HCPCS code description	4mg/1mg=4	8mg/10mg=0.8	1000mg/250mg=4
NDC Information on Vial/Box	2mg/ml	25mg/ml	500mg/vial (powder form)
Determining Conversion Factor (CF) = HCPCS unit from code description divided by NDC unit from vial/box	1mg/2mg=0.5 CF = 0.5	10mg/25mg=0.4 CF = 0.4	250mg/500mg=0.5 CF = 0.5
NDC BILLING UNIT(s) = HCPCS Units x CF	4 x 0.5 = 2 ML	0.8 x 0.4 = 0.32 ML	4 x 0.5 = 2 UN
Quantity Information Required on Claim (HCPCS and NDC)	4 and 2 ML	0.8 and 0.32 ML	4 and 2 UN

5.1.2 Multi-Dose Vials Calculation Examples

Below is an example of calculating the correct billing units for a drug administered from a multi-dose vial. Calculations for multi-dose vials differ from those for single-dose vials.

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A patient receives 8 mg Dexamethasone in the physician's office. A 20 mg multi-dose vial is used. The NDC of the product used is 63323-0165-05 (Dexamethasone 20 MG/5 ml Vial). The provider should bill J1100 for dexamethasone with 8 HCPCS units and the NDC units submitted should be 2 ML. There are 12mg (3 ml) remaining in the vial.

Multi-Dose Calculation Examples for Dexamethasone	
Dose Administered to Patient	8 mg
HCPCS Code and Given Unit	J1100 Per 8 mg
HCPCS CODE BILLING UNIT(s) = Dose divided by units found in HCPCS code	8mg/1mg = 8
NDC Information on Vial/Box	20mg/5ml = 4mg/1ml
NDC BILLING UNIT(s) = Dose divided by NDC unit from vial/box	8/4 = 2
Quantity Information Required on Claim (HCPCS and NDC)	8 and 2 ML

5.1.3 Single and Multi-Use Vials

A single-dose (or single-use) vial of medication intended for administration through injection or infusion contains a single dose of medication. A multi-dose (or multi-use) vial of medication intended for administration through injection or infusion contains more than one dose of medication.

Many drugs have recommended doses that are based on factors such as height, weight, and initial tolerance for the drug. It is important to clearly document how the dosage is calculated so those who review the patient health record can verify the dosage amount when reviewing the claim.

Other resources on clinician-administered drugs may be found online by visiting the TMHP, CDC and CMS websites.

5.1.4 Nonspecific, Unlisted, or Miscellaneous Procedure Codes

Drugs or biologicals that do not have a unique CPT or HCPCS procedure code must be billed using a nonspecific, unlisted, unclassified, or miscellaneous procedure code. All claims for nonspecific, unlisted, unclassified, or miscellaneous procedure codes are processed manually and must be submitted on paper with accompanying documentation. The billing provider must include the following required documentation:

- The name and NDC number of the drug administered.
- The quantity of the drug administered, the amount discarded (if applicable for reimbursement), and the units of measurement.
- A brief description of the recipient's condition(s) that supports the medical need for the drug.
- One of the following pricing information sources:
  - The manufacturer's average wholesale price (AWP)
  - A copy of the invoice for the drug

The claim and attached information will suspend for manual review to determine whether the drug is clinically appropriate based on the information provided and to price the claim using the information provided. Miscellaneous drug or biological procedure codes are reimbursed a percentage of the average wholesale price (AWP). HHSC reserves the option to use other data sources to determine Texas Medicaid fees for drugs when AWP calculations are determined to be unreasonable or insufficient.

The claim will be denied when:

- The information is not sufficient to determine medical necessity.

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- The pricing information is insufficient for pricing the claim.
- There is a more appropriate billing procedure code for the drug or biological.
- The NDC and HCPCs (if applicable) codes are missing.

Providers are responsible for administering drugs based on the U.S. Food and Drug Administration (FDA)-approved guidelines.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

Some injectable medications require prior authorization, which is a condition for reimbursement; it is not a guarantee of payment. To avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity for the service requested. The physician must maintain documentation of medical necessity in the client's medical record. Providers may fax or mail prior authorization requests, including all required documentation, to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

The following injections in the table below are benefits of Texas Medicaid but are subject to the indicated limitations. Those with an asterisk have more information and can be found listed after the table.

6 Outpatient Drugs—Benefits and Limitations

The clinician administered drugs identified throughout this handbook are benefits of Texas Medicaid, but are subject to the indicated limitations.

Clinician administered drugs may be considered for reimbursement in the home, office, or outpatient hospital settings. Certain procedure codes may be restricted for place of service and provider types. Providers should verify the restrictions for specific procedure codes of injectable or infused medications prior to rendering services.

6.1 Abatacept (Orencia)

Abatacept (Orencia) (procedure code J0129) is a selective T-cell costimulation modulator that is indicated for the following:

- Moderate to severe rheumatoid arthritis in adult clients. Concomitant use of abatacept with other immunosuppressives [e.g., biologic disease modifying antirheumatic drugs (bDMARDS), Janus kinase (JAK) inhibitors] is not recommended. Concomitant use with a Tumor necrosis factor (TNF) antagonist can increase the risk of infections and serious infections.
- Moderate to severe juvenile arthritis in adult and pediatric clients who are 2 years of age or older (clients who are 2 years of age or older may receive subcutaneous formulation and clients who are 6 years of age or older may receive intravenous formulation). Abatacept may be used as monotherapy or concomitantly with methotrexate.
- Psoriatic arthritis in clients who are 2 years of age or older.
- The prophylaxis of acute graft versus host disease (aGVHD), in combination with a calcineurin inhibitor and methotrexate, in adults and pediatric clients who are 2 years of age or older undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor.

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6.1.1 Prior Authorization for Abatacept (Orencia)

Prior authorization may be given for an initial six months for eight doses. Prior authorization for an initial request for abatacept injections will be considered when all of the following criteria are met:

- Dates of treatment
- The number of anticipated doses
- The dosage to be administered
- Diagnosis of adult RA, juvenile idiopathic arthritis (JIA), adult psoriatic arthritis (PsA), or as prophylaxis of acute graft versus host disease (aGVHD)

A diagnosis of RA in an adult client must conform to the American College of Rheumatology (ACR) RA classification that requires the following:

- Presence of synovitis in at least one joint
- Absence of an alternative diagnosis to explain the synovitis
- Abatacept will not be used in combination with another biologic agent
- A combined score of at least six out of ten on the level of involved joints, abnormality, and symptom duration from the individual scores in four domains:
    - The number and sites of involved joints
    - Serologic abnormality
    - Elevated acute-phase response
    - Symptom duration

Prior authorization for moderate to severe Juvenile Idiopathic Arthritis (JIA) will be considered when the following criteria are met:

- The client is an adult or pediatric client who is 2 years of age or older.
- Clients who are 2 years of age or older may receive subcutaneous formulation, and clients who are 6 years of age or older may receive intravenous formulation.
- Abatacept (Orencia) may be used as monotherapy or concomitantly with methotrexate.

Prior authorization for adult Psoriatic Arthritis (PsA) will be considered when the following criteria are met:

- The client is 2 years of age or older.
- Abatacept (Orencia) will not be used in combination with another biologic agent.

Prior authorization for prophylaxis acute graft versus host disease will be considered when the following criteria are met:

- The client is 2 years of age or older.
- Abatacept should be used in combination with a calcineurin inhibitor and methotrexate.
- The client is undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor.

Screening for latent tuberculosis (TB) infection and viral hepatitis should be carried out prior to therapy initiation.

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Prior authorization for subsequent dosing may be given when documentation supports medical necessity for continued treatment with abatacept. Prior authorization for a subsequent request must include all of the following:

- Documentation from the physician stating that there has been at least an improvement
- The number of anticipated doses
- The dosage to be administered

The documentation of medical necessity must be maintained by the requesting provider in the client's medical record and is subject to retrospective review.

6.2 Adalimumab

Adalimumab is a benefit when billed with one of the following procedure codes:

Procedure Codes									
J0139	Q5140	Q5141	Q5142	Q5143	Q5144	Q5145			

Procedure codes Q5141, Q5142, and Q5144 are restricted to clients who are 2 years of age or older.

Procedure codes Q5140, Q5143, and Q5145 are restricted to clients who are 4 years of age or older.

Procedure codes Q5140, Q5142, Q5144, and Q5145 may be reimbursed when billed with diagnosis codes M05A and R7681, in addition to the diagnosis codes listed in the table below.

Procedure code Q5141 may be reimbursed when billed with diagnosis code R7681, in addition to the diagnosis codes listed in the table below.

The procedure codes in the table above may be reimbursed when billed with one of the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5100	K51011	K51012	K51013	K51014	K51018	K5120
K51211	K51212	K51213	K51214	K51218	K5130	K51311	K51312
K51313	K51314	K51318	K5140	K51411	K51412	K51413	K51414
K51418	K51419	K5150	K51511	K51512	K51513	K51514	K51518
K5180	K51811	K51812	K51813	K51814	K51818	K5190	K51911
K51912	K51913	K51914	K51918	K51919	L400	L401	L402
L403	L404	L4050	L4051	L4052	L4053	L4054	L4059
L408	L409	M00039	M00071	M00072	M00079	M00171	M00172
M00179	M00271	M00272	M00279	M00871	M00872	M00879	M0500
M05011	M05012	M05019	M05021	M05022	M05029	M05031	M05032
M05039	M05041	M05042	M05049	M05051	M05052	M05059	M05061
M05062	M05069	M05071	M05072	M05079	M0509	M05271	M0530
M05411	M05412	M05421	M05422	M05431	M05432	M05441	M05442
M05451	M05452	M05461	M05462	M05471	M05472	M0549	M05511
M05512	M05521	M05522	M05531	M05532	M05541	M05542	M05551

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Diagnosis Codes							
M05552	M05561	M05562	M05571	M05572	M0559	M0560	M05611
M05612	M05619	M05621	M05622	M05629	M05631	M05632	M05639
M05641	M05642	M05649	M05651	M05652	M05659	M05661	M05662
M05669	M05671	M05672	M05679	M0569	M05711	M05712	M05721
M05722	M05731	M05732	M05741	M05742	M05751	M05752	M05761
M05762	M05769	M05771	M05772	M05779	M0579	M057A	M05811
M05812	M05821	M05822	M05831	M05832	M05841	M05842	M05851
M05852	M05861	M05862	M05871	M05872	M0589	M058A	M06011
M06012	M06021	M06022	M06031	M06032	M06041	M06042	M06051
M06052	M06061	M06062	M06071	M06072	M0608	M0609	M060A
M061	M06811	M06812	M06819	M06821	M06822	M06829	M06831
M06832	M06839	M06841	M06842	M06849	M06851	M06852	M06859
M06861	M06862	M06869	M06871	M06872	M06879	M0688	M0689
M068A	M069	M0800	M08011	M08012	M08019	M08021	M08022
M08029	M08031	M08032	M08039	M08041	M08042	M08049	M08051
M08052	M08059	M08061	M08062	M08069	M08071	M08072	M08079
M0808	M0809	M081	M08811	M08812	M08821	M08822	M08831
M08832	M08839	M08841	M08842	M08849	M08851	M08852	M08859
M08861	M08862	M08871	M08872	M0888	M0889	M08911	M08912
M08919	M08921	M08922	M08929	M08931	M08932	M08939	M08941
M08942	M08949	M08951	M08952	M08959	M08961	M08962	M08969
M08971	M08972	M0898	M13871	M13872	M13879	M450	M451
M452	M453	M454	M455	M456	M457	M458	M459
M45A0	M45A1	M45A2	M45A3	M45A4	M45A5	M45A6	M45A7
M45A8	M45AB	M488X1	M488X2	M488X3	M488X4	M488X5	M488X6
M488X7	M488X8	M488X9					

6.3 Ado-trastuzumab entansine (Kadcyla)

Ado-trastuzumab emtansine (Kadcyla), procedure code J9354, is a benefit of Texas Medicaid for clients of any age when all of the following indications are present:

- Individuals have a diagnosis of HER2 positive metastatic breast cancer
- Individuals have previously received trastuzumab and a taxane separately or in combination, and have either:
  - Received prior therapy for metastatic disease
  - Experienced disease reoccurrence during or within six months of completing adjuvant therapy

Documentation must be maintained by the treating physician in the client's medical record to support administration of Ado-trastuzumab emtansine (Kadcyla). Prior authorization is not required for ado-trastuzumab emtansine (Kadcyla).

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At initiation of treatment, documentation must include all of the following:

- Evidence of HER2 positive breast cancer as evidenced by immunochemistry (IHC) test or fluorescent in situ hybridization (FISH) test
- Evidence of metastatic breast cancer
- Evidence demonstrating prior treatment for this diagnosis with trastuzumab and a taxane oncology agent separately or in combination
- Evidence demonstrating receipt of prior therapy for this diagnosis or recurrent disease, including the previous treatment protocol, within six months of completing adjuvant therapy.

6.4 Afamelanotide Implant (Scenesse)

Afamelanotide implant (Scenesse) (procedure code J7352) is a benefit of Texas Medicaid for clients who are 18 years of age or older and is restricted to diagnosis code E800.

6.5 Afamitresgene autoleucel (Tecelra)

Afamitresgene autoleucel (Tecelra) is a melanoma-associated antigen A4 (MAGE-A4)-directed genetically modified autologous T cell immunotherapy indicated to treat adult clients with unresectable or metastatic synovial sarcoma who have received prior chemotherapy, are HLA-A*02:01P, HLA-A*02:02P, HLA-A*02:03P, or HLA-A*02:06P positive and whose tumor expresses the MAGE-A4 antigen as determined by FDA-approved or cleared companion diagnostic devices.

Afamitresgene autoleucel (Tecelra) (procedure code Q2057) is a benefit of Texas Medicaid with prior authorization.

6.5.1 Prior Authorization Requirements

Afamitresgene autoleucel (Tecelra) is administered as a single intravenous infusion and is indicated to treat clients who meet all the following requirements:

- The client is 18 years of age or older.
- The client has a diagnosis of unresectable or metastatic synovial sarcoma with one of the following diagnosis codes:

Diagnosis Codes							
C380	C381	C382	C383	C384	C388	C481	C482
C488	C490	C4910	C4911	C4912	C4920	C4921	C4922
C493	C494	C495	C496	C498	C499		

- The client's tumor is positive for human leukocyte antigen HLA-A*02:01P, HLA-A*02:02P, HLA-A*02:03P, or HLA-A*02:06P.
- The client's tumor expresses the MAGE-A4 antigen (as determined by an FDA-approved or cleared companion diagnostic device).
- The client is not heterozygous or homozygous for HLA-A*02:05P.
- The client has experienced disease progression following at least one or more prior systemic chemotherapy.
- The client has not received prior treatment with CAR-T therapy.
- The client has not had a prior hematopoietic stem cell transplant (HSCT).
- The client does not have any active or clinically significant infections and/or inflammatory disorders.

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Afamitresgene autoleucel (Tecelra) (procedure code Q2057) is limited to one transfusion treatment per lifetime.

Monitoring parameters for Afamitresgene autoleucel (Tecelra) are as follows:

- Monitor for signs and symptoms of cytokine release syndrome (CRS) for at least 7 days following afamitresgene autoleucel (Tecelra) treatment with continued monitoring for at least 4 weeks.
- Monitor for signs and symptoms of immune effector cell-associated neurotoxicity syndrome (ICANS) for at least 7 days following afamitresgene autoleucel (Tecelra) treatment with continued monitoring for at least 4 weeks.

6.5.2 Documentation Requirements

In addition to documentation requirements outlined in the Prior Authorization Requirements section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.6 Allogeneic Processed Thymus Tissue-agdc (Rethymic)

Allogeneic processed thymus tissue-agdc (Rethymic) is indicated for immune reconstruction in pediatric clients with congenital athymia.

Allogeneic processed thymus tissue-agdc (Rethymic) is a benefit of Texas Medicaid with prior authorization and may be reimbursed using procedure code J3590.

Allogeneic processed thymus tissue-agdc (Rethymic) is limited to once per lifetime.

6.6.1 Prior Authorization Requirements

Providers must submit prior authorization requests for allogeneic processed thymus tissue-agdc (Rethymic) on a Special Medical Prior Authorization (SMPA) Request Form.

The prior authorization request for the one-time surgical procedure for allogeneic processed thymus tissue-agdc (Rethymic) administration must include documentation of the following:

- The client is 18 years of age or younger.
- The client has a diagnosis of congenital athymia that is confirmed by flow cytometry (diagnosis code D821).
- Severe combined immunodeficiency (SCID) has been conclusively ruled out.
- An anti-human leukocyte antigen (HLA) antibody test was conducted prior to treatment. If the client tests positive for anti-HLA antibodies, they must receive allogeneic processed thymus tissue-agdc (Rethymic) from a donor who does not express HLA alleles.
- The prescriber must attest that the benefits and risks of treatment have been evaluated for clients with preexisting cytomegalovirus (CMV) infection or renal impairment.
- The client has not previously received thymus tissue transplantation.

After the surgical implantation of allogeneic processed thymus tissue-agdc (Rethymic), the prescriber must monitor the client for:

- The risk of developing of graft versus host disease (GVHD).
- The possibility of developing autoimmune or lymphoproliferative disorders, which is monitored through complete blood counts (CBC) with differential, liver enzymes, serum creatinine, urinalysis, and thyroid function.
- Renal impairment or failure.

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- The occurrence of an infectious disease, as these may develop due to allogeneic processed thymus tissue-agdc (Rethymic) is derived from human tissue.

In addition to documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.7 Alzheimer's Disease (AD)

Donanemab-azbt (Kisunla) (procedure code J0175) and lecanemab-irmb (Leqembi) (procedure code J0174) are benefits of Texas Medicaid for clients with prior authorization. Procedure codes J0174 and J0175 are limited to diagnosis codes G300, G301, G308, or G309.

Donanemab-azbt (Kisunla) and lecanemab-irmb (Leqembi) are amyloid beta-directed antibodies indicated to treat Alzheimer's disease (AD) by reducing amyloid-beta plaques in clients with mild cognitive impairment (MCI) or mild dementia stage of disease.

This clinical prior authorization applies to Medicaid clients only. Dual eligible clients must follow the Medicare National Coverage Determination policy guidelines for monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease.

6.7.1 Prior Authorization

Initial Requests

Initial therapy for donanemab-azbt (Kisunla) or lecanemab-irmb (Leqembi) may be approved for a 6-month duration if all the following criteria are met:

- Client has a confirmed diagnosis of Alzheimer's disease (G300, G301, G308, or G309).
- Prescriber attestation that other forms of dementia except Alzheimer's disease have been ruled out by appropriate lab and/or other diagnostic testing.
- Prescriber's confirmation of amyloid beta-plaques presence.
- Clinical testing must confirm client has mild cognitive impairment caused by Alzheimer's disease or mild stage of Alzheimer's disease.
- Documentation that client has received a baseline brain-magnetic resonance imaging (MRI) prior to initiating treatment (within the past year) to evaluate for pre-existing Amyloid Related Imaging Abnormalities (ARIA).
- The prescriber attests to having tested for ApoE ε4 status and counsel ApoE ε4 homozygotes clients on higher incidence of developing ARIA prior to initiation of treatment.
- The following are the monitoring requirements during the donanemab-azbt (Kisunla) treatment period:
  - Prescriber must ensure the client is not currently taking any anti-coagulant (except for aspirin at a prophylactic dose or less) or have a history of clotting disorder.
  - Prescriber must monitor for ARIA during the first 24 weeks of treatment.
  - Prescriber attestation to obtain a brain MRI prior to the 2nd, 3rd, 4th, and 7th infusion to check for asymptomatic ARIA.
  - Clients with severe amyloid-related imaging abnormalities-hemosiderin deposition (ARIA-H) may continue therapy only if radiographic stabilization has been confirmed by a follow-up brain MRI and supported by clinical evaluation.

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The following are the monitoring requirements during the lecanemab-irmb (Leqembi) treatment period:

- Prescriber must monitor for ARIA during the first 14 weeks of treatment.
- Prescriber attestation to obtain a brain MRI prior to the 5th, 7th, and 14th infusion to check for ARIA.
- Clients with severe ARIA-H may continue therapy only if radiographic stabilization has been confirmed by a follow-up brain MRI and supported by clinical evaluation.

Re-certification/Extension

For renewal or continuation therapy of donanemab-azbt (Kisunla) or lecanemab-irmb (Leqembi), the client must meet the following requirements:

- Client continues to meet all the initial authorization approval criteria.
- Client has not progressed to moderate or severe dementia caused by Alzheimer's disease.
- Client experienced positive clinical response to therapy as demonstrated by no increase in amyloid plaque or radiographic stabilization as compared to baseline.
- Documentation of a brain MRI prior to the 2nd, 3rd, 4th, and 7th infusion to check for ARIA with donanemab-azbt (Kisunla) treatment.
- Documentation of brain MRI prior to the 5th, 7th, and 14th infusion to check for ARIA with lecanemab-irmb (Leqembi) treatment.
- Client has not experienced any complications or unacceptable toxicities during donanemab-azbt (Kisunla) or lecanemab-irmb (Leqembi) treatment.

6.8 Amisulpride (Barhemsys)

Amisulpride (procedure code J0184) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.9 Antibiotics and Steroids

Injectable antibiotic or steroid medications may be considered for reimbursement even if the same oral medications are appropriate and available. Injected antibiotics or steroid medications, when used in place of oral medications, require the use of the modifier KX.

Physicians billing for injectable antibiotic and steroid medications must indicate the appropriate modifiers with the appropriate injection code and quantity.

Modifier	Use
AT	For acute conditions*
KX	To indicate any of the following: • Oral route contraindicated or an acceptable oral equivalent is not available. • Injectable medication is the accepted treatment of choice. Oral medication regimen has proven ineffective or is not applicable. • The patient has a temperature over 102 degrees and a high level of antibiotic is needed immediately. • Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare-up of a chronic condition.

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If a steroid medication is injected into joints, bursae, tendon sheaths, or trigger points, modifier AT must be used to indicate an acute condition. When performed for a chronic condition, these procedures are denied.

6.10 Antineoplastic (Oncology) Agents

6.10.1 Amivantamab-vmjw (Rybervant)

Amivantamab-vmjw (procedure code J9061) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.2 Cemiplimab-rwlc (Libtayo)

Cemiplimab-rwlc (procedure code J9119) is a benefit for clients who are 18 years of age and older.

6.10.3 Daratumumab and Hyaluronidase-fihj (Darzalex Faspro)

Daratumumab and hyaluronidase-fihj (procedure code J9144) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.4 Degarelix (Firmagon)

Degarelix injection (procedure code J9155) is a benefit when billed with diagnosis codes C61, C7982, D400.

Refer to: Subsection 6.62.9, "Hormonal Therapy Agents" in this handbook for additional information.

6.10.5 Dostarlimab-gxly (Jemperli)

Dostarlimab-gxly (procedure code J9272) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.6 Enfortumab Vedotin-ejfv (Padcev)

Enfortumab vedotin-ejfv (procedure code J9177) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.7 Hydroxyprogesterone Caproate

Hydroxyprogesterone caproate (procedure code J1729) is a benefit and restricted to clients who are nonpregnant women when billed with the following diagnosis codes:

Diagnosis Codes							
C541	N897	N910	N911	N912	N925	N938	

6.10.8 Isatuximab-irfc (Sarclisa)

Isatuximab-irfc (procedure code J9227) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.9 Loncastuximab Tesirine-lpyl (Zynlonta)

Loncastuximab tesirine-lpyl (procedure code J9359) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.10 Lurbinectedin (Zepzelca)

Lurbinectedin (procedure code J9223) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

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6.10.11 Margetuximab-cmkb (Margenza)

Margetuximab-cmkb (procedure code J9353) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.12 Melphalan (Evomela)

Melphalan (procedure codes J9245 and J9246) are a benefit when billed with diagnosis codes C9000, C9001, and C9002.

6.10.13 Mitomycin for Pyelocalyceal Solution (Jelmyto)

Mitomycin for pyelocalyceal solution (procedure code J9281) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.14 Naxitamab-gqgk (Danyelza)

Naxitamab-gqgk (procedure code J9348) is a benefit of Texas Medicaid for clients who are 1 year of age or older.

6.10.15 Polatuzumab vedotin (Polivy)

Polatuzumab vedotin (procedure code J9309) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.16 Sacituzumab govitecan-hziy (Trodelvy)

Sacituzumab govitecan-hziy (procedure code J9317) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.17 Tafasitamab-cxix (Monjuvi)

Tafasitamab-cxix (procedure code J9349) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.10.18 Tisotumab Vedotin-tftv (Tivdak)

Tisotumab Vedotin-tftv (procedure code J9273) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.11 Antisense Oligonucleotides (eteplirsen, golodirsen, and nusinersen)

Antisense oligonucleotides, casimersen (Amondys 45) (procedure code J1426), eteplirsen (Exondys 51) (procedure code J1428), golodirsen (Vyondys 53) (procedure code J1429), nusinersen (Spinraza) (procedure code J2326), tofersen (Qalsody) (procedure code J1304), or viltolarsen (Viltepso) (procedure code J1427) may be benefits of Texas Medicaid with prior authorization.

An antisense oligonucleotide is a synthetic single stranded nucleic acid that binds to RNA and thereby alters or reduces expression of the target RNA. This may result in an improvement in physical function.

6.11.1 Prior Authorization Requirements

Prior authorization requests for procedure codes J1304, J1426, J1427, J1428, J1429, and J2326 must be submitted by the prescribing provider to the Special Medical Prior Authorization (SMPA) department at TMHP using the Special Medical Prior Authorization (SMPA) Request Form.

Prior authorization is not required for physician services associated with the administration of casimersen, eteplirsen, golodirsen, nusinersen, tofersen, or viltolarsen. Physician services include the procedural costs and the associated supplies for the administration of the medication.

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For situations in which procedure code J1304, J1426, J1427, J1428, J1429, or J2326 are being dispensed by a pharmacy via white bagging, the prescribing provider must provide the dispensing durable medical equipment (DME) pharmacy the authorization approval number.

The dispensing DME pharmacy may not request prior authorization.

The DME pharmacy provider billing for nusinersen (Spinraza) (procedure code J2326) will be responsible for coordinating with the rendering provider to obtain the prior authorization request approval number.

The requesting provider (physician or hospital) may coordinate with the DME Pharmacy provider for the initial or recertification prior authorization request for the specific oligonucleotide. DME Pharmacy providers may assist in providing necessary information such as their National Provider Identifier (NPI) number, fax number, and business address to the requesting provider. However, the Special Medical Prior Authorization (SMPA) form must be signed and dated and submitted by the Medicaid-enrolled requesting provider, not the DME Pharmacy provider.

The dispensing pharmacy must submit the authorization approval number when billing for the drug. Reimbursement for dispensing of the drug by the pharmacy may not occur unless an approved prior authorization for the specific oligonucleotide is in place.

Note: *For additional information on white bag delivery, providers may refer to Subsection 11.5.1, "Pharmacy Delivery Method for Clinician-Administered Drugs" in this handbook.*

Documentation of the client's dosage, administration schedule, the number of injections to be administered during the prior authorization period, the requested units per injection, and the dosage calculation must be submitted in Section C of the SMPA Request Form under Statement of Medical Necessity. When the FDA approves dosing guidelines that require a weight based calculation, the client's current weight must be included.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.11.1.1 Initial Requests (for all Antisense Oligonucleotides)

Initial prior authorization requests for all antisense oligonucleotides will be considered by Medical Director Review for a six month period. The initial request must include documentation supporting medical necessity for the requested antisense oligonucleotide in addition to the SMPA request form completed, signed, and dated by the prescribing provider.

Documentation supporting medical necessity for an initial prior authorization for all requested antisense oligonucleotides must include the following information:

- A diagnosis specific to the requested antisense oligonucleotide
- Genetic testing specific to the requested antisense oligonucleotide
- Documentation of baseline physical function. Testing tools used to measure physical function must be age appropriate for the client being tested.
- Documentation of the requested antisense oligonucleotide dosage and administration schedule, including the number of injections to be administered during the prior authorization period, the requested units per injection, and the dosage calculation. This information must be submitted in Section C of the SMPA request form under Statement of Medical Necessity.

Each antisense oligonucleotide has specific clinical indications and unique documentation requirements.

The initial request for casimersen (Amondys 45) must include the following documentation to support medical necessity for casimersen.

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- Genetic testing must confirm that the client's Duchenne muscular dystrophy (DMD) gene is amenable to exon 45 skipping (diagnosis code G7101).
- Serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio should be measured prior to initiating Amondys 45.
- Monitor baseline renal function (i.e. Glomerulus Filtration Rate, GFR) with therapy initiation and continuation.
- Current client weight, including the date the weight was obtained; the weight must be dated no more than 30 days before the requestdate.

Testing tools that can be used to demonstrate physical function include, but are not limited to:

- Baseline 6MWT (6-minute walk test)
- BrookeUpperExtremity Scale
- North Star Ambulatory Assessment

Amondys 45 should not be used concomitantly with other exon skipping therapies for DMD.

The initial request for eteplirsen (Exondys 51) must include the following documentation to support medical necessity for eteplirsen:

- Genetic testing must confirm that the client's DMD gene is amenable to exon 51 skipping (diagnosis code G7101).
- Current client weight, including the date the weight was obtained; the weight must be dated no more than 30 days before the request date.

Testing tools that can be used to demonstrate physical function include, but are not limited to:

- Brooke Upper Extremity Scale
- Baseline 6-minute walk test (6MWT)
- Pediatric Evaluation of Disability Inventory

Exondys 51 should not be used concomitantly with other exon skipping therapies for DMD.

The initial request for golodirsen (Vyondys 53) must include the following documentation to support medical necessity for golodirsen:

- Genetic testing must confirm that the client's Duchenne muscular dystrophy (DMD) gene is amenable to exon 53 skipping (diagnosis code G7101).
- Baseline renal function test (i.e. Glomerulus Filtration Rate, GFR) with therapy initiation and continuation.
- Current client weight, including the date the weight was obtained; the weight must be dated no more than 30 days before the request date.
- Baseline function testing documented in patient chart or electronic health record.

Testing tools that can be used to demonstrate physical function include, but are not limited to:

- Brooke Upper Extremity Scale
- Baseline 6MWT (6-minute walk test)
- Pediatric Evaluation of Disability Inventory

Vyondys 53 should not be used concomitantly with other exon skipping therapies for DMD.

The initial request for nusinersen (Spinraza) must include the following documentation to support medical necessity for nusinersen:

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- Genetic testing must confirm biallelic pathogenic variants in the client's survival motor neuron 1 (SMN1) gene (diagnosis codes G120, G121, G128, and G129).
- Baseline pulmonary status, including any requirements for invasive or non-invasive ventilation

Testing tools that can be used to demonstrate physical function include, but are not limited to:

- The Hammersmith Infant Neurological Exam (HINE).
- The Hammersmith Functional Motor Scale Expanded (HFMSE).
- The Upper Limb Module (UML).
- Baseline 6MWT.
- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND).

The initial request for tofersen (Qalsody) must include the following documentation:

- The client is 18 years of age or older.
- Diagnostic testing confirming client has amyotrophic lateral sclerosis (ALS) (diagnosis code G1221).
- Genetic testing must confirm there is the presence of a mutation in the superoxide dismutase1 (SOD1) gene.
- Documentation of baseline measure of the plasma neurofilament light chain (NfL).
- Documentation of baseline functional ability (e.g., climbing stairs, walking, and speech) prior to treatment initiation.

The initial request for viltolarsen (Viltepso) must include the following documentation:

- Genetic testing must confirm that the client's Duchenne muscular dystrophy (DMD) gene is amenable to exon 53 skipping (diagnosis code G7101).
- Current client weight, including the date the weight was obtained; the weight must be dated no more than 30 days before the request date.
- Baseline renal function test (i.e. Glomerulus Filtration Rate) and urine protein-to-creatinine ratio should be measured before starting treatment.

Testing tools that can be used to demonstrate physical function include, but are not limited to:

- Brooke Upper Extremity Scale
- Baseline 6MWT (6-minute walk test)
- Pediatric Evaluation of Disability Inventory

Viltepso should not be used concomitantly with other exon skipping therapies for DMD.

6.11.1.2 Recertification/Extension Requests (for all Antisense Oligonucleotides)

Recertification/extension prior authorization requests for antisense oligonucleotides, excluding nusinersen (Spinraza), will be considered by Medical Director Review for additional six month periods. Recertification/extension prior authorization requests for nusinersen (Spinraza) will be considered by Medical Director Review for additional 12-month periods. All recertification/extension requests must include documentation supporting the ongoing medical necessity for the requested antisense oligonucleotide in addition to a new SMPA request form completed, signed, and dated by the prescribing provider.

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A complete recertification/extension request must be received no earlier than 30 days before the current authorization period expires. Requests for recertification/extension of prior authorization received after the current prior authorization expires will be denied for dates of service that occurred before the date the request is received.

Documentation supporting a recertification/extension prior authorization for all requested antisense oligonucleotide must include the following:

- A diagnosis specific to the requested antisense oligonucleotide
- Current documentation of physical function
- Testing tools used to measure physical function must be age appropriate for the client being tested. Providers must use the same testing instrument as used in the initial evaluation. If re-use of the initial testing instrument is not appropriate, for example, due to change in client status or restricted age range of the testing tool, the provider must explain the reason for the change.
- The physical function testing tool results must include one of the following:
  - An increase in physical function from baseline has been observed
  - Baseline physical function has been maintained
- Statement from prescribing clinician that the client has been compliant with the treatment
- Documentation of the requested antisense oligonucleotide dosage and administration schedule, including the number of injections to be administered during the prior authorization period, the requested units per injection, and the dosage calculation must be submitted in Section C of the Special Medical Prior Authorization (SMPA) Request Form under Statement of Medical Necessity.

The medical necessity documentation for eteplirsen (Exondys 51) recertification/extension requests must include the client's current weight the date on which the weight was obtained. The weight must be dated no more than 30 days before the request date.

The medical necessity documentation for casimersen, golodirsen and viltolarsen recertification/ extension requests must include the client's continual renal function test while on therapy and current client weight, including the date the weight was obtained. The weight must be dated no more than 30 days before the request date.

The medical necessity documentation for nusinersen (Spinraza) recertification/extension requests must include the client's pulmonary status, including any requirements for invasive or non-invasive ventilation. Any changes in pulmonary status that have occurred since the previous prior authorization request must be addressed.

The medical necessity documentation for tofersen (Qalsody) recertification/extension requests must include the following:

- The client has met all initial authorization approval criteria sat the time of initial approval.
- The client has responded positively to therapy as evident by any improvement in the plasma neurofilament light chain (NfL) measurement as compared to baseline.
- Documentation that client has stabilization in disease state and has shown a slowed pattern in disease progression.
- Absence of unacceptable toxicities (aseptic meningitis, serious myelitis and/or radiculitis, papilledema, and elevated cranial pressure) from tofersen therapy.

6.11.1.3 Exclusions

Casimersen (Amondys 45), Eteplirsen (Exondys 51), Golodirsen (Vyondys 53), nusinersen (Spinraza), tofersen (Qalsody), and viltolarsen (Viltepso) should not be continued on clients who experience decreasing physical function while on the medication.

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Casimersen (Amondys 45), Eteplirsen (Exondys 51) and Golodirsen (Vyondys 53) should not be used concomitantly or with other exon skipping therapies for DMD.

Nusinersen (Spinraza) is not a continuing benefit for clients with decreasing pulmonary function while on the medication.

6.12 Aripiprazole (Abilify Asimtufii)

Aripiprazole (Abilify asimtufii) (procedure code J0402) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.13 Aripiprazole Lauroxil, (Aristada Initio)

Aripiprazole lauroxil (procedure codes J1943 and J1944) are benefits of Texas Medicaid for clients who are 18 years of age or older.

6.14 Asparginine Specific Enzymes

6.14.1 Calaspargase Pegol-Mknl (Asparlas)

Calaspargase pegol-mknl (procedure code J9118) is a benefit of Texas Medicaid for clients who are birth through 21 years of age.

Procedure code J9118 is limited to diagnosis codes C9100, C9101, and C9102.

6.14.2 Pegaspargase (Oncaspar)

Pegaspargase injection (procedure code J9266) is a benefit of Texas Medicaid when billed with diagnosis codes C9100, C9101, or C9102.

6.15 Atidarsagene Autotemcel (Lenmeldy)

Atidarsagene Autotemcel (Lenmeldy) (procedure code J3391) is a benefit of Texas Medicaid with prior authorization.

Atidarsagene Autotemcel (Lenmeldy) is an autologous hematopoietic stem cell-based gene therapy indicated for the treatment of clients with pre-symptomatic late infantile (PSLI), pre-symptomatic early juvenile (PSEJ), or early symptomatic early juvenile (ESEJ) metachromatic leukodystrophy.

6.15.1 Prior Authorization Requirements

Atidarsagene Autotemcel (Lenmeldy) is a once per lifetime infusion therapy indicated for the treatment of a client for whom hematopoietic stem cell therapy (HSCT) is appropriate and must meet all the following requirements:

- The client is 7 years of age or younger or the client is between 7 years and 17 years of age with the onset of symptoms before 7 years of age.
- The client has a documented biochemical and molecular diagnosis of one of the following forms of metachromatic leukodystrophy (MLD) (diagnosis code E7525):
  - Pre-symptomatic late infantile
  - Pre-symptomatic early juvenile (PSEJ)
  - Early symptomatic early juvenile
- The client has an MLD diagnosis that is confirmed by:
  - Biochemical testing indicating Arylsulfatase A (ARSA) activity below the normal range.
  - Genetic testing confirming two disease causing ARSA alleles.

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  - If ARSA mutations are present, a 24-hour urine collection showing elevated sulfatide levels.
- The client is a candidate for and has not previously received HSCT.
- The client will not take prophylactic human immunodeficiency virus (HIV) anti-retroviral medications for at least one month prior to mobilization or for the expected duration of time needed for the elimination of medications.

The required monitoring parameters following atidarsagene autotemcel (Lenmeldy) are:

- Monitor for signs and symptoms of encephalitis, thrombocytopenia and/or serious infection after atidarsagene autotemcel (Lenmeldy) infusion.
- Monitor for signs and symptoms of veno-occlusive disease including liver function tests during the first month post atidarsagene autotemcel (Lenmeldy) infusion.
- Monitor life-long for hematologic malignancies, including a complete blood count (with differential) annually and integration site analysis, as warranted, for at least 15 years after treatment.

In addition to the documentation requirements outlined in the Prior Authorization Requirements section, all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.16 Axatilimab-csfr (Niktimvo)

Axatilimab-csfr (Niktimvo) (procedure code J9038) is a benefit of Texas Medicaid with prior authorization.

Axatilimab-csfr (Niktimvo) is a colony stimulating factor-1 receptor (CSF-1R)-blocking antibody indicated for the treatment of chronic graft-versus-host disease (cGVHD) after failure of at least two prior lines of systemic therapy in adult and pediatric clients weighing at least 40 kilograms.

6.16.1 Prior Authorization Requirements

Axatilimab-csfr (Niktimvo) is an intravenous infusion indicated for clients who meet the following requirements:

- The client weighs at least 40 kg (88 pounds).
- The client has a confirmed diagnosis of cGVHD (diagnosis codes D89811 and D89812).
- The client has undergone allogenic stem cell transplantation.
- The client has previously had at least two failed systemic therapies for cGVHD.
- The prescribing provider attests to counseling female clients of childbearing age regarding the use of an effective method of contraception to prevent pregnancy during treatment of axatilimab-csfr (Niktimvo) and for 30 days after the last dose of therapy.

Clients who are taking axatilimab-csfr (Niktimvo) must be monitored prior to starting axatilimab-csfr (Niktimvo) therapy, every two weeks for the first month of axatilimab-csfr (Niktimvo) therapy, and one to two months after completing axatilimab-csfr (Niktimvo) therapy. Clients will be monitored for aspartate aminotransferase (AST), alanine aminotransferase (ALT), alkaline phosphatase (ALP), creatine phosphokinase (CPK), amylase, and lipase.

For continuation therapy, the client must meet the following requirements:

- The client must meet the initial requirements for prior authorization.
- The client must be undergoing treatment with axatilimab-csfr (Niktimvo) with the absence of unacceptable toxicity (e.g., severe infusion-related reactions).
- The client must experience a positive clinical response to therapy.

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In addition to the documentation requirements outlined in the Prior Authorization Requirements section, all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.17 Azacitidine (Vidaza)

Procedure code J9025 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes							
C9200	C9202	C9210	C9212	C9220	C9222	C9232	C9242
C9252	C9262	C9290	C9292	C92A2	C92Z2	C9310	C9312
C9330	C9332	C9502	C9510	C9512	C9592	D460	D461
D4620	D4621	D4622	D464	D469	D46A	D46B	D46C
D46Z	D640	D641	D642	D643			

6.18 Beremagene geperpavec-svdt (Vyjuvek)

Beremagene geperpavec-svdt (Vyjuvek) is a herpes-simplex virus type 1 (HSV-1) vector-based gene therapy indicated to treat wounds in adults and pediatric clients with dystrophic epidermolysis bullosa (DEB) with mutation in the collagen type VII alpha 1 chain (COL7A1) gene.

Beremagene geperpavec-svdt (Vyjuvek) (procedure code J3401) is a benefit of Texas Medicaid for clients who are 6 months of age or older with prior authorization and restricted to diagnosis code Q812.

6.18.1 Prior Authorization Requirements

Prior authorization is required for beremagene geperpavec-svdt (Vyjuvek) therapy and must be submitted with a Special Medical Prior Authorization (SMPA) Request Form.

Initial therapy for beremagene geperpavec-svdt (Vyjuvek) may be approved for a 6-month duration if all the following criteria are met:

- The client has a confirmed diagnosis of DEB (diagnosis code Q812).
- Genetic test confirming client has a mutation in the collagen type VII alpha 1 chain (COL7A1) gene.
- The client does not have current evidence or history of squamous cell carcinoma or active infection in the area requiring beremagene geperpavec-svdt (Vyjuvek) application.
- The prescriber attests to counseling female clients of childbearing age regarding the use of an effective method of contraception to prevent pregnancy during treatment with beremagene geperpavec-svdt (Vyjuvek).

For renewal or continuation of beremagene geperpavec-svdt (Vyjuvek) therapy, the client must meet the following requirements:

- The client continues to meet all the initial requirements for prior authorization and is currently treated with beremagene geperpavec-svdt (Vyjuvek) with no severe adverse reactions.
- The client has experienced positive clinical response to therapy as documented by any of the following:
  - Reduction in the number of wounds, decrease in wound size, increase in granulation tissue, and/or complete wound closure.
  - The client has not experienced any complications while being treated with beremagene geperpavec-svdt (Vyjuvek).

All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

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Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

6.19 Betibeglogene Autotemcel (Zynteglo)

Betibeglogene autotemcel (Zynteglo) (procedure code J3393) is a benefit of Texas Medicaid for clients who are 4 years of age or older with prior authorization. Prior authorization may be approved for a duration of 12 months.

Betibeglogene autotemcel (Zynteglo) is an autologous hematopoietic stem cell-based gene therapy indicated for treating adult and pediatric clients with β-thalassemia who require regular red blood cell (RBC) transfusions.

Betibeglogene autotemcel (Zynteglo) (procedure code J3393) is limited to one transfusion treatment per lifetime and may be infused as a single infusion in one or more infusion bags.

6.19.1 Prior Authorization Requirements

Betibeglogene autotemcel (Zynteglo) is a one-time infusion therapy indicated for the treatment of clients with β-thalassemia who meet the following requirements:

- The client is 4 years of age or older.
- The client has a documented diagnosis of β-thalassemia (diagnosis code D561) and other forms of thalassemia have been ruled out.
- The client is RBC transfusion dependent and has documented history of receiving RBC transfusions of at least 100 ml per kilogram per year (pRBC/kg/yr) or at least 8 or more transfusions of regular RBCs per year for two years.
- The client has not had a prior hematopoietic stem cell transplant (HSCT) and is unable to find a matched related donor.
- The client is stable and eligible for HSCT, according to the following criteria:
  - No advanced liver disease
  - No human immunodeficiency virus (HIV) positive diagnosis
  - No hepatitis B virus (HBV) and hepatitis C virus (HCV)
  - No prior or current malignancies
  - No bleeding disorders
  - Normal iron levels in the heart
  - Normal levels of white blood cells
  - Normal platelet counts
- The prescriber attests to avoid the use of anti-retroviral medications or hydroxyurea for one month prior to mobilization and until all cycles of apheresis are completed
- The prescriber attests to discontinue iron chelators at least seven days prior to initiation of myeloablative conditioning and the use of myelosuppressive iron chelators should be avoided for 6 months after betibeglogene autotemcel (Zynteglo) infusion

In addition to the documentation requirements outlined in the Prior Authorization Requirements section, the prescriber must monitor the following:

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- The client's platelet count for thrombocytopenia and bleeding during the treatment period with betibeglogene autotemcel (Zynteglo)
- The client for at least 15 years post betibeglogene autotemcel (Zynteglo) infusion for possible hematologic malignancies

All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.20 * Botulinum Toxin Type A and Type B

OnabotulinumtoxinA (Botox brand of botulinum toxin type A), abobotulinumtoxinA (Dysport brand of botulinum toxin type A), incobotulinumtoxin A (Xeomin brand of botulinum toxin type A), rimabotulinumtoxinB (Myobloc brand of botulinum toxin type B), and daxibotulinumtoxinA-lanm (Daxxify brand toxin type A) are benefits of Texas Medicaid.

Botulinum toxins are potent neuromuscular blocking agents that are useful in treating various focal muscle spastic disorders and excessive muscle contractions, such as dystonia, spasms, and twitches. They produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. Since the resulting chemical denervation of muscle produces local paresis or paralysis, selected muscles can be treated. Two of the seven naturally occurring serotypes of botulinum toxin have been approved by the FDA for human use in the United States-type A and type B.

Due to the unique manufacturing process of each toxin, botulinum toxins are chemically, clinically, and pharmacologically distinct; as a consequence, these products are not interchangeable. The units of biological activity of one botulinum toxin product cannot be compared to, nor converted into, units of any other botulinum toxin product. The established drug names of the botulinum products emphasize the differing dose-to-potency ratios of these products.

Procedure code J0585 is a benefit when billed with one of the following diagnosis codes:

[Revised] Diagnosis Codes							
G114	G2401	G241	G243	G244	G245	G248	G250
G251	G252	G253	G35A	G35B0	G35B1	G35B2	G35C0
G35C1	G35C2	G35D	G360	G370	G371	G372	G374
G375	G3781	G3789	G379	G43701	G43709	G43711	G43719
G800	G801	G802	G803	G804	G808	G809	G8110
G8111	G8112	G8113	G8114	G8220	G8221	G8222	G8250
G8251	G8252	G8253	G8254	G830	G8310	G8311	G8312
G8313	G8314	G8320	G8321	G8322	G8323	G8324	G8330
G8331	G8332	G8333	G8334	G834	H4901	H4902	H4903
H4911	H4912	H4913	H4921	H4922	H4923	H4931	H4932
H4933	H4941	H4942	H4943	H499	H5000	H50011	H50012
H50021	H50022	H50031	H50032	H50041	H50042	H5005	H5006
H5007	H5008	H5010	H50111	H50112	H50121	H50122	H50131
H50132	H50141	H50142	H5015	H5016	H5017	H5018	H5021
H5022	H5030	H50311	H50312	H5032	H50331	H50332	H5034
H5040	H50411	H50412	H5042	H5043	H5050	H5051	H5052
H5053	H5054	H5055	H5060	H50611	H50612	H50621	H50622
H50629	H50631	H50632	H50639	H50641	H50642	H50649	H50651
H50652	H50659	H50661	H50662	H50669	H50671	H50672	H50679

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[Revised] Diagnosis Codes							
H50681	H50682	H50689	H5069	H50811	H50812	H5089	H510
H5111	H5112	H5121	H5122	H5123	H518	H519	I69031
I69032	I69033	I69034	I69041	I69042	I69043	I69044	I69051
I69052	I69053	I69054	I69061	I69062	I69063	I69064	I69065
I69098	I69131	I69132	I69133	I69134	I69141	I69142	I69143
I69144	I69151	I69152	I69153	I69154	I69161	I69162	I69163
I69164	I69165	I69198	I69231	I69232	I69233	I69234	I69241
I69242	I69243	I69244	I69251	I69252	I69253	I69254	I69261
I69262	I69263	I69264	I69265	I69298	I69331	I69332	I69333
I69334	I69341	I69342	I69343	I69344	I69351	I69352	I69353
I69354	I69361	I69362	I69363	I69364	I69365	I69398	I69831
I69832	I69833	I69834	I69841	I69842	I69843	I69844	I69851
I69852	I69853	I69854	I69861	I69862	I69863	I69864	I69865
I69898	J385	K117	K220	K600	K601	K602	M436
M62838	N318	N319	N3281	N3644	R490	R498	

Procedure code J0586 is a benefit when billed with one of the following diagnosis codes:

[Revised] Diagnosis Codes for J0586							
G114	G241	G243	G244	G245	G248	G35	G360
G370	G371	G372	G374	G375	G3781	G3789	G379
G800	G801	G802	G804	G808	G809	G8110	G8111
G8112	G8113	G8114	G8253	G8254	G830	G8320	G8321
G8322	G8323	G8324	I69059	I69259	I69359	I69859	I69959
I69051	I69052	I69151	I69152	I69251	I69252	I69351	I69352
I69851	I69852	I69951	I69952	I69053	I69054	I69153	I69154
I69253	I69254	I69353	I69354	I69853	I69854	I69953	I69954
I69039	I69139	I69239	I69339	I69839	I69939	I69031	I69032
I69131	I69132	I69231	I69232	I69331	I69332	I69831	I69832
I69931	I69932	I69033	I69034	I69133	I69134	I69233	I69234
I69333	I69334	I69833	I69834	I69933	I69934	J385	M436
M62838							

Procedure code J0587 is a benefit when billed with diagnosis code G243 or K117.

Procedure code J0589 is a benefit when billed with diagnosis code G243.

Procedure code J0588 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes for J0588							
G243	G245	G800	G801	G802	G830	G8110	G8111
G8112	G8113	G8114	G8253	G8254	G8320	G8321	G8322
G8323	G8324	I69059	I69259	I69359	I69859	I69959	I69051
I69052	I69151	I69152	I69251	I69252	I69351	I69352	I69851

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Diagnosis Codes for J0588							
I69852	I69951	I69952	I69053	I69054	I69153	I69154	I69253
I69254	I69353	I69354	I69853	I69854	I69953	I69954	I69039
I69139	I69239	I69339	I69839	I69939	I69031	I69032	I69131
I69132	I69231	I69232	I69331	I69332	I69831	I69832	I69931
I69932	I69033	I69034	I69133	I69134	I69233	I69234	I69333
I69334	I69833	I69834	I69933	I69934			

Procedure codes J0586, J0587, J0588, and J0589 are denied when billed on the same date of service by any provider as procedure code J0585. Procedure codes J0587, J0588, and J0589 are denied when billed on the same date of service by any provider as procedure code J0586. Procedure code J0587 and J0589 are denied when billed on the same date of service by any provider as procedure code J0588. Procedure code J0588 is denied when billed on the same date of service by any provider as procedure code J0589.

IncobotulinumtoxinA, procedure code J0588, is FDA-approved for the treatment of adults with blepharospasm previously treated with onabotulinumtoxinA (J0585).

Physicians, hospitals, and other providers and suppliers should care for and administer drugs to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner. Texas Medicaid encourages scheduling patients to make the most efficient use of the drugs administered. Safe handling guidelines per manufacturer must be observed (e.g., shelf life, cold chain requirements). The smallest size vial to cover the dose is encouraged to be used.

Claims for botulinum toxin type A and B must indicate the number of units used. If the number of units is not specified, the claim will be paid a quantity of one. Claims that exceed the following quantity limitations, per day, may be considered on appeal with documentation of medical necessity:

Procedure Codes	Quantity Limitations of Medication	Billing Units
J0585	400 units	One billing unit is equal to 1 unit of medication. ***Example:*** *A provider that administers 400 units of medication would submit a claim for a quantity of 400.*
J0586	1,500 units	One billing unit is equal to 5 units of medication. ***Example:*** *A provider that administers 1,500 units of medication would submit a claim for a quantity of 300.*
J0587	10,000 units	One billing unit is equal to 100 units of medication. ***Example:*** *A provider that administers 10,000 units of medication would submit a claim for a quantity of 100.*
J0588	400 units	One billing unit is equal to 1 unit of medication. ***Example:*** *A provider that administers 400 units of medication would submit a claim for a quantity of 400.*

Procedures performed in conjunction with botulinum toxin injections are subject to guidelines set forth in the policies specific for those procedures. Any supplies billed by the provider for the administration of botulinum toxin type A or B are not separately payable.

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Botulinum toxins administered more frequently than every 12 weeks must include documentation of medical necessity justifying why the medication was given at an interval sooner than 12 weeks.

Documentation in the client's medical record must include the following elements:

- Support for the medical necessity of the botulinum toxin injection:
- A covered diagnosis
- Dosage and frequency of the injections
- Support of the clinical effectiveness of the injections
- Specific site(s) injected

All documentation is subject to retrospective review.

6.21 Brolucizumab-DBLL (Beovu)

Brolucizumab-dbll (procedure code J0179) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.22 Bupivacaine

Bupivacaine (procedure code J0665) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.23 Burosumab-Twza (Crysvita)

Burosumab-Twza (Crysvita) (procedure code J0584) is a benefit of Texas Medicaid with prior authorization. Burosumab-Twza (Crysvita) may be approved for a duration of every 12 months per prior authorization request.

Burosumab-twza (Crysvita) is a fibroblast growth factor 23 (FGF23) blocking antibody, indicated to treat the following:

- X-linked hypophosphatemia (XLH, a rare, inherited form of rickets) in adult and pediatric clients who are 6 months of age and older
- FGF23-related hypophosphatemia in tumor-induced osteomalacia associated with phosphaturic mesenchymal tumors that cannot be localized or is not amenable by surgical excision in adult and pediatric clients who are two years of age and older

The initial therapy for X-linked hypophosphatemia (XLH) must meet the following criteria:

- The client is 6 months of age or older.
- The client has a diagnosis of X-linked hypophosphatemia (XLH) (diagnosis code E8331 or E8339) that is supported by one of the following:
  - Confirmed phosphate regulating gene with homology to endopeptidases located on the X chromosome (PHEX-gene) mutation
  - Serum fibroblast growth factor-23 (FGF23) level >30 pg/ml
- The prescriber discontinues any oral phosphate or active vitamin D analog supplementation at least one week prior to starting burosumab-twza (Crysvita) therapy.
- The prescriber agrees to measure serum phosphate throughout therapy and withhold medication when serum phosphorus is above 5 mg/dl.

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The initial therapy for FGF23-related hypophosphatemia in tumor-induced osteomalacia must meet the following criteria:

- The client is 2 years of age or older.
- The client has a diagnosis of FGF23-related hypophosphatemia produced by an underlying tumor that cannot be localized or is not amenable to surgical excision (diagnosis code M838).
- The prescriber discontinues any oral phosphate or vitamin D analog supplement at least two weeks prior to starting burosumab-twza (Crysvita) therapy.
- The prescriber agrees to measure serum phosphate throughout therapy.

For renewal or continuation therapy, the following criteria must be met:

- The client has previously received treatment with burosumab-twza (Crysvita).
- Documentation from the physician that the client has demonstrated a positive clinical response to burosumab-twza (Crysvita) (e.g., enhanced height velocity, improvement in a skeletal deformity, reduction of fractures, reduction of generalized bone pain).
- The physician continues to monitor serum phosphate level.

Burosumab-twza (Crysvita) is not a benefit for the following:

- Clients who currently use oral phosphates and active vitamin D analogs.
- Clients whose serum phosphorus is within or above the normal range for client's age.
- Clients with severe renal impairment or end stage renal disease.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.24 Cabotegravir and Rilpivirine (Cabenuva)

Cabotegravir and Rilpivirine (Cabenuva) (procedure code J0741) is a benefit of Texas Medicaid for clients who are 12 years of age or older.

Cabotegravir (Apretude) (procedure code J0739) is a benefit of Texas Medicaid for clients who are 10 years of age or older.

6.25 Caffeine Citrate (Cafcit)

Caffeine citrate (procedure code J0706) is a benefit of Texas Medicaid for clients who are birth through 6 months of age.

6.26 Calcitonin Gene Related Peptide (CGRP) agents

6.26.1 Eptinezumab-JJMR (Vyepti)

Eptinezumab-jjmr (procedure code J3032) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.26.2 Ajovy (Fremanezumab-vfrm)

Ajovy (fremanezumab-vfrm) (procedure code J3031) is a benefit of Texas Medicaid for clients who are 6 years of age or older.

6.27 Cantharidin

Cantharidin (procedure code J7354) is a benefit of Texas Medicaid for clients who are 2 years of age or older and is restricted to diagnosis code B081.

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6.28 Cefiderocol (Fetroja)

Cefiderocol (procedure code J0699) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.29 Chelating Agents

Chelating agent procedure code J0895 is a benefit of Texas Medicaid when billed with an appropriate diagnosis code.

6.29.1 Deferoxamine Mesylate (Desferal)

Procedure code J0895 must be billed with one of the following diagnosis codes:

Diagnosis Codes							
D560	D561	D562	D563	D568	D569	D5700	D5701
D5702	D5703	D5704	D5709	D571	D5720	D57211	D57212
D57213	D57214	D57218	D57219	D5740	D57411	D57412	D57413
D57414	D57418	D57419	D5742	D57431	D57432	D57433	D57434
D57438	D57439	D5744	D57451	D57452	D57453	D57454	D57458
D57459	D5780	D57811	D57812	D57813	D57814	D57818	D57819
E83111	E83118	N181	N182	N1830	N1831	N1832	N184
N185	N186	N189	N19	T454X1A	T454X1D	T454X1S	T454X2A
T454X2D	T454X2S	T454X3A	T454X3D	T454X3S	T454X4A	T454X4D	T454X4S
T470X1A	T470X1D	T470X1S	T470X2A	T470X2D	T470X2S	T470X3A	T470X3D
T470X3S	T470X4A	T470X4D	T470X4S	T471X1A	T471X1D	T471X1S	T471X2A
T471X2D	T471X2S	T471X3A	T471X3D	T471X3S	T471X4A	T471X4D	T471X4S
T564X1A	T564X1D	T564X1S	T564X2A	T564X2D	T564X2S	T564X3A	T564X3D
T564X3S	T564X4A	T564X4D	T564X4S	T565X1A	T565X1D	T565X1S	T565X2A
T565X2D	T565X2S	T565X3A	T565X3D	T565X3S	T565X4A	T565X4D	T565X4S
T566X1A	T566X1D	T566X1S	T566X2A	T566X2D	T566X2S	T566X3A	T566X3D
T566X3S	T566X4A	T566X4D	T566X4S	T56811A	T56811D	T56811S	T56812A
T56812D	T56812S	T56813A	T56813D	T56813S	T56814A	T56814D	T56814S
T56821A	T56821D	T56821S	T56822A	T56822D	T56822S	T56823A	T56823D
T56823S	T56824A	T56824D	T56824S	T56891A	T56891D	T56891S	T56892A
T56892D	T56892S	T56893A	T56893D	T56893S	T56894A	T56894D	T56894S
T5691XA	T5691XD	T5691XS	T5692XA	T5692XD	T5692XS	T5693XA	T5693XD
T5693XS	T5694XA	T5694XD	T5694XS				

6.30 Chimeric Antigen Receptor (CAR) T-Cell Therapy

Axicabtagene ciloleucel (Yescarta) (procedure code Q2041), brexucabtagene autoleucel (Tecartus) (procedure code Q2053), ciltacabtagene autoleucel (Carvykti) (procedure code Q2056), idecabtagene vicleucel (ABECMA) (procedure code Q2055), lisocabtagene maraleucel (Breyanzi) (procedure code Q2054), obecabtagene autoleucel (Aucatzyl) (procedure code Q2058), and tisagenlecleucel (Kymriah) (procedure code Q2042) are benefits of Texas Medicaid with prior authorization.

Procedure codes Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, and Q2058 are limited to once per lifetime, any provider.

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Axicabtagene ciloleucel (Yescarta) is a CD-19-directed genetically modified autologous T-cell immunotherapy indicated to treat the following:

- Adult clients with relapsed or refractory large B-cell Lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma.
- Adult clients with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy.
- Adult clients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy.

Brexucabtagene autoleucel (Tecartus) is a CD-19-directed genetically modified autologous T-cell immunotherapy indicated to treat adult clients with relapsed or refractory mantel cell lymphoma (MCL). Brexucabtagene autoleucel is also indicated to treat adult clients with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).

Ciltacabtagene autoleucel (Carvykti) is a B-cell maturation antigen-directed genetically modified autologous T-cell immunotherapy indicated to treat adult clients with relapsed or refractory multiple myeloma after one or more lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and are refractory to lenalidomide.

Idecabtagene vicleucel (ABECMA) is a B-cell maturation antigen directed genetically modified autologous T-cell immunotherapy indicated to treat adult clients with relapsed or refractory multiple myeloma after two or more prior lines of therapy including an immunomodulatory agent, a proteasome inhibitor and an anti-CD38 monoclonal antibody.

Lisocabtagene maraleucel (Breyanzi) is a CD-19 directed genetically modified autologous T-cell immunotherapy indicated to treat adult clients with the following:

- Large B-cell lymphoma, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B who have:
  - Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first- line chemoimmunotherapy.
  - Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplant (HSCT) due to comorbidities or age.
  - Relapsed or refractory disease after two or more lines of systemic therapy.
- Relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) who have received at least two prior lines of therapy, including a Bruton tyrosine kinase (BTK) inhibitor and a B-cell lymphoma 2 (BCL-2) inhibitor.
- Relapse or refractory follicular lymphoma who has received two or more lines of systemic therapy.
- Relapse or refractory mantle cell lymphoma (MCL) who have received at least two prior lines of systemic therapy.

Obecabtagene autoleucel (Aucatzyl) is a CD19-directed genetically modified autologous T-cell immunotherapy indicated to treat adult clients with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).

Tisagenlecleucel (Kymriah) is a CD-19-directed genetically modified autologous T-cell immunotherapy indicated to treat the following:

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- Clients who are 25 years of age or younger who have acute lymphoblastic leukemia (ALL) that is refractory or second/later relapse.
- Adult clients who have relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma.
- Adult clients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy.

Providers and facilities must ensure that the client:

- Receives the recommended pre-medications before treatment.
- Is closely monitored for at least two weeks, including daily monitoring for at least one week.
- Is instructed to remain within proximity of a certified healthcare facility for at least two weeks and to avoid driving for two weeks following product administration.

6.30.1 Prior Authorization Criteria for Axicabtagene Ciloleucel (Yescarta)

Prior authorization approval of axicabtagene ciloleucel (Yescarta) (procedure code Q2041) infusion therapy will be considered for the following:

- The client is 18 years of age or older.
- The client has one of the following:
  - Relapsed or refractory disease, defined as progression after two or more lines of systemic therapy (which may or may not include therapy supported by autologous stem cell transplant)
  - Large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy
- The client does not have primary central nervous system lymphoma/disease.
- The client does not have an active infection or inflammatory disorder.
- The client has not received prior CD-19 directed CAR-T therapy.
- The client must have a histologically confirmed diagnosis of one of the following types of aggressive non-Hodgkin's lymphoma diagnosis codes:

Diagnosis Codes							
C8330	C8331	C8332	C8333	C8334	C8335	C8336	C8337
C8338	C83398	C833A	C8510	C851A	C8520	C852A	

Prior authorization approval for clients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy will be considered when all of the following criteria are met:

- The client is 18 years of age or older.
- The client has relapsed or refractory disease defined as progression after two or more lines of systemic therapy (which may or may not include therapy supported by autologous stem cell transplant).
- The client does not have primary central nervous system lymphoma/disease.
- The client does not have an active infection or inflammatory disorder.
- The client has not received prior CD-19 directed CAR-T therapy.
- The client has a histologically confirmed diagnosis of one of the following types of follicular lymphoma:

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Diagnosis Codes							
C8200	C8201	C8202	C8203	C8204	C8205	C8206	C8207
C8208	C8209	C820A	C8210	C8211	C8212	C8213	C8214
C8215	C8216	C8217	C8218	C8219	C821A	C8220	C8221
C8222	C8223	C8224	C8225	C8226	C8227	C8228	C8229
C822A	C8230	C8231	C8232	C8233	C8234	C8235	C8236
C8237	C8238	C8239	C823A	C8240	C8241	C8242	C8243
C8244	C8245	C8246	C8247	C8248	C8249	C824A	C8250
C8251	C8252	C8253	C8254	C8255	C8256	C8257	C8258
C8259	C825A	C8260	C8261	C8262	C8263	C8264	C8265
C8266	C8267	C8268	C8269	C826A	C8280	C8281	C8282
C8283	C8284	C8285	C8286	C8287	C8288	C8289	C828A
C8290	C8291	C8292	C8293	C8294	C8295	C8296	C8297
C8298	C8299	C829A					

6.30.2 Prior Authorization Criteria for Brexucabtagene Autoleucel (Tecartus)

Prior authorization approval for brexucabtagene autoleucel (Tecartus) (procedure code Q2053) infusion therapy for mantel cell lymphoma will be considered when all of the following criteria are met:

- The client has histologically confirmed diagnosis of relapse or refractory mantel cell lymphoma (diagnosis codes C8310, C8311, C8312, C8313, C8314, C8315, C8316, C8317, C8318, C8319, and C831A).
- The client is 18 years of age or older.
- The client does not have primary central nervous system lymphoma/disease.
- The client has not received prior CD-19 directed CAR-T therapy.

Prior authorization approval for clients with B-cell Precursor Acute Lymphoblastic Leukemia (ALL) will be considered once all of the following criteria are met:

- The client has histologically confirmed diagnosis of relapse or refractory B-cell precursor Acute Lymphoblastic Leukemia (ALL) (diagnosis codes C9100, C9101, C9102).
- The client is 18 years of age or older.
- The client does not have primary central nervous system lymphoma/disease.
- The client does not have an active infection or inflammatory disorder.
- The client has not received prior CD-19 directed CAR-T therapy.

6.30.3 Prior Authorization Criteria for Ciltacabtagene Autoleucel (Carvykti)

Prior authorization approval for ciltacabtagene autoleucel (Carvykti) (procedure code Q2056) infusion therapy will be considered when all of the following criteria are met:

- The client is 18 years of age or older.
- The client has histologically confirmed diagnosis of relapse or refractory multiple myeloma (diagnosis codes C9000 and C9002).
- The client has relapsed or refractory disease and has received at least one line of the following systemic therapies before treatment with ciltacabtagene autoleucel (Carvykti) and are refractory to lenalidomide, which must include:

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  - A proteasome inhibitor
  - An immunomodulatory agent
- The client does not have primary central nervous system lymphoma/disease.
- The client does not have an active infection or inflammatory disorder.
- The client has not received prior CAR-T therapy.
- Ciltacabtagene autoleucel (Carvykti) (procedure code Q2056) is limited to once per lifetime.

6.30.4 Prior Authorization Criteria for Idecabtagene Vicleucel (ABECMA)

Prior authorization approval of idecabtagene vicleucel (ABECMA) (procedure code Q2055) infusion therapy will be considered when all of the following criteria are met:

- The client is 18 years of age or older.
- The client has a histologically confirmed diagnosis of relapse or refractory multiple myeloma (diagnosis codes C9000 and C9002).
- The client must have received two or more prior lines of the following therapies before treatment with idecabtagene vicleucel:
  - An immunomodulatory agent
  - A proteasome inhibitor
  - An anti-CD-38 monoclonal antibody
- The client does not have primary central nervous system lymphoma/disease.
- The client does not have an active infection or inflammatory disorder.
- The client has not received prior CAR-T therapy.

Idecabtagene vicleucel (ABECMA) (procedure code Q2055) is limited to once per lifetime.

6.30.5 Prior Authorization Criteria for Lisocabtagene Maraleucel (Breyanzi)

Prior authorization approval of lisocabtagene maraleucel (Breyanzi) (procedure code Q2054) infusion therapy will be considered when the client has one of the diagnoses listed below, and also meets the following criteria:

- The client has a histologically confirmed diagnosis of large B-cell lymphoma, including diffuse large B-cell lymphoma not otherwise specified (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, or follicular lymphoma grade 3B with one of the following:
  - Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first line chemoimmunotherapy; or
  - Refractory disease to first-line chemoimmunotherapy or relapse after first line chemoimmunotherapy, and are not eligible for hematopoietic stem cell transplant (HSCT) due to comorbidities or age; or
  - Relapsed or refractory disease after two or more lines of systemic therapy.
- The client has confirmed diagnosis of relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) who has received at least two prior lines of therapy, including a Bruton tyrosine kinase (BTK) inhibitor and a B-cell lymphoma 2 (BCL-2) inhibitor.
- The client has confirmed diagnosis of relapsed or refractory follicular lymphoma who has received two or more lines of systemic therapy.

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- The client has confirmed diagnosis of relapsed or refractory mantle cell lymphoma (MCL) who has received at least two prior lines of systemic therapy.
- The client is 18 years of age or older.
- The client does not have primary central nervous system lymphoma/disease.
- The client does not have an active infection or inflammatory disorder.
- The client has not received prior CD-19 directed CAR-T therapy.
- The client has one of the following lymphoma diagnosis codes:

Diagnosis Codes							
C8200	C8201	C8202	C8203	C8204	C8205	C8206	C8207
C8208	C8209	C820A	C8210	C8211	C8212	C8213	C8214
C8215	C8216	C8217	C8218	C8219	C821A	C8220	C8221
C8222	C8223	C8224	C8225	C8226	C8227	C8228	C8229
C822A	C8230	C8231	C8232	C8233	C8234	C8235	C8236
C8237	C8238	C8239	C823A	C8240	C8241	C8242	C8243
C8244	C8245	C8246	C8247	C8248	C8249	C824A	C8250
C825A	C8280	C8281	C8282	C8283	C8284	C8285	C8286
C8287	C8288	C8289	C828A	C8290	C8291	C8292	C8293
C8294	C8295	C8296	C8297	C8298	C8299	C829A	C8300
C8301	C8302	C8303	C8304	C8305	C8306	C8307	C8308
C8309	C830A	C8310	C8311	C8312	C8313	C8314	C8315
C8316	C8317	C8318	C8319	C831A	C8330	C8331	C8332
C8333	C8334	C8335	C8336	C8337	C8338	C83398	C833A
C8390	C8391	C8392	C8393	C8394	C8395	C8396	C8397
C8398	C8399	C839A	C8510	C8511	C8512	C8513	C8514
C8515	C8516	C8517	C8518	C8519	C851A	C8520	C8521
C8522	C8523	C8524	C8525	C8526	C8527	C8528	C8529
C852A	C8580	C8581	C8582	C8583	C8584	C8585	C8586
C8587	C8588	C8589	C858A	C9110	C9112		

Lisocabtagene maraleucel (Breyanzi) (procedure code Q2054) is limited to once per lifetime.

6.30.6 Prior Authorization Criteria for Obecabtagene Autoleucel (Aucatzyl)

Obecabtagene autoleucel (Aucatzyl) may be approved for a duration of 12 months.

Obecabtagene autoleucel (Aucatzyl) is a once in a lifetime cell suspension therapy with split dose infusion and is indicated for clients who meet all the following requirements:

- The client is 18 years of age or older.
- The client has a confirmed diagnosis of relapsed or refractory B-cell precursor ALL (diagnosis codes C9100 and C9102).
- The client has adequate cardiac, hepatic, pulmonary, and renal function.
- A bone marrow blast assessment was conducted, and results from the sample were obtained in order to start lymphodepleting chemotherapy.

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- The client does not have a clinically significant active infection or inflammatory disorder.
- The client has been screened and does not have active/latent Hepatitis B virus, active Hepatitis C virus or human immunodeficiency virus (HIV).
- The client has not previously received CAR-T therapy.

Obecabtagene autoleucel (Aucatzyl) (procedure code Q2058) is limited to a one-time split dose transfusion treatment.

The required monitoring parameters following obecabtagene autoleucel (Aucatzyl) are:

- Monitor for signs and symptoms of cytokine release syndrome (CRS), neurologic toxicities/ immune effector cell-associated neurotoxicity syndrome (ICANS), and other acute toxicities daily for at least 14 days at the healthcare facility following Aucatzyl infusion.
- Monitor blood counts for cytopenia (e.g., anemia, neutropenia, thrombocytopenia) and secondary malignancies.

6.30.7 Prior Authorization Criteria for Tisagenlecleucel (Kymriah)

Prior authorization approval of tisagenlecleucel (Kymriah) (procedure code Q2042) infusion for the treatment of clients with refractory or second relapse B-cell precursor acute lymphoblastic leukemia will be considered when all of the following criteria are met:

- The client has a confirmed diagnosis of B-cell acute lymphoblastic leukemia (diagnosis codes C9100, C9101, and C9102).
- The client is 25 years of age or younger.
- The client has a confirmed CD-19 tumor expression.
- The client has not received prior CAR-T therapy.

Prior authorization approval of tisagenlecleucel (Kymriah) infusion for the treatment of clients with relapsed or refractory diffuse large B-cell lymphoma will be considered when all of the following criteria are met:

- The client has a confirmed diagnosis of relapsed or refractory large B-cell lymphoma (diagnosis codes C8330, C8331, C8332, C8333, C8334, C8335, C8336, C8337, C8338, C83398, and C833A):
  - Diffuse large B-cell lymphoma, not otherwise specified
  - High grade B-cell lymphoma
  - Diffuse large B-cell lymphoma arising from follicular lymphoma
- The client is 18 years of age or older.
- The client must have relapsed or refractory disease defined as progression after two or more lines of systemic therapy (which may or may not include therapy supported by autologous stem cell transplant).
- The client does not have primary central nervous system lymphoma
- The client has not received prior CD-19 directed CAR-T therapy

Prior authorization approval for clients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy will be considered once all the following criteria are met:

- The client is 18 years of age or older
- The client has relapsed, or refractory disease defined as progression after two or more lines of systemic therapy.
- The client does not have primary central nervous system lymphoma/disease

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- The client does not have an active infection or inflammatory disorder
- The client has not received prior CD-19 directed CAR-T therapy
- The client has histologically confirmed diagnosis of one of the following types of follicular lymphoma:

Diagnosis Codes							
C8200	C8201	C8202	C8203	C8204	C8205	C8206	C8207
C8208	C8209	C820A	C8210	C8211	C8212	C8213	C8214
C8215	C8216	C8217	C8218	C8219	C821A	C8220	C8221
C8222	C8223	C8224	C8225	C8226	C8227	C8228	C8229
C822A	C8230	C8231	C8232	C8233	C8234	C8235	C8236
C8237	C8238	C8239	C823A	C8240	C8241	C8242	C8243
C8244	C8245	C8246	C8247	C8248	C8249	C824A	C8250
C8251	C8252	C8253	C8254	C8255	C8256	C8257	C8258
C8259	C825A	C8260	C8261	C8262	C8263	C8264	C8265
C8266	C8267	C8268	C8269	C826A	C8280	C8281	C8282
C8283	C8284	C8285	C8286	C8287	C8288	C8289	C828A
C8290	C8291	C8292	C8293	C8294	C8295	C8296	C8297
C8298	C8299	C829A					

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.31 Clofarabine

Clofarabine is used for the treatment of relapsed or refractory acute lymphoblastic leukemia for clients who are 1 through 21 years of age. Clofarabine is administered by IV infusion once daily for five days and is repeated every two to six weeks, as needed.

6.31.1 Prior Authorization for Clofarabine

Prior authorization is required for treatment with clofarabine (procedure code J9027) and may be granted for a maximum of six weeks.

Clofarabine may be prior authorized for the treatment of relapsed or refractory acute lymphoblastic leukemia. The following criteria apply to requests for prior authorization:

- The number of anticipated injections needed as well as the dosage per injection must be submitted with the request for prior authorization.
- Prior authorization must be obtained before services are rendered whenever possible. If authorization cannot be obtained prior to the rendering of the service, the authorization request must be submitted within three business days from the date the treatment is initiated.

Prior authorization requests may be considered with documentation of the following:

- The client is 1 through 21 years of age.
- A diagnosis of refractory or relapsed acute lymphoblastic leukemia
- A history of at least two prior failed chemotherapy regimens

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The prior authorization number must be included on the claim along with the number of units, based on the dosage given. Failure to place the prior authorization number on the claim or to obtain prior authorization within the allotted timeframe will result in denied claims.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.32 Coagulation Factor IX (Ixinity)

Coagulation factor IX (Ixinity) (procedure code J7213) is a benefit of Texas Medicaid for clients who are 12 years of age or older.

6.33 * Colony Stimulating Factors (Filgrastim and Pegfilgrastim)

Colony stimulating factors (CSFs) are growth factors (glycoproteins) that support survival, clonal expansion and differentiation of blood forming cells and are a benefit of Texas Medicaid. CSFs reduce the likelihood of neutropenic complications due to chemotherapy and bone marrow transplant.

Filgrastim (Neupogen) (procedure code J1442), tbo-filgrastim (Granix) (procedure code J1447), pegfilgrastim (Neulasta) (procedure code J2506), sargramostim (Leukine) (procedure code J2820), eflapegrastim-xnst (Rolvedon) (procedure code J1449), and efbemalenograstim alfa-vuxw (Ryzneuta) (procedure code J9361) are granulocyte colony stimulating factors (G-CSFs).

[Revised] Filgrastim (Neupogen) (procedure code J1442) biosimilars are filgrastim-aafi (Nivestym) (procedure code Q5110), filgrastim-ayow (Releuko) (procedure code Q5125), filgrastim-sndz (Zarxio) (procedure code Q5101), filgrastim-txid (Nypozi) (procedure code Q5148), and filgrastim-laha (Filkri) (procedure code Q5172).

[Revised] Pegfilgrastim (Neulasta) (procedure code J2506) biosimilars are pegfilgrastim-jmdb (Fulphila) (procedure code Q5108), pegfilgrastim-pbbk (Fylnetra) (procedure code Q5130), pegfilgrastim-apgf (Nyvepria) (procedure code Q5122), pegfilgrastim-fpgk (Stimufend) (procedure code Q5127), pegfilgrastim-cbqv (Udenyca) (procedure code Q5111), pegfilgrastim-bmez (Ziextenzo) (procedure code Q5120), and pegfilgrastim-unne (Armlupeg) (procedure code Q5169).

To submit claims for reimbursement of colony stimulating factors, providers must submit the most appropriate procedure code with the number of units administered.

Procedure code J2506 will be denied if billed on the same date of service as procedure codes J1442, J1449, and J2820.

Procedure code J1442 will be denied if billed on the same date of service as procedure codes J1449, J2506, and J2820.

Procedure code J1449 will be denied if billed on the same date of service as procedure codes J1442, J2506, and J2820.

Procedure code J2820 will be denied if billed on the same date of service as procedure codes J1442, J1449, and J2506.

Procedure code 96377 must be billed with procedure code J2506 on the same day by the same provider.

Procedure code J1449 is restricted to clients who are 18 years of age or older.

Procedure code J9361 is restricted to clients who are 18 years of age or older.

6.34 Crizanlizumab-tmca (Adakveo)

Crizanlizumab-tmca (Adakveo) (procedure code J0791) is a benefit of Texas Medicaid for clients who are 16 years of age and older.

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Crizanlizumab-tmca (Adakveo) is indicated for clients with sickle cell disease to reduce the frequency of vaso-occlusive crises (VOCs).

6.34.1 Prior Authorization

Prior authorization is required for crizanlizumab-tmca (Adakveo) and may be approved for a duration of 12 months.

Initial therapy requests for Crizanlizumab-tmca (Adakveo) may be approved for a 12-month duration if all of the following criteria are met:

- The client must be 16 years of age or older.
- The client has a diagnosis of sickle cell disease of any genotype.
- The client has experienced two or more vaso-occlusive events in the past 12 months.

For renewal or continuation therapy requests, the client must meet all of the following requirements:

- The client continues to meet the following initial approval criteria:
  - The client must be 16 years of age or older.
  - The client has a diagnosis of sickle cell disease of any genotype.
- The client experienced positive clinical response to therapy as demonstrated by reduced frequency of vaso-occlusive crisis.
- The client has previously received treatment with Crizanlizumab-tmca (Adakveo) without complications.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.35 * Delandistrogene moxeparvovec-rokl (Elevidys)

[Revised] Delandistrogene moxeparvovec-rokl (Elevidys) is an adeno-associated virus vector-based gene therapy indicated for the treatment of ambulatory clients who are 4 years of age or older with Duchenne muscular dystrophy (DMD) with a confirmed mutation in the DMD gene.

Delandistrogene moxeparvovec-rokl (Elevidys) (procedure code J1413) is a benefit of Texas Medicaid and limited to one transfusion treatment per lifetime. Procedure code J1413 is restricted to diagnosis code G7101.

6.35.1 * Prior Authorization Requirements

Prior authorization is required for delandistrogene moxeparvovec-rokl (Elevidys) therapy and must be submitted with a Special Medical Prior Authorization (SMPA) Request Form.

Delandistrogene moxeparvovec-rokl (Elevidys) is a one-time intravenous infusion therapy indicated for the treatment of clients with Duchenne muscular dystrophy who meet the following requirements:

- [Revised] The client is 4 years of age or older and ambulatory.
- The client has a confirmed mutation in the DMD gene (diagnosis code G7101). Prescribers should monitor clients with a mutation in exon0s 1-17 and/or 59-71 of the DMD gene, for immune-mediated myositis.
- The client does not have any deletion in exon 8 or exon 9 in the DMD gene.
- The client is not on concomitant DMD antisense oligonucleotide therapy (e.g., golodirsen, casimersen, viltolarsen, eteplirsen, etc.).
- Documentation of client's baseline testing for presence of anti-AAVrh74 total binding antibody titers of <1:400.

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- The client has no current infection. If there are signs of infection prior to infusion, treatment with delandistrogene moxeparvovec-rokl (Elevidys) should be postponed until the infection clears.
- Due to the possibility of acute serious liver injury, client's liver function must be monitored prior and post delandistrogene moxeparvovec-rokl (Elevidys) therapy.
- Documentation of client's platelet count and troponin-l level should be obtained prior to infusion.
- The client does not have a history of previously receiving treatment with delandistrogene moxeparvovec-rokl (Elevidys) infusion.

The required monitoring parameters following delandistrogene moxeparvovec-rokl (Elevidys) infusion are:

- Liver function should be monitored upon initiation of therapy and continued on a weekly schedule for the first 3 months after delandistrogene moxeparvovec-rokl (Elevidys) infusion.
- Troponin-l level should be monitored weekly for the first month after treatment with delandistrogene moxeparvovec-rokl (Elevidys).

All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

6.36 Denileukin Diftitox-cxdl (Lymphir)

Denileukin diftitox-cxdl (Lymphir) (procedure code J9161) is a benefit of Texas Medicaid for clients with prior authorization.

Denileukin diftitox-cxdl (Lymphir) is an IL-2 receptor directed cytotoxin indicated for the treatment of adult patients with relapsed or refractory stage I–III cutaneous T-cell lymphoma (CTCL) after at least one prior systemic therapy.

6.36.1 Prior Authorization Requirements

6.36.1.1 Initial Requests

Denileukin diftitox-cxdl (Lymphir) is a subcutaneous injection and the initial prior authorization for this drug will be approved for 12 months for clients who meet the following requirements:

- The client is 18 years of age or older.
- The client has a confirmed diagnosis of cutaneous T-cell lymphoma (CTCL).
  - The client's lymphoma is categorized as Stage I to III.
  - The client's CTCL is relapsed or refractory after at least one prior systemic treatment.

Diagnosis Codes							
C8400	C8401	C8402	C8403	C8404	C8405	C8406	C8407
C8408	C8409	C8410	C8411	C8412	C8413	C8414	C8415
C8416	C8417	C8418	C8419	C84A0	C84A1	C84A2	C84A3
C84A4	C84A5	C84A6	C84A7	C84A8	C84A9	C84AA	

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- The client's serum albumin level must be > 3 g/dL prior to treatment cycle.
- The prescriber attests to counseling female clients of childbearing age regarding the use of an effective method of contraception during treatment with denileukin diftitox-cxdl (Lymphir) as there may be potential risk to the fetus.

The required monitoring parameters following denileukin diftitox-cxdl (Lymphir) are:

- Monitor the client for signs and symptoms of capillary leak syndrome (e.g., low blood pressure, severe swelling).
- Monitor the client's liver enzymes and bilirubin at baseline and during treatment as hepatotoxicity may occur.
- Monitor the client's renal function prior to starting each treatment. If serum albumin is less than 3 g/dL, delay administration of Lymphir until serum albumin is ≥ 3 g/dL.
- Monitor and evaluate the client for any visual impairment throughout treatment.

6.36.1.2 Recertification/Extension

For renewal or continuation of denileukin diftitox-cxdl (Lymphir) therapy, the client must meet the following requirements:

- The client meets the initial requirements for prior authorization and is currently treated with denileukin diftitox-cxdl (Lymphir) with the absence of severe adverse reactions or unacceptable toxicity (e.g., visual impairment, infusion related reactions, or hepatotoxicity).
- The client demonstrates partial/complete response to treatment or stabilization of disease, as shown by a decrease in spread or size of the tumor.

6.36.2 Documentation Requirements

In addition to the documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

6.37 Dexamethasone (Hemady)

Dexamethasone (Hemady) (procedure code J8541) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.38 Dexmedetomidine

Dexmedetomidine (procedure code J1105) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.39 Dimethyl sulfoxide

Dimethyl sulfoxide (procedure code J1212) is a benefit of Texas Medicaid and is limited to diagnosis codes N3010 and N3011.

6.40 Eculizumab (Soliris)

Eculizumab (Soliris) (procedure code J1299) is a benefit of Texas Medicaid and is limited to the following diagnosis codes:

Diagnosis Codes							
D5932	D5939	D595	G360	G7000	G7001		

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6.41 Edaravone (Radicava)

Procedure code J1301 is a benefit of Texas Medicaid for clients who are 18 years of age and older with prior authorization. Client must have a diagnosis of amyotrophic lateral sclerosis (ALS).

6.42 Efgartigimod

Efgartigimod alfa-fcab (Vyvgart) (procedure code J9332) and efgartigimod alfa (Vyvgart Hytrulo) (procedure code J9334) are benefits of Texas Medicaid and are limited to clients who are 18 years of age or older and restricted to diagnosis codes G700 and G7001. Procedure code J9334 is also restricted to diagnosis code G6181.

6.43 Elivaldogene Autotemcel (Skysona)

Elivaldogene autotemcel (Skysona) (procedure code J3387) is a benefit of Texas Medicaid for male clients who are 4 through 17 years of age with prior authorization.

Elivaldogene autotemcel (Skysona) is indicated to slow the progression of neurological dysfunction in boys who are 4 through 17 years of age with early, active cerebral adrenoleukodystrophy (CALD).

Elivaldogene autotemcel (Skysona) (procedure code J3387) is limited to one transfusion treatment per lifetime.

6.43.1 Prior Authorization Requirements

Elivaldogene autotemcel (Skysona) is a one-time infusion therapy indicated for the treatment of clients who meet the following requirements:

- The client is male who is 4 through 17 years of age.
- The client has a documented diagnosis of CALD (diagnosis code E71511, E71520, E71521, E71528, or E71529).
- The client has a variant in the ABCD1 gene as evident by a genetic test.
- The client's CALD is caused by the presence of a variant of the ABCD1 gene causing elevated very long chain fatty acid (VLCFA) and not secondary to head trauma.
- The client has early, active CALD as defined by all the following:
  - The client is asymptomatic or mildly symptomatic with neurologic function score (NFS) of less than or equal to 1.
  - The client has gadolinium enhancement on brain magnetic resonance imaging (MRI).
  - The client has a Loes score ranging from 0.5 to 9.
- The client has not had a hematopoietic stem cell transplant (HSCT), is eligible for HSCT, and is unable to find a matched related donor.
- The client's screening result is negative for hepatitis B virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV)-1 and HIV-2, and Human T-lymphotropic virus type I (HTLV-I) and type II (HTLV-II) prior to the collection of cells for manufacturing.
- The prescriber must attest to monitor the client closely for evidence of life-threatening hematological malignancy through complete blood counts (CBC) at least every six months and through assessment for possible clonal expansion a least twice in the first year and annually thereafter.
- The prescriber must attest to monitor the client for signs of bleeding and infections after the treatment with elivaldogene autotemcel (Skysona) as life-threatening bacterial or viral infections may occur as well as thrombocytopenia and prolonged cytopenia.

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- The client must avoid taking anti-retroviral medications for at least one month prior to initiating medication for stem cell mobilization and for the expected duration for elimination of the medications, and until all cycles of apheresis are complete.

In addition to the documentation requirements outlined in the Prior Authorization Requirements section, all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.44 Elranatamab-bcmm (Elfrexio)

Elranatamab-bcmm (Elfrexio) (procedure code J1323) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.45 Emapalumab-lzsg (Gamifant)

Emapalumab-lzsg (Gamifant) is an interferon gamma (IFNy) blocking antibody that is indicated for the treatment of the following:

- Adult and pediatric (newborn and older) clients with primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or intolerance with conventional HLH therapy.
- Adult and pediatric (newborn and older) clients with HLH/macrophage activation syndrome (MAS) in known or suspected Still's disease, including systemic juvenile idiopathic arthritis (sJIA), with an inadequate response or intolerance to glucocorticoids, or with recurrent MAS.

Emapalumab-lzsg (Gamifant) (procedure code J9210) is a benefit of Texas Medicaid for clients (newborn and older) with prior authorization.

Prescriber must administer dexamethasone concomitantly with emapalumab-lzsg (Gamifant) therapy.

Emapalumab-lzsg (Gamifant) is administered as part of the induction/maintenance phase of hematopoietic stem cell transplant (HSCT) and therapy will be discontinued once client is at the initiation phase for HSCT and no longer requires emapalumab-lzsg (Gamifant) therapy for HLH.

6.45.1 Prior Authorization Requirements

Prior authorization is required for emapalumab-lzsg (Gamifant) (procedure code J9210).

Prior authorization for initial therapy will be approved for a duration of six months when the client has one of the diagnoses listed below and meets the following criteria:

- Client has a documented diagnosis of primary HLH (diagnosis code D761) based on the following:
  - Genetic mutation of the gene known to cause primary HLH (e.g., PRF1, UNC13D, STX11, or STXBP2) or a family history consistent with primary HLH or
  - Confirmation of least 5 of the following criteria:
    - Fever ≥101.3 °F
    - Splenomegaly
    - Cytopenia defined by at least 2 of the following: Hemoglobin <9 g/dl; OR platelet count <100 x 10^9/L; OR neutrophils <1 x 10 Fasting triglycerides >265 mg/dl OR fibrinogen ≤1.5 g/L
    - Hemophagocytosis in the liver, bone marrow, spleen or lymph node
    - Low or absent natural killer (NK) cell activity
    - Serum ferritin concentration ≥ 500 mg/L

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    - High plasma concentration of soluble CD25 (i.e., soluble interleukin-2 receptor) >2,400 U/mL
- Client has refractory, recurrent or progressive disease or intolerance with conventional HLH therapy (e.g., etoposide, cyclosporine A, or anti-thymocyte globulin).
- Client has been tested/screened for latent tuberculosis infection prior to initiation of emapalumab-lzsg (Gamifant) therapy.
- Client has not undergone hematopoietic stem cell transplant and is candidate for HSCT once emapalumab-lzsg (Gamifant) therapy has been discontinued.
- Client has a documented diagnosis of HLH/MAS in Still's disease based on the following:
    - Client has a diagnosis of HLH along with a confirmed or suspected diagnosis of systemic juvenile idiopathic arthritis or adult onset of Still's disease.

Diagnosis Codes							
D761	M061	M0820	M08211	M08212	M08219	M08221	M08222
M08229	M08231	M08232	M08239	M08241	M08242	M08249	M08251
M08252	M08259	M08261	M08262	M08269	M08271	M08272	M08279
M0828	M0829						

    - Client has a diagnosis of active MAS with ferritin level greater than 684 ng/mL and any two of the four laboratory criteria listed below:
        - Platelet count ≤ 181×109/L
        - Aspartate aminotransferase (AST) > 48 U/L
        - Triglycerides > 156 mg/dL
        - Fibrinogen levels ≤ 360 mg/dL
    - Client has an inadequate response to high-dose IV glucocorticoids.
    - Client does not have any active infections caused by specific pathogens favored by IFNγ neutralization (e.g., mycobacteria and Histoplasma capsulatum).

For renewal or continuation therapy with emapalumab-lzsg (Gamifant), the client must meet all of the following requirements:

- Client continues to meet the initial approval criteria.
- Client continues to require emapalumab-lzsg (Gamifant) as HLH treatment pending the initiation of HSCT or when treatment is no longer needed for HLH/MAS.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.46 * Enzyme Replacement Therapy (ERT)

ERT is a medical treatment that replaces a specific enzyme that is deficient or absent in the body.

The following ERT therapies are benefits of Texas Medicaid:

- Agalsidase beta (Fabrazyme) is indicated in clients who are 2 years of age or older with Fabry disease and may be reimbursed with diagnosis code E7521.
- Alglucosidase alfa (Lumizyme) is indicated for clients with Pompe disease (GAA deficiency) and may be reimbursed with diagnosis code E7402.

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- Apadamtase alfa (Adzynma) is indicated in pediatric and adult clients for prophylactic or on demand ERT for congenital thrombotic thrombocytopenic purpura (cTTP) and may be reimbursed with diagnosis code D6942.
- Avalglucosidase alfa-ngpt (Nexviazyme) is indicated for clients who are 1 year of age or older with late onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) and may be reimbursed with diagnosis code E7402.
- Cerliponase alfa (Brineura) is indicated to slow the loss of ambulation in pediatric clients with late neuronal ceroid lipofuscinosis type 2 (CLN2) and may be reimbursed with diagnosis code E754.
- Cipaglucosidase alfa-atga (Pombiliti) is indicated to treat adult clients who are 18 years of age or older with Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) who weigh over 40 kilograms, are not improving on current ERT, and may be reimbursed with diagnosis code E7402.
- Elosulfase alfa (Vimizim) is a hydrolytic lysosomal glycosaminoglycan- (GAG) specific enzyme indicated for clients who are 5 years of age or older with mucopolysaccharidosis type IVA and may be reimbursed with diagnosis code E76210.
- [Revised] Galsulfase (Naglazyme) is a hydrolytic lysosomal glycosaminoglycan- (GAG) specific enzyme indicated for clients who are 5 years of age or older with mucopolysaccharidosis VI (MPS VI; Maroteaux-Lamy syndrome) and may be reimbursed with diagnosis code E7629.
- Idursulfase (Elaprase) is a hydrolytic lysosomal glycosaminoglycan- (GAG) specific enzyme indicated for clients with Hunter syndrome (mucopolysaccharidosis II [MPS II]) and may be reimbursed with diagnosis code E761.
- [Revised] Imiglucerase (Cerezyme) is indicated for long-term ERT for adult and pediatric clients with a confirmed diagnosis of Type 1 Gaucher disease (diagnosis code E7522) that results in one or more of the following conditions:
  - Anemia (low red blood cell count)
  - Thrombocytopenia (low blood platelet count)
  - Bone disease
  - Hepatomegaly or splenomegaly (enlarged liver or spleen)
- Laronidase (Aldurazyme) is indicated in clients with Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I) and clients with the Scheie form who have moderate to severe symptoms and may be reimbursed with diagnosis codes E7601, E7602, and E7603.
- Olipudase alfa-rpcp (Xenpozyme) is indicated for the treatment of non-central nervous system manifestations of acid sphingomyelinase deficiency (ASMD) in adult and pediatric patients and may be reimbursed with diagnosis codes E75240, E75241, E75244, E75248, and E75249. The following requirements must be met:
  - Pregnancy status of female clients of reproductive potential must be verified prior to initiating treatment.
  - Client's baseline transaminase level must be obtained.
  - Assessment of alanine transaminase (ALT) and aspartate aminotransferase (AST) must be conducted within one month prior to initiation of Olipudase alfa-rpcp, within 72 hours prior to any infusion during dose escalation, or prior to the next scheduled Olipudase alfarpcp infusion upon resuming treatment following a missed dose.
- Pegunigalsidase alfa-iwxj (Elfabrio) is indicated for the treatment of adult clients with confirmed Fabry disease and may be reimbursed with diagnosis code E7521.

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- [Revised] Pegzilarginase-nbln (Loargys) is indicated to treat hyperargininemia in clients who are 2 years of age or older with arginase 1 deficiency (ARG1-D) in conjunction with dietary protein restriction with diagnosis code E7221.
- Protein C concentrate, human (Ceprotin) is indicated in pediatric and adult clients with severe congenital protein C deficiency for the prevention and treatment of venous thrombosis and purpura fulminans and may be reimbursed with diagnosis cod D6859.
- Sebelipase alfa (Kanuma) is indicated for the treatment of pediatric and adult clients with a diagnosis of lysosomal acid lipase (LAL) deficiency and may be reimbursed with diagnosis code E755.
- [Revised] Taliglucerace alfa (Elelyso) is indicated for long-term ERT for adult and pediatric clients who are 4 years of age or older with Type 1 Gaucher disease and may be reimbursed with diagnosis code E7522.
- [Revised] Tividenofusp alfa-eknm (Avlayah) is indicated for the treatment of neurologic manifestations of Hunter syndrome (Mucopolysaccharidosis type II, MPS II) in presymptomatic or symptomatic pediatric clients weighing at least five kilograms before advanced neurologic impairment with diagnosis code E761.
- Velaglucerase alfa (VPRIV) is indicated for long-term ERT for clients with Type 1 Gaucher disease and may be reimbursed with diagnosis code E7522.
- Velmanase alfa-tycv (Lamzede) is indicated to treat non-central nervous system manifestation of alpha-mannosidosis in adult and pediatric clients and may be reimbursed with diagnosis code E771. The following requirement must be met:
    - Pregnancy status of female clients of reproductive potential must be verified prior to initiating treatment.

Vestronidase alfa-vjbk (Mepsevii) is indicated to treat Mucopolysaccharidosis VII (MPS VII, Sly syndrome) in pediatric and adult clients with prior authorization. Vestronidase alfa-vjbk (Mepsevii) may be approved for a duration of every 12 months per prior authorization request.

For initial therapy, the following criteria must be met:

- Documentation of clinical signs and symptoms of Mucopolysaccharidosis VII (MPS VII) (e.g., skeletal deformities; enlarged liver, spleen, or both; airway obstruction or pulmonary problems; joint limitations; etc.)
- Diagnosis of Mucopolysaccharidosis VII (MPS VII, Sly syndrome) (diagnosis code E7629 or E763) supported by elevated urine glycosaminoglycans excretion at a minimum of 3-fold over the mean normal for age at screening and either or the following:
    - Beta-glucuronidase enzyme deficiency in peripheral blood based on leukocytes or cultured fibroblasts
    - Mutation in the glucuronidase beta (GUSB) gene, confirmed by molecular genetic testing

For renewal or continuation of therapy, the following criteria must be met:

- Client has previously received treatment with vestronidase alfa-vjbk without an adverse reaction.
- Documentation from physician confirms the client has experienced an improvement in clinical response compared to pretreatment baseline (e.g., stability in skeletal deformities; reduction in liver volume; reduction in spleen volume, or both; stable or improved pulmonary function; improved endurance; and functional capacity, etc.).

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

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6.46.1 * Reimbursement for ERT

The following procedure codes may be reimbursed for ERT services:

[Revised] Procedure Codes									
J0180	J0217	J0218	J0219	J0221	J0567	J1203	J1322	J1458	J1743
J1757	J1786	J1818	J1931	J2508	J2724	J2840	J3060	J3385	J3397
J7171									

6.46.2 Prior Authorization

Prior authorization is required for enzyme replacement therapy and documentation must include all of the following:

- A request for the specific enzyme replacement therapy.
- Laboratory evidence of the enzyme deficiency, (i.e., below the laboratory-defined cut-off value as determined by the laboratory).

The requesting provider may be asked for additional information to clarify or complete a request for enzyme replacement therapy.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies.

6.47 Epcoritamab-bysp (Epkinly)

Epcoritamab-bysp (procedure code J9321) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.48 Eravacycline (Xerava)

Eravacycline (procedure code J0122) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.49 Esketamine (Spravato)

Esketamine (Spravato) is a benefit of Texas Medicaid for clients who are 18 years of age or older with prior authorization. Providers must submit claims for esketamine (Spravato) with procedure code J0013.

Esketamine (Spravato) nasal spray is an N-methyl-D-aspartate (NMDA) receptor antagonist that is indicated for any of the following treatments:

- Treatment-resistant depression (TRD) in adult clients, as monotherapy or in conjunction with an oral antidepressant
- Depressive symptoms in adult clients with major depressive disorder (MDD) with acute suicidal ideation or behavior in conjunction with an oral antidepressant

Esketamine (Spravato) is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).

Providers/health-care settings must be certified in the Spravato REMS program to administer Spravato to clients enrolled in the REMS program. Administration of the drug must take place in a health-care facility under the direct observation of a health-care provider.

Pharmacies must be certified in the Spravato REMS program to dispense to health-care settings who are authorized to administer the drug.

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Clients must be enrolled in the Spravato REMS program and comply with the ongoing requirements for Spravato treatment.

Esketamine (Spravato) is not a benefit for clients who have aneurysmal vascular disease, arteriovenous malformation or history of intracerebral hemorrhage.

6.49.1 Prior Authorization

Prior authorization is required for esketamine (Spravato) (procedure code J0013) and may be approved for a duration of six months.

Initial therapy for esketamine (Spravato) nasal spray may be approved when all of the following criteria is met:

- The client is 18 years of age or older.
- The client has a diagnosis of major depressive disorder (MDD) with one of the following diagnosis codes:

Diagnosis Codes							
F0631	F0632	F0634	F320	F321	F322	F323	F324
F325	F3289	F329	F32A	F330	F331	F332	F333
F3340	F3341	F3342	F338	F339	F341	F350	

- Client has either of the following:
  - A treatment-resistance depression (as monotherapy or in combination with an oral antidepressant) that has been confirmed as an inadequate response/failure to previous antidepressant treatment.
  - A major depressive disorder with acute suicidal ideation or behavior (in conjunction with an oral antidepressant) and the prescriber's evaluation shows that the client:
    - Has suicidal ideation with intent.
    - Needs acute psychiatric hospitalization due to an imminent risk of suicide.
- Esketamine (Spravato) must be administered under the direct observation of a health-care provider and the client must be monitored for at least 2 hours after each treatment.
- Prior to starting esketamine (Spravato) treatment, there must be an attestation of baseline scoring of clinical assessment of MDD.
- The client must not have contraindications to esketamine (Spravato), such as aneurysmal vascular disease, arteriovenous malformation, or intracerebral hemorrhage.

For renewal or continuation therapy, the client must meet all of the following requirements:

- The client continues to meet the initial prior authorization approval criteria.
- The client demonstrates positive clinical response to esketamine (Spravato) therapy by an improvement from baseline assessment.
- The client has previously received treatment esketamine (Spravato) without complications.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.50 Esmolol Hydrochloride

Esmolol hydrochloride (procedure code J1805 and J1806) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

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6.51 Etranacogene Dezaparvovec-drlb (Hemgenix)

Etranacogene dezaparvovec-drlb (Hemgenix) is an adeno-associated virus vector-based gene therapy indicated to treat adult clients with Hemophilia B (congenital Factor IX deficiency).

Etranacogene dezaparvovec-drlb (Hemgenix) (procedure code J1411) is a benefit of Texas Medicaid for adult clients who are 18 years of age or older with prior authorization.

6.51.1 Prior Authorization Requirements

Prior authorization is required for etranacogene dezaparvovec-drlb (Hemgenix) therapy.

Etranacogene dezaparvovec-drlb (Hemgenix) is a one-time infusion therapy indicated for the treatment of clients who meet the following requirements:

- The client is 18 years of age or older.
- The client has a confirmed diagnosis of Hemophilia B (Hereditary factor IX deficiency) (diagnosis code D67) and all other bleeding disorders not related to Hemophilia B have been ruled out.
- The client must meet one of the following criteria:
  - Is currently using Factor IX prophylaxis therapy, or
  - Has current or historical life-threatening hemorrhage, or
  - Has a history of repeated, serious spontaneous bleeding episodes.
- A Factor IX inhibitor titer testing must be performed, and client must have a baseline anti-AAV5 antibody titer of ≤1:678.
- The client must be tested for Factor IX inhibitor presence and testing result must be negative.
  - If testing yields a positive result, a second Factor IX inhibitor titer test should be performed within two weeks.
  - Etranacogene dezaparvovec-drlb (Hemgenix) should not be administered if the results for the initial and second test for human Factor IX inhibitor are positive.
- Baseline liver condition and function assessment must be assessed prior to etranacogene dezaparvovec-drlb (Hemgenix) infusion.
  - Documentation includes, but is not limited to alanine aminotransferase (ALT), aspartate aminotransferase (AST), alkaline phosphatase (ALP), and total bilirubin
  - Documentation of hepatic ultrasound and elastography must be provided.
- The client does not have a history of previously receiving treatment with etranacogene dezaparvovec-drlb (Hemgenix) infusion.

Etranacogene dezaparvovec-drlb (Hemgenix) (procedure code J1411) is limited to one infusion per lifetime.

These are the required monitoring parameters following etranacogene dezaparvovec-drlb (Hemgenix) infusion:

- Liver transaminase levels must be assessed once weekly for at least three months after etranacogene dezaparvovec-drlb (Hemgenix) infusion to monitor for any signs of potential hepatotoxicity.
- Factor IX activity must be monitored weekly for at least three months post-infusion.

In addition to the documentation requirements outlined in this section, if any, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

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6.52 Evinacumab-dgnb (Evkeeza)

Evinacumab-dgnb (procedure code J1305) is a benefit of Texas Medicaid for clients who are 1 year of age or older.

6.53 Fam-trastuzumab Deruxtecan-nxki

Fam-trastuzumab Deruxtecan-nxki (procedure code J9358) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.54 * Fecal Microbiota

[Revised] Fecal microbiota (procedure code J1440) is a benefit of Texas Medicaid for clients who are 18 years of age or older and restricted to diagnosis codes A0471, A0472, and Z8617.

6.55 Fluocinolone Acetonide (Retisert)

Procedure code J7311 is a benefit of Texas Medicaid for clients of all ages but is only considered for reimbursement with a posterior uveitis diagnosis of more than six months in duration and only when the condition has been unresponsive to oral or systemic medication treatment.

Refer to: Subsection 4.2.11, "Fluocinolone Acetonide" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional prior authorization requirements.

6.56 Furosemide (Furoscix)

Furosemide (Furoscix) (procedure code J1941) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.57 Givosiran (Givlaari)

Givosiran (procedure code J0223) is a benefit of Texas Medicaid for clients who are 18 years of age or older and when billed with diagnosis codes E8020, E8021, and E8029.

6.58 Glofitamab-gxbm

Glofitamab-gxbm (procedure code J9286) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.59 Granisetron Hydrochloride

Granisetron hydrochloride (procedure code J1626) is a benefit of Texas Medicaid and is limited to diagnosis codes Z510, Z5111, Z5112, and Z5189.

6.60 Hematopoietic Injections

Hematopoietic agents erythropoietin alfa, epoetin alfa (EPO), methoxy polyethylene glycol-epoetin beta (Mircera), and darbepoetin alfa are benefits of Texas Medicaid and reimbursed using procedure codes J0881, J0885, and J0888 with an appropriate diagnosis code.

Providers must maintain medical records in their offices that document regular monitoring of hemoglobin or hematocrit levels and explain the rationale for the dosing of epoetin alfa, methoxy polyethylene glycol-epoetin beta, and darbepoetin alfa. These records are subject to retrospective review to determine appropriate utilization and reimbursement for this service.

EPO, Mircera, and darbepoetin alfa injections are limited to specific diagnosis codes as indicated in this section.

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Refer to: Subsection 7.2.7.1, "Hematopoietic Injections" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about outpatient facility criteria.

6.60.1 Darbepoetin Alfa

Darbepoetin alfa (procedure code J0881) is an erythropoiesis-stimulating protein closely related to erythropoietin. Darbepoetin stimulates erythropoiesis by the same mechanism as EPO. Darbepoetin alfa has approximately a three-fold longer half-life than EPO, resulting in a sustained erythropoietic effect and less frequent dosing. Darbepoetin alfa is indicated for:

- Treatment of anemia associated with chronic renal failure (CRF), including clients on dialysis and clients not on dialysis.
- Treatment of anemia in clients who have non-myeloid malignancies where anemia is due to the effect of chemotherapy.

Procedure code J0881 must be billed with one of the following diagnosis codes:

Diagnosis Codes							
C9000	C9001	C9002	D460	D461	D4621	D464	D46A
D46B	D611	D612	D613	D6189	D619	D630	D631
D644	D6481	D6489	D649	N181	N182	N1830	N1831
N1832	N184	N189	N19	Z5111	Z5112		

Darbepoetin alfa injections are limited to once weekly (Sunday through Saturday).

6.60.2 Epoetin Alfa (EPO)

EPO (procedure code J0885) is a glycoprotein that stimulates the formation of red blood cells and the production of the precursor red blood cells of the bone marrow. EPO is indicated for:

- Anemia associated with chronic renal failure (CRF), including clients not on dialysis.
- Anemia related to therapy with zidovudine (AZT) in HIV-infected clients.
- Anemia due to the effects of concomitantly administered chemotherapy in clients who have non-myeloid malignancies.
- Anemia of prematurity.
- Clients scheduled to undergo elective noncardiac, nonvascular surgery to decrease need for allogenic blood transfusion.

Procedure code J0885 must be billed with one of the following diagnosis codes:

Diagnosis Codes							
B20	C9000	C9001	C9002	D460	D461	D4621	D4622
D464	D469	D46A	D46B	D46C	D46Z	D471	D479
D47Z9	D611	D612	D613	D6189	D619	D630	D631
D644	D6481	D6489	D649	I120	N181	N182	N1830
N1831	N1832	N184	N189	N19	P612		

EPO may be considered for reimbursement when the dose is titrated consistent with prevailing, evidence-based clinical guidelines, as published by the National Kidney Foundation Kidney Disease Outcomes Quality Initiative, including appropriate monitoring of the rise and fall of the hemoglobin or hematocrit levels.

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EPO is limited to three injections per calendar week (Sunday through Saturday).

6.60.3 Methoxy Polyethylene Glycol-Epoetin Beta (Mircera)

Methoxy polyethylene glycol-epoetin beta (Mircera) is indicated for the treatment of anemia associated with chronic kidney disease (CKD) and may be administered subcutaneously or intravenously. Mircera is not indicated for use in the treatment of anemia due to cancer chemotherapy or as a substitute for red blood cell transfusions in clients who require immediate correction of anemia. Mircera is indicated for the following:

- Treatment of anemia associated with CKD in adult clients on hemodialysis and adult clients not on hemodialysis.
- Treatment of anemia associated with CKD in pediatric clients who are 5 through 17 years of age. These clients must be on hemodialysis and converting from another erythropoiesis-stimulating agent (ESA) after their hemoglobin level was stabilized with an ESA.

Note: *In pediatric clients, Mircera is administered by intravenous injection only.*

Methoxy polyethylene glycol-epoetin beta (Mircera) (procedure code J0888) is limited to the following diagnosis codes:

Diagnosis Codes							
D631	I129	I130	N181	N182	N1830	N1831	N1832
N184							

Methoxy polyethylene glycol-epoetin beta (Mircera) may be considered for reimbursement when the dose is titrated consistent with prevailing, evidence-based, clinical guidelines as published by the National Kidney Foundation Kidney Disease Outcomes Quality Initiative, including appropriate monitoring of the rise and fall of the hemoglobin or hematocrit levels.

Methoxy polyethylene glycol-epoetin beta (Mircera) is limited to one injection every 2 calendar weeks, any provider (Sunday through Saturday).

6.61 Hemophilia Drugs

6.61.1 Alhemo (Concizumab-mtci)

Alhemo (Concizumab-mtci) (procedure code J7173) is a benefit of Texas Medicaid for clients who are 12 years of age or older.

6.61.2 Coagulation factor Xa (Recombinant), Inactivated-zhzo (Andexxa)

Coagulation factor XA (recombinant), inactivated-zhzo (procedure code J7169) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.61.3 Factor VIIa (Antihemophilic factor, Recombinant-JNCW) (Sevenfact)

Factor VIIa (Antihemophilic factor, recombinant-jncw) (procedure code J7212) is a benefit of Texas Medicaid for clients who are 12 years of age or older.

6.61.4 Prothrombin complex concentrate (Human-lans), per I.U. of factor 1x activity

Prothrombin complex concentrate, human-lans, (procedure code J7165) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.61.5 Prothrombin complex (Human), per I.U. of factor 1x activity (Kcentra)

Prothrombin complex, human (procedure code J7168) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

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6.61.6 Qfitlia (Fitusiran)

Qfitlia (Fitusiran) (procedure code J7174) is a benefit of Texas Medicaid for clients who are 12 years of age or older.

6.62 Hereditary Angioedema (HAE) agents

6.62.1 C1 Esterase Inhibitor (Human) (Berinert)

C-1 esterase inhibitor (human) (Berinert) (procedure code J0597) is a benefit of Texas Medicaid for clients who are 5 years of age or older when billed with diagnosis code D841.

6.62.2 C1 Esterase Inhibitor (Human) (Cinryze)

C-1 esterase inhibitor (human) (Cinryze) (procedure code J0598) is a benefit of Texas Medicaid for clients who are 6 years of age or older when billed with diagnosis code D841.

6.62.3 C1 Esterase Inhibitor (Human) (Haegarda)

C1 esterase inhibitor (human) (Haegarda) (procedure code J0599) is a benefit of Texas Medicaid for clients who are 6 years of age or older when billed with diagnosis code D841.

6.62.4 C1 Esterase Inhibitor (Recombinant) (Ruconest)

C1 esterase inhibitor (recombinant) (procedure code J0596) is a benefit of Texas Medicaid for clients who are 13 years of age or older when billed with diagnosis code D841.

6.62.5 Ecallantide (Kalbitor)

Ecallantide (Kalbitor) (procedure code J1290) is a benefit of Texas Medicaid for clients who are 12 years of age or older when billed with diagnosis code D841.

6.62.6 Hympavzi (Marstacimab-hncq)

Hympavzi (Marstacimab-hncq) (procedure code J7172) is a benefit of Texas Medicaid for clients who are 6 years of age or older.

6.62.7 Icatibant (Firazyr)

Icatibant (Firazyr) (procedure code J1744) is a benefit of Texas Medicaid for clients who are 18 years of age or older when billed with diagnosis code D841.

6.62.8 Lanadelumab-flyo (Takhzyro)

Lanadelumab-flyo (Takhzyro) (procedure code J0593) is a benefit of Texas Medicaid for clients who are 2 years of age or older when billed with diagnosis code D841.

6.62.9 Hormonal Therapy Agents

The following hormonal therapy agent procedure codes require prior authorization. Hormonal therapy agents are not a benefit when submitted with diagnosis codes F640, F641, F642, F648, and F649.

Procedure Codes									
J1000	J1071	J1072	J1073	J1380	J1950	J1951	J3121	J3145	J3315
J3316	J9155	J9217	J9218	J9226					

6.63 Ibalizumab-uiyk (Trogarzo)

Ibalizumab-uiyk (Trogarzo) (procedure code J1746) is a benefit of Texas Medicaid for clients who are 18 years of age and older with prior authorization. Ibalizumab-uiyk (Trogarzo) may be approved for a duration of every 12 months per prior authorization request.

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For initial therapy, all of the following criteria must be met:

- The client is 18 years of age or older.
- The client has a documented diagnosis of multi-drug resistant human immunodeficiency virus (diagnosis code B20) from the provider and meets the following criteria:
  - Has received antiretroviral treatment for at least 6 months and is failing or has recently failed therapy
  - Has documented resistance, measured by resistance testing, to at least one antiretroviral medication from each of the following 3 classes of ARV:
    - Nucleoside reverse transcriptase inhibitors (NRTI)
    - Non-Nucleoside reverse transcriptase inhibitors (NNRTI)
    - Protease inhibitor (PI)
- The client has documented RNA viral load greater than 1,000 copies/mL.

Providers must use ibalizumab-uiyk (Trogarzo) concomitantly with another antiretroviral medication to which the client's virus is susceptible.

For renewal or continuation of therapy, all of the following criteria must be met:

- The client has previously received treatment with ibalizumab-uiyk (Trogarzo).
- Documentation from the physician confirming that the client has achieved a clinical viral response defined as one of the following:
  - Decrease in viral load
  - Sustained viral load reduction
- The physician continues ibalizumab-uiyk (Trogarzo) therapy with another antiretroviral.

Trogarzo is not a benefit for clients who fail to demonstrate heavily treated multi-drug resistance.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.64 Imetelstat (Rytelo)

Imetelstat (Rytelo) is an oligonucleotide telomerase inhibitor indicated for the treatment of adult clients meeting both of the following criteria:

- The client has low- to intermediate-1 risk myelodysplastic syndromes (MDS) with transfusion-dependent anemia requiring four or more red blood cell (RBC) units over eight weeks.
- The client has not responded to, has lost response to, or is ineligible for erythropoiesis-stimulating agents (ESA).

Imetelstat (Rytelo) (procedure code J0870) is a benefit of Texas Medicaid for clients with prior authorization.

6.64.1 Prior Authorization Requirements

Prior authorization requests for imetelstat (Rytelo) must be submitted with a Special Medical Prior Authorization (SMPA) Request Form and documentation of all the following.

Imetelstat (Rytelo) is an intravenous infusion indicated for the treatment of a client who meets all of the following requirements:

- The client is 18 years of age or older.

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- The client has a confirmed diagnosis of low- to intermediate-1 risk MDS (diagnosis codes D460, D461, D464, D469, D46A, D46B, D46C, and D46Z).
- The client has transfusion-dependent anemia requiring regular RBC transfusions defined as >4 RBC units over eight weeks.
- The prescriber has ruled out or addressed other causes of anemia (e.g., abnormal bleeding, hemolysis, nutritional deficiency, renal disease)
- The prescriber attests that the client has not responded to, has lost response to, or is ineligible for ESAs.
- The client does not have deletion 5q cytogenic abnormalities.
- Imetelstat (Rytelo) will not be prescribed concomitantly with other erythropoiesis stimulating agents.
- The prescriber attests to counseling female clients of childbearing age regarding the use of an effective method of contraception to prevent pregnancy during treatment with imetelstat (Rytelo).

The required monitoring parameters following imetelstat (Rytelo) infusion are:

- Monitor for thrombocytopenia and neutropenia.
- Monitor liver function tests prior to imetelstat (Rytelo) administration, then weekly for the first cycle, and prior to each cycle thereafter.

6.64.2 Documentation Requirements

In addition to documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.65 Imipenem, Cilastatin, and Relebactam (Recarbrio)

Imipenem, Cilastatin, and Relebactam (procedure code J0742) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.66 * Immunosuppressive Drugs

Immunosuppressive drugs weaken or modulate the activity of the immune system and are most often used in organ transplantation to prevent rejection or to treat autoimmune diseases such as rheumatoid arthritis.

The following procedure codes are benefits of Texas Medicaid:

[Revised] Procedure Codes									
J0202	J0257	J0480	J0485	J0717	J1595	J1602	J7501	J7516	J7524
J7525	J7526	J7529	J7530						

The following procedure codes may be indicated for, but are not limited to, treatment of the following conditions:

[Revised] Procedure Code	Conditions
J0202	Multiple sclerosis (MS): For treatment of relapsing forms of MS and should be reserved for adult clients who have had an inadequate response to two or more drugs indicated for the treatment of MS.

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[Revised] Procedure Code	Conditions
J0257	Alpha-1 proteinase inhibitor deficiency: For the treatment of adult clients who have a deficiency of the alpha-1 proteinase inhibitor enzyme (also known as alpha-1 antitrypsin deficiency) in the treatment of emphysema.
J0480	Organ rejection: For the prophylaxis of acute organ rejection in clients receiving renal transplantation when used as part of an immunosuppressive regimen that includes cyclosporine and corticosteroids.
J0485	Organ rejection: For the prophylaxis of organ rejection in adult clients receiving a kidney transplant, to be used in combination with basiliximab injection, mycophenolate mofetil, and corticosteroids.
J0717	Psoriatic arthritis, ankylosing spondylitis, Crohn's disease, rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, non-radiographic axial spondylarthritis, and plaque psoriasis.
J1595	Multiple sclerosis (MS): For the reduction of the frequency of relapses in adult clients with relapsing remitting MS, including clients who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with MS.
J1602	Psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis, and polyarticular juvenile idiopathic arthritis.
J7501	Renal homotransplantations: Adjunct for the prevention of rejection in renal homotransplantation. Rheumatoid arthritis: Azathioprine is indicated only in clients meeting the criteria for classic or definite rheumatoid arthritis as specified by the American Rheumatism Association.
J7516, J7524, J7526, J7529, J7530	Allogeneic transplants: For prophylaxis of organ rejection in kidney, liver, and heart allogeneic transplants.
J7525	Organ rejection prophylaxis: For the prophylaxis of organ rejection in clients receiving allogeneic liver, kidney, or heart transplants.

Note: *Oral, self-administered immunosuppressive drugs may be reimbursed for Medicaid fee-for-service clients through the Texas Vendor Drug Program (VDP).*

Retrospective review may be performed to ensure documentation supports the medical necessity of the service. Authorization is not required for immunosuppressive drugs.

6.67 Inclisiran (Leqvio)

Inclisiran (Leqvio) (procedure code J1306) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.68 * Inebilizumab-cdon (Uplizna)

Inebilizumab-cdon (Uplizna) (procedure code J1823) is a benefit of Texas Medicaid for clients who are 18 years of age or older with prior authorization.

Inebilizumab-cdon (Uplizna) is indicated for the treatment of adult clients with the following:

- Neuromyelitis optica spectrum disorder (NMOD/NMOSD) who are anti-aquaporin-4 antibody positive

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- Immunoglobulin G4-related disease (IgG4-RD)
- [Revised] Generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.

6.68.1 * Prior Authorization Criteria

Prior authorization approval for initial therapy for inebilizumab-cdon (Uplizna) will be considered and approved for a 12-month duration when the client has one of the diagnoses listed below and meets the following criteria:

Neuromyelitis Optica Spectrum Disorder

- Client must be 18 years of age or older.
- Client has a diagnosis of neuromyelitis optica spectrum disorder (diagnosis code G360).
- Client is anti-aquaporin 4 (AQP4) antibody seropositive.
- Client has been screened for hepatitis B virus (HBV), quantitative serum immunoglobulins, and tuberculosis (TB) prior to initiating treatment.
- Client has at least one attack requiring rescue therapy in the last year OR two attacks requiring rescue therapy in the last 2 years.
- Client is not receiving Inebilizumab-cdon (Uplizna) concomitantly with the following therapies:
  - Anti-CD20 monoclonal antibody treatments
  - Complement inhibitors (e.g. Eculizumab, Ravulizumab)
  - Immunosuppressant drugs (e.g. Cyclosporine, Methotrexate)
  - Satralizumab

Immunoglobulin Related Disease

- Client must be 18 years of age or older.
- Client has a diagnosis of immunoglobulin G4-related disease (diagnosis code D8984) and other conditions that mimic IgG4-RD have been ruled out (e.g., malignancy, infection, other autoimmune disorders).
- Client experiences (or recently experienced) an IgG4-RD flare that requires initiation or continuation of glucocorticoid treatment.
- Client has history of IgG4-RD affecting at least two organs.

For renewal or continuation of therapy, the client must meet all of the following requirements:

- Client continues to meet the following initial approval criteria.
- Client experienced positive clinical response to therapy as demonstrated by decreased attacks or disease stabilization.
- Client has previously received inebilizumab-cdon (Uplizna) treatment without complications or unacceptable toxicity (e.g., infusion reactions, serious infections).

*** Generalized myasthenia gravis (gMG)**

- [Revised] Client must be 18 years of age or older.
- [Revised] Client has a diagnosis of gMG, Myasthenia Gravis Foundation of America (MGFA) clinical classification of II, III, or IV (diagnosis codes G7000 and G7001).

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- [Revised] Client is anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.
- [Revised] Client's Myasthenia Gravis-Activities of Daily Living (MG-ADL) score is between six and ten.
- [Revised] Client has a Quantitative Myasthenia Gravis (QMG) score greater than 11.
- [Revised] Client is on a stable dose of corticosteroid, a specific non-steroidal immunosuppressive therapy, or a combination of both.
- [Revised] Client is not receiving inebilizumab-cdon (Uplizna) to treat myasthenia gravis concomitantly with the following therapies:
  - [Revised] Anti-CD20 monoclonal antibody treatments
  - [Revised] Complement inhibitors (e.g., ravulizumab-cwvz (Ultomiris), or zilucoplan (Zilbrysq))
  - [Revised] A neonatal Fc receptor (FcRn) blocker (e.g., nipocalimab-aahu (Imaavy), rozanolixizumab-noli (Rystiggo), efgartigimod alfa-fcab (Vyvgart), efgartigimod alfa or hyaluronidase-qvfc (Vyvgart Hytrulo))

6.69 Infliximab (Remicade), Avsola, Inflectra, Renflexis, and Zymfentra

Procedure codes J1745, Q5103, Q5104, and Q5121 are benefits of Texas Medicaid, and may not be reimbursed for the same date of service by any provider. Procedure codes J1745, Q5103, Q5104, and Q5121 are limited to the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5100	K51011	K51012	K51013	K51014	K51018	K5120
K51211	K51212	K51213	K51214	K51218	K5130	K51311	K51312
K51313	K51314	K51318	K5150	K51511	K51512	K51513	K51514
K51518	K5180	K51811	K51812	K51813	K51814	K51818	K5190
K51911	K51912	K51913	K51914	K51918	K6030	K60311	K60312
K60313	K60319	K60321	K60322	K60323	K60329	K632	L400
L401	L402	L403	L404	L4050	L4051	L4052	L4053
L4054	L4059	L408	M05011	M05012	M05021	M05022	M05031
M05032	M05041	M05042	M05051	M05052	M05061	M05062	M05071
M05072	M0509	M05411	M05412	M05421	M05422	M05431	M05432
M05441	M05442	M05451	M05452	M05461	M05462	M05471	M05472
M0549	M05511	M05512	M05521	M05522	M05531	M05532	M05541
M05542	M05551	M05552	M05561	M05562	M05571	M05572	M0559
M05611	M05612	M05621	M05622	M05631	M05632	M05641	M05642
M05651	M05652	M05661	M05662	M05671	M05672	M0569	M05711
M05712	M05721	M05722	M05731	M05732	M05741	M05742	M05751
M05752	M05761	M05762	M05769	M05771	M05772	M05779	M0579
M057A	M05811	M05812	M05821	M05822	M05831	M05832	M05841

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Diagnosis Codes							
M05842	M05851	M05852	M05861	M05862	M05871	M05872	M0589
M058A	M06011	M06012	M06021	M06022	M06031	M06032	M06041
M06042	M06051	M06052	M06061	M06062	M06071	M06072	M0608
M0609	M060A	M06811	M06812	M06819	M06821	M06822	M06829
M06831	M06832	M06839	M06841	M06842	M06849	M06851	M06852
M06859	M06861	M06862	M06869	M06871	M06872	M06879	M0688
M0689	M068A	M069	M08011	M08012	M08021	M08022	M08031
M08032	M08041	M08042	M08051	M08052	M08061	M08062	M08071
M08072	M0809	M08811	M08812	M08821	M08822	M08831	M08832
M08841	M08842	M08851	M08852	M08861	M08862	M08871	M08872
M0888	M0889	M08931	M08932	M08941	M08942	M08951	M08952
M08961	M08962	M08971	M08972	M0898	M450	M451	M452
M453	M454	M455	M456	M457	M458	M45A0	M45A1
M45A2	M45A3	M45A4	M45A5	M45A6	M45A7	M45A8	M45AB

Procedure code J1745 is also limited to diagnosis code M05A.

Procedure code J1748 is a benefit for clients who are 18 years of age or older and limited to the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K50019	K5010
K50111	K50112	K50113	K50114	K50118	K5080	K50811	K50812
K50813	K50814	K50818	K50819	K5090	K50911	K50912	K50913
K50914	K50918	K5100	K51011	K51012	K51013	K51014	K51018
K51019	K5120	K51211	K51212	K51213	K51214	K51218	K5130
K51311	K51312	K51313	K51314	K51318	K5180	K51811	K51812
K51813	K51814	K51818	K5190	K51911	K51912	K51913	K51914
K51918	K51919						

6.70 Inotuzumab ozogamicin (Besponsa)

Inotuzumab ozogamicin (Besponsa) (procedure code J9229) is a benefit of Texas Medicaid for pediatric and adult clients who are 1 year of age or older with prior authorization.

Inotuzumab ozogamicin (Besponsa) is a CD22-directed antibody-drug conjugate (ADC) that has 3 components:

- The antibody inotuzumab
- N-acetyl-gamma-calicheamicin dimethylhydrazide (a cytotoxic agent)
- An acid cleavable linker

Besponsa is indicated for the treatment of relapsed or refractory precursor B-cell acute lymphoblastic leukemia (ALL).

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6.70.1 Prior Authorization Requirements for Inotuzumab ozogamicin (Besponsa)

Prior authorization approval for Besponsa intravenous injection (procedure code J9229) will be considered when all of the following criteria are met:

- Client is 1 year of age or older
- Client has a confirmed diagnosis of precursor B-cell acute lymphoblastic leukemia (ALL) that is refractory or in relapse
- The prescriber must agree to monitor the client for signs and symptoms of hepatic veno-occlusive disease (VOD) for the duration of Besponsa therapy

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.70.2 Documentation Requirements

In addition to documentation requirements outlined above all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.70.3 Exclusions

Besponsa is not a benefit for patients who have hepatic veno-occlusive disease.

6.71 Insulin

Insulin [Fiasp (procedure code J1812) and Lyumjev (procedure code J1814)] is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.72 Invega Hafyera

Invega hafyera (procedure code J2427) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.73 Iron Injections

Ferric derisomaltose (procedure code J1437) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

Ferric carboxymaltose (procedure code J1439) is a benefit of Texas Medicaid for clients who are 1 year of age or older.

Iron Dextran injection (procedure code J1750) is a benefit of Texas Medicaid for clients who are 4 months of age or older.

Iron Sucrose injection (procedure code J1756) is a benefit of Texas Medicaid for clients who are 2 years of age or older.

Sodium Ferric Gluconate Complex injection (procedure code J2916) is a benefit of Texas Medicaid for clients who are 6 years of age or older.

Ferumoxytol injection (procedure code Q0138) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.74 Eladocagene Exuparvovec-tneq (Kebilidi)

Eladocagene exuparvovec-tneq (Kebilidi) is an adeno-associated virus (AAV) vector-based gene therapy indicated to treat adult and pediatric clients with aromatic L-amino acid decarboxylase (AADC) deficiency.

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Eladocagene exuparvovec-tneq (Kebilidi) is a benefit of Texas Medicaid with prior authorization.

Eladocagene exuparvovec-tneq (Kebilidi) may be reimbursed using procedure code J3590 and is limited to once per lifetime.

6.74.1 Prior Authorization Requirements

Providers must submit prior authorization requests for eladocagene exuparvovec-tneq (Kebilidi) on a Special Medical Prior Authorization (SMPA) Request Form.

Eladocagene exuparvovec-tneq (Kebilidi) is a single-dose intraputaminal infusion indicated for clients who meet the following requirements:

- The client is 16 months of age or older.
- The client has a confirmed diagnosis of AADC deficiency (diagnosis code E7081).
- The client has presence of biallelic mutations in the dopa decarboxylase (DDC) gene identified by molecular genetic testing.
- There is documentation of skull assessment confirming that the client has achieved skull maturity by neuroimaging, which is necessary for stereotactic neurosurgical administration of eladocagene exuparvovec-tneq (Kebilidi) therapy.
- The client has not previously received eladocagene exuparvovec-tneq (Kebilidi) infusion for AADC deficiency.

After eladocageneexuparvovec-tneq (Kebilidi) infusion, providers must monitor the client for the following:

- Post-procedural complications, which may include events of respiratory and cardiac arrest after administration
- Additional procedure-related adverse events, such as cerebrospinal fluid leak, intracranial bleeding, neuroinflammation, acute infarction, and infection
- Signs of dyskinesia or involuntary movements of the face, arm, leg, or entire body (fidgeting, writhing, wriggling, head bobbing, or body swaying) after administration

In addition to documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.75 Labetalol Hydrochloride

Labetalol hydrochloride [(procedure code J1920) and Hikma (procedure code J1921)] is a benefit of Texas Medicaid for clients who are 1 year of age or older.

6.76 Lactated Ringer's

Lactated Ringer's (procedure code J7121) is a benefit of Texas Medicaid for clients who are birth through 20 years of age.

6.77 Lenacapavir (Sunlenca)

Lenacapavir (Sunlenca) (procedure code J1961) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

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6.78 Leuprolide Acetate (Lupron Depot)

Procedure codes J1950, J9217, or J9218 may be reimbursed for leuprolide acetate injections with prior authorization. The following limitations apply to procedure codes J1950 and J9217:

Procedure Code	Limitation(s)
J1950	Reimbursed once every 28 days

Procedure code J9217 may be reimbursed in monthly, three-month, four-month, and six-month doses as follows:

Frequency	Dosage	Limitations
Monthly	7.5 mg	Billed with a quantity of 1 Reimbursed once every 28 days
3-month	22.5 mg	Billed with a quantity of 3 Reimbursed once every 84 days
4-month	30 mg	Billed with a quantity of 4 Reimbursed once every 112 days
6-month	45 mg	Billed with a quantity of 6 Reimbursed once every 168 days

The total dosage allowed within a 6-month period is 45 mg.

Procedure codes J1950, J9217, and J9218 will be denied if billed on the same date of service by the same provider.

Refer to: Subsection 6.62.9, "Hormonal Therapy Agents" in this handbook for additional information.

6.79 Lumasiran (Oxlumo)

Lumasiran (procedure code J0224) is a benefit of Texas Medicaid for clients when billed with diagnosis code E72530.

6.80 Lupus Treatment Agents

Anifrolumab-fnia (Saphnelo) (procedure code J0491) and Belimumab (Benlysta) (procedure code J0490) are benefits of Texas Medicaid for clients with prior authorization.

Anifrolumab-fnia (Saphnelo) is indicated to treat moderate to severe systemic lupus erythematosus (SLE) in adult clients who are receiving standard therapy.

Belimumab (Benlysta) is indicated to treat the following:

- Active, autoantibody-positive, systemic lupus erythematosus (SLE) in clients who are 5 years of age or older, and receiving standard therapy.
- Adult clients with active Lupus Nephritis who are receiving standard therapy.

6.80.1 Initial Requests

Initial therapy for anifrolumab-fnia (Saphnelo) may be approved for a 12-month duration if all the following criteria are met:

- The client is 18 years of age or older.
- The client has a confirmed diagnosis of systemic lupus erythematosus (M3210, M3211, M3212, M3213, M3214, M3215, M3219, M328, M329).
- The client does not have active lupus nephritis or severe active central nervous lupus.

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- The client is currently receiving at least one stable standard-of-care treatment for active systemic lupus erythematosus.
- The client is not receiving anifrolumab-fina (Saphnelo) in combination with a biologic agent.

Initial therapy for belimumab (Benlysta) may be approved for a 12-month duration if all the following criteria are met:

- Diagnosis of SLE:
  - The client is 5 years of age or older.
  - The client has a confirmed diagnosis of SLE (M320, M3210, M3211, M3212, M3213, M3214, M3215, M3219, M328, M329).
  - The client has laboratory testing confirming the presence of autoantibodies.
  - The client is currently receiving at least one standard-of-care treatment for active SLE.
  - The client is not receiving belimumab (Benlysta) in combination with a biologic disease-modifying antirheumatic drug (DMARD) agent.
- Diagnosis of active lupus nephritis:
  - The client is 18 years of age or older.
  - The adult client has a confirmed diagnosis of active lupus nephritis.
  - The client has laboratory testing confirming the presence of autoantibodies.
  - The client is currently receiving at least one standard-of-care treatment.
  - The client is not receiving belimumab (Benlysta) in combination with a biologic DMARD agent.

6.80.2 Recertification or Extension

For renewal or continuation therapy for anifrolumab-fnia (Saphnelo), the client must meet the following criteria:

- The client continues to meet the initial authorization approval criteria.
- The client has experienced a positive clinical response to therapy as demonstrated by stabilization of the disease or absence of disease progression.
- The client has not experienced any complications or unacceptable toxicities during anifrolumab-fnia (Saphnelo) treatment.

For renewal or continuation therapy for belimumab (Benlysta), the client must meet the following criteria:

- The client continues to meet the initial authorization approval criteria.
- The client has experienced a positive clinical response to therapy as demonstrated by stabilization of the disease or absence of disease progression.
- The client has not experienced any complications or unacceptable toxicities during belimumab (Benlysta) treatment.

6.81 Luspatercept-aamt (Reblozyl)

Luspatercept-aamt (Reblozyl) (procedure code J0896) is a benefit of Texas Medicaid with prior authorization.

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Luspatercept-aamt (Reblozyl) is restricted to clients who are 18 years of age or older, and may be approved for treatment of the following:

- Anemia in adult clients with beta thalassemia requiring red blood cell (RBC) transfusions
- Anemia failing an erythropoiesis stimulating agent and requiring two or more red blood cell units over eight weeks in adult clients with low to intermediate-risk myelodysplastic syndrome with ring sideroblasts (MDS-RS) or with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)

6.81.1 Prior Authorization for Luspatercept-aamt (Reblozyl)

Prior authorization requests for procedure code J0896 must be submitted with a Special Medical Prior Authorization (SMPA) Request Form.

For initial prior authorization requests for Luspatercept-aamt (Reblozyl), the client must be 18 years of age or older and meet the following criteria:

- Client who has anemia with beta thalassemia requiring regular RBC transfusions:
  - The client must have a diagnosis of beta thalassemia.
  - The client requires regular RBC transfusions of six or more units within the previous 24 weeks and has had no transfusion-free period for 35 days or longer during the review period.
- Client who has anemia failing an erythropoiesis stimulating agent:
  - The client must have a diagnosis of myelodysplastic syndrome classified as low to intermediate risk disease.
  - The client must require RBC transfusions of two or more units over a period of eight weeks.
  - The client must be ineligible or must have failed prior erythropoietin stimulating agent treatment.

For renewal or continuation of therapy, the client must meet the initial age and diagnosis criteria, in addition to the following requirements:

- Client who has anemia with beta thalassemia requiring regular RBC transfusions:
  - The client had a positive response/hematological improvement demonstrated by a reduction in RBC transfusion as indicated by the prescribing physician.
  - The client previously received treatment with luspatercept-aamt (Reblozyl) without complications.
- Client who has anemia failing an erythropoiesis stimulating agent:
  - The client had a positive response demonstrated by RBC transfusion independence during any consecutive eight-week period or a decrease in transfusion requirement as indicated by the prescribing physician.
  - The client previously received treatment with luspatercept-aamt (Reblozyl) without complications.

6.82 Medroxyprogesterone Acetate (Depo Provera)

Refer to: The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about procedure code J1050.

6.83 Meloxicam (Anjeso)

Meloxicam (procedure code J1738) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

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6.84 Methotrexate

Methotrexate (Jylamvo) (procedure code J8611) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

Methotrexate (Xatmep) (procedure code J8612) is a benefit of Texas Medicaid for clients who are 18 years of age or younger.

6.85 Mirikizumab-mrkz

Mirikizumab-mrkz (procedure code J2267) is a benefit of Texas Medicaid for clients who are 18 years of age or older and is restricted to the following diagnosis codes:

Diagnosis Codes							
K5100	K51011	K51012	K51013	K51014	K51018	K51019	K5120
K51211	K51212	K51213	K51214	K51218	K51219	K5130	K51311
K51312	K51313	K51314	K51318	K51319	K5180	K51811	K51812
K51813	K51814	K51818	K51819	K5190	K51911	K51912	K51913
K51914	K51918	K51919					

6.86 Mirvetuximab Soravtansine-gynx (Elahere)

Mirvetuximab Soravtansine-gynx (Elahere) (procedure code J9063) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.87 Mogamulizumab-kpkc (Poteligeo)

Mogamulizumab-kpkc (Poteligeo) procedure code J9204 is a benefit of Texas Medicaid. Mogamulizumab-kpkc (Poteligeo) is a CCR4-directed monoclonal antibody indicated for the treatment of an adult client with relapsed or refractory mycosis fungoides or Sézary syndrome after at least one prior systemic therapy.

Mogamulizumab-kpkc (Poteligeo) (procedure code J9204) may be approved for a duration of every 12 months.

6.87.1 Prior Authorization Criteria

Prior authorization for initial therapy using mogamulizumab-kpkc (Poteligeo) infusion will be considered when all of the following criteria are met:

- The client is 18 years of age or older
- The client has relapsed or refractory disease
- The client has received at least one prior systemic therapy
- The client has a histologically confirmed diagnosis of Mycosis fungoides or Sézary syndrome

One of the following diagnosis codes must be submitted with procedure code J9204 if the diagnosis is mycosis fungoides:

Diagnosis Codes for Mycosis Fungoides							
C8400	C8401	C8402	C8403	C8404	C8405	C8406	C8407
C8408	C8409						

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One of the following diagnosis codes must be submitted with procedure code J9204 if the diagnosis is sézary syndrome:

Diagnosis for Sézary Syndrome							
C8410	C8411	C8412	C8413	C8414	C8415	C8416	C8417
C8418	C8419						

For renewal or continuation of therapy, the client must meet all the following requirements:

- The client demonstrates partial or complete response to treatment or stabilization of disease, shown by a decrease in spread or size of the tumor
- The absence of unacceptable drug toxicity, such as dermatological toxicity, severe infection, infusion reactions (Stevens-Johnson Syndrome or toxic epidermal necrolysis), and life-threatening autoimmune complications

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.88 Monoclonal Antibodies

Monoclonal antibodies omalizumab (Xolair) (procedure code J2357), benralizumab (Fasenra) (procedure code J0517), mepolizumab (Nucala) (procedure code J2182), reslizumab (Cinqair) (procedure code J2786), tezepelumab-ekko (Tezspire) (procedure code J2356), or depemokimab-ulaa (Exdensur) (procedure code J2361) are benefits of Texas Medicaid when medically necessary with prior authorization. Clients who are younger than the FDA-approved age indicated for each medication will be considered on a case-by-case basis and determined by the TMHP medical director.

6.88.1 Omalizumab (Xolair)

Omalizumab (Xolair) (procedure code J2357) is an injectable drug that is FDA-approved for the following treatments:

- Clients who are 6 years of age or older with moderate to severe persistent asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and management of Asthma).
- Clients who are 12 years of age or older and have chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment.
- Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRwNP) in adult clients who are 18 years of age or older with inadequate response to nasal corticosteroids.
- IgE-mediated food allergy in adult and pediatric clients who are 1 year of age or older for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods.

6.88.2 Benralizumab (Fasenra)

Benralizumab (Fasenra) (procedure code J0517) is an injectable drug that is FDA-approved and indicated for the following treatment:

- Add-on maintenance treatment of clients who are 6 years of age or older and have severe asthma with an eosinophilic phenotype
- Adult clients who are 18 years of age or older with eosinophilic granulomatosis with polyangiitis (EGPA)
- Adult and pediatric clients who are 12 years of age or older with hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause.

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6.88.3 Mepolizumab (Nucala)

Mepolizumab (Nucala) (procedure code J2182) is an injectable drug that is approved by the FDA and indicated for the following treatments:

- Add-on maintenance treatments for clients who are 6 years of age or older and have severe asthma with an eosinophilic phenotype
- Adult clients who are 18 years of age or older with eosinophilic granulomatosis with polyangiitis (EGPA)
- Adult and pediatric clients who are 12 years of age or older with hypereosinophilic symptoms (HES) for 6 months or longer without identifiable non-hematologic secondary cause
- Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult clients who are 18 years of age or older with inadequate response to nasal corticosteroids
- Add-on maintenance treatment for adult clients who are 18 years of age or older with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype

6.88.4 Reslizumab (Cinqair)

Reslizumab (Cinqair) (procedure code J2786) is an injectable drug that is FDA-approved and indicated for the treatment of clients who are 18 years of age or older and have severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma) with an eosinophilic phenotype.

6.88.5 Tezepelumab-ekko (Tezspire)

Tezepelumab-ekko (Tezspire) (procedure code J2356) is an injection drug that is FDA-approved and indicated as an add-on maintenance treatment of adult and pediatric clients who are 12 years of age or older with severe asthma or inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP).

6.88.6 Depemokimab-ulaa (Exdensur)

Depemokimab-ulaa (Exdensur) (procedure code J2361) is a subcutaneous injection that is FDA-approved and indicated as an add-on maintenance treatment of severe asthma characterized by an eosinophilic phenotype in adult and pediatric clients who are 12 years of age or older.

6.88.7 Prior Authorization for Omalizumab, Benralizumab, Mepolizumab, Reslizumab, Tezepelumab-ekko, and Depemokimab-ulaa

Prior authorization for omalizumab (Xolair) will be considered for the following:

- Moderate to severe persistent asthma
  - Client is 6 years of age or older.
  - Client has a diagnosis of moderate to severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and management of Asthma) (diagnosis code J4540 or J4550).
  - Client has a positive skin test or radioabsorbent assay test (RAST) to a perennial (not seasonal) aeroallergen within the past 36 months.
  - Client has a total IgE level greater than 30 IU/ml but less than 1300 IU/ml within the past 12 months.
- Chronic Spontaneous Urticaria (CSU)
  - Client is 12 years of age or older

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    - Client has a diagnosis of CSU with symptomats despite H1 antihistamine treatment (diagnosis code L501).
    - Documentation supporting medical necessity for the treatment of CSU with omalizumab (Xolair) must be submitted with request and include the following:
        - Documented failure of, or contraindication to, antihistamine
        - Evidence of an evaluation that excludes other medical diagnosis associated with chronic urticaria
- Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRwNP)
    - Client is 18 years of age or older
    - Client has a diagnosis of CRwNP (diagnosis code J330, J331, J338, or J339) with inadequate response to nasal corticosteroids
    - Documentation supporting medical necessity for maintenance treatment of nasal polyps with omalizumab (Xolair) must be submitted with the request and include the following:
        - Client has bilateral nasal polyposis confirmed by physical examination or nasal endoscopy
        - Documented failure of, or contraindication to, prior corticosteroids as monotherapy
        - Documented inadequate response to prior corticosteroid treatments
- IgE-mediated food allergy to reduce allergic reactions (Type I)
    - Client has a diagnosis of IgE-mediated food allergy (diagnosis code Z91010, Z910110, Z910111, Z910112, Z910120, Z910121, Z910122, Z91013, or Z91018)
    - Client is 1 year of age or older
    - Must use drug in conjunction with food allergen avoidance

Prior authorization for benralizumab (Fasenra) will be considered for the following:

- Severe asthma with eosinophilic phenotype
    - Client is 6 years of age or older
    - Client has a diagnosis of severe asthma with eosinophilic phenotype (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma) (diagnosis code J4550, J4551, J4552, or J8283)
- Eosinophilic Granulomatosis with Polyangiitis (EGPA)
    - Client is 18 years of age or older
    - Client has a medical history of asthma
    - Client has a diagnosis of EGPA (diagnosis code M301)
    - Client has a refractory disease or has had a history of EGPA relapse
- Hypereosinophilic Symptoms (HES)
    - Client is 12 years of age or older
    - Client has a diagnosis of HES without identifiable non-hematologic secondary cause (diagnosis code D72110, D72111, D72118, or D72119)
    - Documents supporting medical necessity for treatment of benralizumab must be submitted with the request and meet the following:
        - Diagnosis or sign, and symptoms of HES without any non-hematologic secondary cause

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- History of two or more HES flares (flare defined as worsening clinical symptoms or blood eosinophil counts requiring an increase in prior therapy) within the past 12 months prior to the initiation of benralizumab therapy
- Prescriber's attestation that the client has been on a stable dose of HES therapy which includes, but is not limited to, oral corticosteroids, immunosuppressive and cytotoxic therapy.

Prior authorization for mepolizumab (Nucala) will be considered for the following:

- Severe asthma with eosinophilic phenotype
  - Client is 6 years of age or older
  - Client has a diagnosis of severe asthma with eosinophilic phenotype (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and management of Asthma) (diagnosis code J4550, J4551, J4552, or J8283).
- Eosinophilic granulomatosis with polyangiitis (EGPA)
  - Client is 18 years of age or older
  - Confirmed diagnosis of eosinophilic granulomatosis with polyangiitis (diagnosis code M301)
  - Documentation supporting medical necessity for treatment of EGPA with mepolizumab (Nucala) must be submitted with the requestand meet the following:
    - Diagnosis of EGPA
    - Medical history of asthma
    - Presence of at least 2 of the following EGPA characteristics below:
      - Histopathological findings of eosinophilic vascularitis, perivascularitis eosinophilic infiltration or eosinophil-rich granulomatous inflammation
      - Neuropathy
      - Pulmonary infiltrates, non-fixed; Sino-nasal abnormality
      - Cardiomyopathy
      - Glomerulonephritis
      - Alveolar hemorrhage
      - Palpable purpura
      - Anti-neutrophils cytoplasmic antibody
    - Client use of an oral glucocorticoid and/or cyclophosphamide, azathioprine, methotrexate, or leflunomide
    - Refractory disease or has had a history of EGPA relapse
- Hypereosinophilic Symptoms (HES)
  - Client is 12 years of age or older
  - Client has a diagnosis of hypereosinophilic symptoms (HES) for 6 months or longer without identifiable non-hematologic secondary cause (diagnosis code D72110, D72111, D72118, or D72119)

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- Documents supporting medical necessity for treatment of HES in clients who are 12 years of age or older with mepolizumab (Nucala) must be submitted with the request and meet all of the following:
  - Diagnosis of HES for 6 months or longer without any non-hematologic secondary cause
  - History of two or more HES flares (flare defined as worsening clinical symptoms or blood eosinophil counts requiring an increase in prior therapy) within the past 12 months prior to the initiation of mepolizumab (Nucala) therapy
  - Prescriber's attestation that client has been on a stable dose of HES therapy which includes, but no limited to corticosteroids, immunosuppressive and cytotoxic therapy

Prior authorization for mepolizumab (Nucala) will be considered for clients as an add-on maintenance treatment of:

- Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
  - Client is 18 years of age or older
  - Confirmed diagnosis of chronic rhinosinusitis with nasal polyps (diagnosis code J330, J331, J338, or J339)
  - Evidence of inadequate response to nasal corticosteroid
- Eosinophilic Chronic Obstructive Pulmonary Disease (COPD)
  - The client is 18 years of age or older.
  - The client has a diagnosis of inadequately controlled COPD (diagnosis codes J440, J441, J4489, or J449), confirmed by either spirometry or classic signs and symptoms.
  - The client's COPD is uncontrolled despite treatment with triple therapy, which includes an inhaled corticosteroid (ICS), long-acting beta agonist (LABA), and long-acting muscarinic antagonist (LAMA).
  - The client's inadequately controlled COPD is demonstrated by one or both of the following within the previous year:
    - At least two moderate exacerbations despite treatment with triple inhaled therapy.
    - One or more severe exacerbations despite treatment with triple inhaled therapy.
  - The client has an eosinophilic phenotype defined by a baseline blood eosinophil level of at least ≥ 150 cells per microliter prior to treatment with mepolizumab (Nucala).

Mepolizumab (Nucala) will be used as an add-on maintenance therapy and not as the primary treatment for COPD.

Prior authorization for reslizumab (Cinqair®) will be considered for clients who are 18 years of age or older with severe asthma (as defined by the National Heart, Lung and Blood Institute's Guidelines for the Diagnosis and management of Asthma) (diagnosis code J4550, J4551, J4552, or J8283).

Prior authorization for tezepelumab-ekko (Tezspire) will be considered for the following:

- Add-on maintenance for severe asthma or chronic rhinosinusitis with nasal polyps
  - Client is 12 years of age or older.
  - Client has one of the following diagnoses:
    - Severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma) (diagnosis code J4550 or J4551)
    - Chronic rhinosinusitis with nasal polyps (diagnosis code J330, J331, J338, or J339)

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- Tezepelumab-ekko (Tezspire) is being used as an add-on maintenance therapy and not to be used as a single or primary therapy.
- For severe asthma client is currently on the following as a regular treatment and compliant on the therapy:
  - Medium or high-dose inhaled corticosteroid therapy, and
  - An additional asthma controller
- Tezepelumab-ekko (Tezspire) should not be used for relief of acute bronchospasm or status asthmaticus.
- Tezepelumab-ekko (Tezspire) may not be used in combination with anti-IgE, anti-IL4 or anti-IL5 monoclonal antibody agents (i.e., benralizumab [Fasenra], omalizumab [Xolair], mepolizumab [Nucala], reslizumab [Cinqair], etc.)
- Tezepelumab-ekko (Tezspire) should not be administered concurrently with live attenuated vaccination.

Prior authorization for depemokimab-ulaa (Exdensur) will be considered when the following criteria are met:

- The client is 12 years of age or older.
- The client has a diagnosis of severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma) (diagnosis code J4550, J4551, or J8283).
- The client's asthma is characterized by an eosinophilic phenotype with baseline blood eosinophilic count of at least 150 cells/microliter or greater.
- The client has asthma that is uncontrolled before administration of depemokimab-ulaa (Exdensur) as add-on treatment.
- The client has adhered to at least three consecutive months of inhaled corticosteroid therapy and used at least one additional asthma controller or asthma maintenance medication.
- The client's asthma is inadequately controlled despite the use of controller therapy, i.e., medium- to high-dose inhaled corticosteroid (ICS) plus at least one asthma controller with or without maintenance oral corticosteroids (OCS), indicated by either of the following within the previous year:
  - At least two or more asthma exacerbations that required treatment with systemic corticosteroids (SCS)
  - Reduced lung function with forced expiratory volume in one second (FEV1) that was less than 80% of predicted
- Depemokimab-ulaa (Exdensur) will be used as an add-on maintenance therapy to the client's medication for asthma and may not be used as a single or primary therapy.
- Depemokimab-ulaa (Exdensur) may not be used in combination with anti-IgE, anti-IL4 or anti-IL5 monoclonal antibody agents (i.e., omalizumab (Xolair), benralizumab (Fasenra), mepolizumab (Nucala), reslizumab (Cinqair), etc.).

A client with preexisting helminth infections should be treated prior to receiving omalizumab (Xolair), benralizumab (Fasenra), mepolizumab (Nucala), reslizumab (Cinqair), tezepelumab-ekko (Tezspire), or depemokimab-ulaa (Exdensur) therapy.

- If there is active helminth infection, the client should be treated with anti-helminth treatment.
- If there is no response, treatment should be discontinued until the parasitic infection resolves.

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Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.88.8 Prior Authorization Criteria for Asthma — Moderate to Severe (Omalizumab) and Severe (Benralizumab, Mepolizumab, Reslizumab, Tezepelumab-ekko, and Depemokimab-ulaa)

Requests for prior authorization must be submitted by the treating physician to the Special Medical Prior Authorization (SMPA) department by mail or approved electronic method using the SMPA request form.

Documentation supporting medical necessity for treatment of asthma with omalizumab (Xolair), benralizumab (Fasenra), mepolizumab (Nucala), reslizumab (Cinqair), tezepelumab-ekko (Tezspire), or depemokimab-ulaa (Exdensur) must be submitted with the request and must indicate the following:

- Symptoms are inadequately controlled with use of any of the following combination therapies:
    - A minimum of 3 months of controller medication (which includes but is not limited to a long-acting beta2-agonist [LABA], an inhaled or oral corticosteroid, leukotriene receptor antagonist [LTRA], or theophylline), unless the individual is intolerant of or has a medical contraindication to these agents

Note: *Exceptions to the criteria above will be considered on a case-by-case basis, which will require a letter from the prescribing provider stating the medical necessity for these monoclonal antibodies, the client's asthma severity level, and the duration of current and past therapies and lack of asthma control. Consideration for these exceptions will be reviewed by the TMHP medical director.*

Prior authorization approvals for omalizumab (Xolair), benralizumab (Fasenra), mepolizumab (Nucala), reslizumab (Cinqair), or tezepelumab-ekko (Tezspire) are for intervals of six months at a time. Prior authorization approvals for Depemokimab-ulaa (Exdensur) are for intervals of 12 months. Clients must be compliant with their regimen in order to qualify for additional prior authorizations. The provider must submit a statement documenting compliance with the requests for each renewal.

Treatment of benralizumab (Fasenra), mepolizumab (Nucala), or reslizumab (Cinqair) may not be used concurrently with omalizumab (Xolair) or any other interleukin-5 antagonist.

Tezepelumab-ekko (Tezspire) may not be used in combination with anti-IgE, anti-IL4 or anti-IL5 monoclonal antibody agents (i.e., benralizumab [Fasenra], omalizumab [Xolair], mepolizumab [Nucala], reslizumab [Cinqair], dupilumab [Dupixent], depemokimab-ulaa [Exdensur], etc.).

6.88.9 Requirements for Continuation of Therapy for Omalizumab, Benralizumab, Mepolizumab, Reslizumab, Tezepelumab-ekko, or Depemokimab-ulaa

For continuation of therapy with omalizumab (Xolair), benralizumab (Fasenra), mepolizumab (Nucala), reslizumab (Cinqair), tezepelumab-ekko (Tezspire), or depemokimab-ulaa (Exdensur), the requesting provider must submit the following documentation of the client's compliance and satisfactory clinical response to omalizumab (Xolair), benralizumab (Fasenra), mepolizumab (Nucala), reslizumab (Cinqair), tezepelumab-ekko (Tezspire), or depemokimab-ulaa (Exdensur):

- Documentation of clinical improvement must include one or more of the following:
- Decreased utilization of rescue medications; or
- Increase in predicted FEV1 (forced expiratory volume) from pretreatment baseline; or
- Reduction in reported asthma-related symptoms, as evidenced by decreases in frequency or magnitude of one or more of the following symptoms:
    - Asthma attacks

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- Chest tightness or heaviness
- Coughing or clearing throat
- Difficulty taking deep breath or difficulty breathing out
- Shortness of breath
- Sleep disturbance, night wakening, or symptoms upon awakening
- Tiredness
- Wheezing/heavy breathing/fighting for air, and

- Member has not exhibited symptoms of hypersensitivity or anaphylaxis (bronchospasm, hypotension, syncope, urticaria, and/or angioedema) after administration of omalizumab (Xolair), benralizumab (Fasenra), mepolizumab (Nucala), reslizumab (Cinqair), tezepelumab-ekko (Tezspire), or depemokimab-ulaa (Exdensur).

After lapses in treatment of 3 months or greater, prior authorization requests submitted with documentation will be reviewed by the TMHP medical director.

Requests for clients who do not meet the above criteria will be reviewed for medical necessity by the TMHP medical director.

6.88.10 Reimbursement

Procedure codes J0517, J2182, J2356, J2357, J2361, and J2786 may not be billed in any combination for the same date of service by any provider.

Providers may not bill for an office visit if the only reason for the visit is an omalizumab (Xolair), benralizumab (Fasenra), mepolizumab (Nucala), reslizumab (Cinqair), tezepelumab-ekko (Tezspire), or depemokimab-ulaa (Exdensur) injection.

6.89 Mosunetuzumab-axgb

Mosunetuzumab-axgb (procedure code J9350) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.90 Nadofaragene Firadenovec-vncg (Adstiladrin)

Nadofaragene firadenovec-vncg (Adstiladrin) is an adenoviral vector-based gene therapy indicated to treat adult clients with high-risk Bacillus Calmette-Guérin (BCG)-unresponsive non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors.

Nadofaragene firadenovec-vncg (Adstiladrin) (procedure code J9029) is a benefit of Texas Medicaid for clients who are 18 years of age or older with prior authorization.

6.90.1 Prior Authorization Requirements

Prior authorization is required for nadofaragene firadenovec-vncg (Adstiladrin) therapy and must be submitted with a Special Medical Prior Authorization (SMPA) Request Form.

Initial therapy for nadofaragene firadenovec-vncg (Adstiladrin) may be approved for a 6-month duration for clients who meet the following requirements:

- The client is 18 years of age or older.
- The client has a confirmed diagnosis of non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors.
- The client's disease is high-risk and BCG unresponsive as defined as persistent disease following adequate BCG therapy, disease recurrence after an initial tumor-free state following adequate BCG therapy, or T1 disease following a single induction course of BCG.

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- The client does not have any metastatic urothelial carcinoma.
- The client does not have a hypersensitivity to interferon alfa.
- The client is not immunocompromised or immunodeficient.

For renewal or continuation of therapy, the client continues to meet the requirements listed above and must:

- Have been treated with nadofaragene firadenovec-vncg (Adstiladrin) with no adverse reactions.
- Have no signs of unacceptable toxicity (e.g., risk of disseminated adenovirus infection) while on treatment with nadofaragene firadenovec-vncg (Adstiladrin).

All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

6.91 Natalizumab

Procedure code J2323 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes							
G35A	G35C0	G35D	G35C1	K5000	K50011	K50012	K50013
K50014	K50018	K5010	K50111	K50112	K50113	K50114	K50118
K5080	K50811	K50812	K50813	K50814	K50818	K5090	K50911
K50912	K50913	K50914	K50918	K50919			

6.92 Nitroglycerin

Nitroglycerin (procedure code J2305) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.93 Nivolumab and Relatlimab-rmbw

Nivolumab and relatlimab-rmbw (procedure code J9298) is a benefit of Texas Medicaid for clients who are 12 years of age or older.

6.94 Nogapendekin Alfa Inbakicept-pmln (Anktiva)

Nogapendekin alfa inbakicept-pmln (Anktiva) is an interleukin-15 (IL-15) receptor agonist indicated to treat adult clients with Bacillus Calmette-Guérin (BCG)-unresponsive non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors.

Nogapendekin alfa inbakicept-pmln (Anktiva) is a benefit of Texas Medicaid (procedure code J9028) for adult clients with prior authorization.

6.94.1 Initial Requests

Initial therapy for nogapendekin alfa inbakicept-pmln (Anktiva) may be approved for a 6-month duration for clients who meet the following requirements:

- The client is at least 18 years of age or older.

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- The client has a confirmed diagnosis of NMIBC with CIS with or without papillary tumors.
- The client's disease is high-risk and BCG unresponsive, defined as persistent disease following adequate BCG therapy, disease recurrence after an initial tumor-free state following adequate BCG therapy, or T1 disease following a single induction course of BCG.
- Nogapendekin alfa inbakicept-pmln (Anktiva) is used in combination with BCG.
- The client has undergone transurethral resection of bladder tumor (TURBT) to remove all resectable disease (Ta and T1 components).
- The client does not have any metastatic urothelial carcinoma.

6.94.2 Recertification or Extension

For renewal or continuation of therapy of nogapendekin alfa inbakicept-pmln (Anktiva), the client must meet the following requirements:

- The client continues to have a diagnosis as listed in the initial authorization section above and has been treated with nogapendekin alfa inbakicept-pmln (Anktiva) in the past with no adverse reactions.
- The client has no signs of unacceptable toxicity (e.g., hematuria, dysuria, or micturition urgency) while on treatment with nogapendekin alfa inbakicept-pmln (Anktiva).

All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.95 * Omidubicel-onlv (Omisirge)

Omidubicel-onlv (Omisirge) is a nicotinamide modified allogeneic hematopoietic progenitor cell therapy derived from cord blood and indicated for the following:

- Hematologic malignancies in clients who are 12 years of age or older and are scheduled for umbilical cord blood transplantation (UCBT) following myeloablative conditioning to reduce the time to neutrophil recovery and the risk of developing infection.
- Severe aplastic anemia (SAA) in clients who are 6 years of age or older, following reduced intensity conditioning.

[Revised] Omidubicel-onlv (Omisirge) is a benefit of Texas Medicaid with prior authorization and may be reimbursed using procedure code J3406.

Omidubicel-onlv (Omisirge) is administered as a one-time infusion treatment per lifetime.

6.95.1 Prior Authorization Requirements

Providers must submit prior authorization requests for omidubicel-onlv (Omisirge) on the Special Medical Prior Authorization (SMPA) Request Form.

Prior authorization for omidubicel-onlv (Omisirge) may be approved for 12 months for clients who have one of the following diagnoses:

- Hematologic malignancies in clients who meet all the following criteria:
  - The client is 12 years of age or older.
  - The client has a confirmed diagnosis of a high-risk hematologic malignancy and is scheduled for UCBT after undergoing a myeloablative conditioning regimen such as radiation and chemotherapy (diagnosis code D701, D708, D709, or Z9481).
  - The client is receiving therapy to reduce the time to neutrophil recovery and the risk of developing infection.

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- The client does not have a matched related or unrelated donor for allogeneic hematopoietic stem cell transplantation (HSCT).
- The client does not have a history of receiving prior allogeneic HSCT.

- SAA in clients who meet all the following criteria:
  - The client is 6 years of age or older.
  - The client has a confirmed diagnosis of SAA following a reduced intensity conditioning regimen (diagnosis code D611, D612, D6189, or D619).
  - The client has a history of intolerance or failure to respond to immunosuppressive therapy.
  - The client does not have a matched related or unrelated donor.

Note: *Regardless of the diagnosis, the client does not have known sensitivity to dimethyl sulfoxide (DMSO), Dextran 40, gentamicin, human serum albumin, or bovine material.*

After omidubicel-onlv (Omisirge) infusion, providers must monitor the client for the following:

- Allergic reactions, particularly in clients with a history of allergic reactions to antibiotics
- Graft failure
- Graft-versus-host disease
- Engraftment syndrome
- Infections
- Secondary malignancies
- Other post-transplant complications

In addition to documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.96 Onasemnogene Abeparvovec-brve (Itvisma)

Onasemnogene abeparvovec-brve (Itvisma) is an adeno-associated virus (AAV) vector-based gene therapy indicated for the treatment of spinal muscular atrophy (SMA) in adult and pediatric clients who are 2 years of age or older with confirmed mutation in the survivor motor neuron 1 (SMN1) gene.

Onasemnogene abeparvovec-brve (Itvisma) is a benefit of Texas Medicaid with prior authorization.

Onasemnogene abeparvovec-brve (Itvisma) (procedure code J3405) is limited to once per lifetime.

Onasemnogene abeparvovec-brve (Itvisma) is not a benefit for clients with tracheostomy or invasive ventilator support.

6.96.1 Prior Authorization Requirements

Providers must submit prior authorization requests for onasemnogene abeparvovec-brve (Itvisma) on the Special Medical Prior Authorization (SMPA) Request Form.

A prior authorization request for onasemnogene abeparvovec-brve (Itvisma) single-dose intrathecal injection must include documentation of all the following:

- The client is 2 years of age or older.
- The client has a confirmed diagnosis of SMA (diagnosis code G120, G121, G1225, G128, or G129).
- An SMA diagnostic test has confirmed SMN1 deletion, or the client has documentation of a previous test that confirmed SMN1 deletion.

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- The client's medical record supports any one of the following mutations or deletions of genes in chromosome 5q:
  - Homozygous gene deletion of the SMN1 gene (e.g., absence of the SMN1 gene)
  - Homozygous mutation of the SMN1 gene (e.g., biallelic mutation of exon 7)
  - Compound heterozygous mutation in the SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])
- The client has a baseline documentation of AAV serotype 9 (AAV9) antibody titer of 1:50 or lower as determined by enzyme-linked immunosorbent assay (ELISA) binding immunoassay.
- The client's overall baseline health status is stable, as evidenced by the following:
  - The client's complete blood count, liver function, and creatinine are within normal limits.
  - The client has no signs or symptoms of active infection.
- The prescriber attests to counseling female clients of childbearing age regarding the use of an effective method of contraception to prevent pregnancy during treatment and to refrain from egg donation for up to six months after dose administration of onasemnogene abeparvovecbrve (Itvisma) therapy.

Important: *Male clients should refrain from fathering a child or donating sperm for three months following therapy.*

- Physician attests that the client has not previously received onasemnogene abeparvovec-brve (Itvisma), onasemnogene abeparvovec-xioi (Zolgensma), or any other gene therapy for SMA.

If nusinersen (Spinraza) or risdiplam (Evrysdi) have been previously prescribed, the prescriber must provide documentation of one of the following prior to switching to onasemnogene abeparvovec-brve (Itvisma) therapy:

- The client's clinical deterioration (e.g., decreased physical function and motor skill/function test scores) while receiving nusinersen (Spinraza) or risdiplam (Evrysdi) therapy
- Discontinuation of nusinersen (Spinraza) or risdiplam (Evrysdi) therapy

6.96.1.1 Requirements for Safe Drug Administration

The administration of onasemnogene abeparvovec-brve (Itvisma) may cause acute serious liver injury or failure. To administer the drug, providers must:

- Examine the client's liver function using clinical examination and laboratory testing such as hepatic aminotransferases (aspartate aminotransferase [AST] and alanine aminotransferase [ALT]), total bilirubin, and prothrombin time prior to infusion of onasemnogene abeparvovec-brve (Itvisma).
- Administer a systemic corticosteroid before and after the infusion.
- Continue to monitor client's liver function for at least three months after the infusion.

6.96.1.2 Required Monitoring Parameters

After administering onasemnogene abeparvovec-brve (Itvisma) intrathecal injection, the prescriber must monitor the client for signs of the following:

- Hepatotoxicity
- Thrombocytopenia
- Peripheral sensory neuropathy
- Thrombotic microangiopathy

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- Elevated cardiac troponin I levels

In addition to documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.97 Onasemnogene abeparvovec-xioi (Zolgensma)

Onasemnogene abeparvovec-xioi (Zolgensma) is a benefit of Texas Medicaid, with prior authorization. Claims for onasemnogene abeparvovec-xioi (Zolgensma) must be submitted with unlisted procedure code J3399.

Onasemnogene abeparvovec-xioi (Zolgensma) (procedure code J3399) is limited to one treatment per lifetime, per client.

Onasemnogene abeparvovec-xioi (Zolgensma) is a one-time infusion therapy indicated for the treatment of a client who meets all of the following requirements:

- Has spinal muscular atrophy (SMA)
- Has biallelic mutations in the survival motor neuron 1 (SMN1) gene
- Is 24 months of age or younger

Onasemnogene abeparvovec-xioi (Zolgensma) is not a benefit for clients with a tracheostomy or invasive ventilator support.

6.97.1 Prior Authorization Requirements

To be considered for the approval of a one-time intravenous infusion, prior authorization requests for onasemnogene abeparvovec-xioi (Zolgensma) (unlisted procedure code J3399) must be submitted with a Special Medical Prior Authorization (SMPA) Request Form.

All of the following must be included in Section C (located under Statement of Medical Necessity) of the Special Medical Prior Authorization (SMPA) Request Form:

- Documentation of the client's dosage
- Administration schedule
- Number of injections to be administered during the prior authorization period
- Requested units per injection
- Dosage calculation

The Special Medical Prior Authorization (SMPA) Request Form must be completed, signed, and dated by the prescribing provider. The completed form must be maintained by the prescribing provider in the client's medical record and is subject to retrospective review. The form will not be accepted beyond 90 days from the date of the prescribing provider's signature.

6.97.2 Documentation Requirements

The prior authorization request for an onasemnogene abeparvovec-xioi (Zolgensma) single-dose intravenous infusion must include documentation of all of the following:

- Client is 24 months of age or younger.
- Medical record supports any of the following mutation or deletion of genes in chromosome 5q:
  - Homozygous gene deletion of the SMN1 gene (e.g., absence of SMN1 gene)
  - Homozygous mutation of the SMN1 gene (e.g., biallelic mutation of exon 7)

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  - Compound heterozygous mutation in the SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])
- Confirmed diagnosis of SMA (diagnosis codes G120, G121, G128, and G129) based on gene mutation analysis with biallelic SMN1 mutation (deletion or point mutation).
- The administration of onasemnogene abeparvovec-xioi (Zolgensma) may cause serious liver injury or failure. Providers must also complete the following to administer the drug:
  - Examine the client's liver function by clinical examination and laboratory testing (e.g., hepatic aminotransferases [aspartate aminotransferase (AST) and alanine aminotransferase (ALT)], total bilirubin, and prothrombin time) before infusion of onasemnogene abeparvovec-xioi (Zolgensma).
  - Administer a systemic corticosteroid before and after the administration of the drug.
  - Continue to monitor the client's liver function at least 3 months after the infusion of the drug.
- Evaluation of motor skill and function must be documented using a standardized test. However, it is not a prerequisite of therapy and should not delay treatment. Standardized testing tools that may be used to evaluate motor skill/function include, but are not limited to:
  - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND) score
  - Bayley scale of infant and toddler development screening test
  - WHO Multicenter Growth Reference Study (WHO MGRS)
- Baseline documentation supports an AAV9 antibody titer of 1:50 or lower, as determined by enzyme-linked immunosorbent assay (ELISA) binding immunoassay.
- Baseline platelet counts, and the provider must assess safety by continually checking weekly counts for the first month and then every other week for the second and third months until platelet counts return to baseline.

  Note: *In addition to the documentation requirements outlined in the Prior Authorization section, post-monitoring requirements like liver function tests and platelet counts must be part of the client's record and are subject to retrospective review.*
- Physician attestation supports that the client has not received prior onasemnogene abeparvovec-xioi (Zolgensma) therapy.

If nusinersen (Spinraza) (procedure code J2326) or risdiplam (Evrysdi) have been previously prescribed, the prescriber must provide documentation of one of the following before switching to onasemnogene abeparvovec-xioi (Zolgensma) therapy:

- Evidence of clinical deterioration (e.g., decreased physical function and motor skill/function test scores) while on nusinersen (Spinraza) or risdiplam (Evrysdi) therapy
- Prescriber's attestation that nusinersen (Spinraza) or risdiplam (Evrysdi) therapy has been discontinued

6.98 Panhematin

Panhematin (procedure code J1640) is a benefit of Texas Medicaid and is limited to diagnosis code E8021.

6.99 Pegcetacoplan (Syfovre)

Pegcetacoplan (Syfovre) (procedure code J2781) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

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6.100 Phenylephrine Hydrochloride (Immphentiv)

Phenylephrine hydrochloride (Immphentiv) (procedure code J2373) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.101 * Polyneuropathy of Hereditary Transthyretin-mediated (hATTR) Amyloidosis

[Revised] Eplontersen (Wainua), patisiran (Onpattro), and vutrisiran (Amvuttra) are benefits of Texas Medicaid with prior authorization for the treatment of the polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis in adult clients. Patisiran (Onpattro) and vutrisiran (Amvuttra) are transthyretin-directed small interfering ribonucleic acid (RNA), while eplontersen (Wainua) is an antisense oligonucleotide.

[Revised] Prior authorization requests for eplontersen (Wainua) (procedure code C9311), patisiran (Onpattro) (procedure code J0222), and vutrisiran (Amvuttra) (procedure code J0225) must be submitted with a Special Medical Prior Authorization (SMPA) Request Form and may be approved for 12 months per prior authorization request.

For initial therapy of patisiran (Onpattro), all of the following criteria must be met:

- The client is 18 years of age or older.
- The client has a diagnosis of hATTR amyloidosis (diagnosis code E851), supported by the following:
  - Transthyretin (TTR) mutation proven by genetic testing
  - [Revised] Clinical signs and symptoms of the disease (e.g., peripheral autonomic neuropathy, or motor disability)
- [Revised] The client will not receive patisiran (Onpattro) therapy in combination with other polyneuropathy hATTR amyloidosis therapies (e.g., eplontersen, inotersen, tafamidis, meglumine, or vutrisiran).
- The client has not had a liver transplant.

For initial therapy of vutrisiran (Amvuttra), all of the following criteria must be met:

- The client is 18 years of age or older
- The client has a diagnosis of hATTR amyloidosis (diagnosis code E851), supported by the following:
  - Transthyretin (TTR) mutation proven by genetic testing
  - [Revised] Clinical signs and symptoms of the disease (e.g., peripheral autonomic neuropathy, or motor disability)
- [Revised] The client will not receive vutrisiran (Amvuttra) therapy in combination with other therapies for polyneuropathy caused by hATTR amyloidosis (e.g., eplontersen, inotersen, patisiran, or tafamidis meglumine).
- The client will receive vitamin A supplementation at the recommended daily allowance while on vutrisiran (Amvuttra) therapy.
- The client has not had a liver transplant.

[Revised] For initial therapy of eplontersen (Wainua), all of the following criteria must be met:

- [Revised] The client must be 18 years of age or older.
- [Revised] The client has a diagnosis of polyneuropathy of hereditary transthyretin (hATTR) amyloidosis (diagnosis code E851), supported by the following:
  - [Revised] Transthyretin (TTR) mutation proven by genetic testing

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  - [Revised] Clinical signs and symptoms of the disease (e.g., peripheral autonomic neuropathy, or motor disability)
- [Revised] The client will not receive eplontersen (Wainua) therapy in combination with other polyneuropathy hATTR amyloidosis therapies (e.g., inotersen, patisiran, vutrisiran, or tafamidis meglumine).
- [Revised] The client will receive vitamin A supplementation at the recommended daily allowance while on eplontersen (Wainua) therapy.

For renewal or continuation of therapy, all of the following criteria must be met:

- [Revised] The client has previously received treatment with eplontersen (Wainua), patisiran (Onpattro) or vutrisiran (Amvuttra) without an adverse reaction.
- [Revised] The client has a positive clinical response to eplontersen (Wainua), patisiran (Onpattro) or vutrisiran (Amvuttra) (e.g., improved neurologic impairment, improved motor function, or slowing of disease progression).

Documentation of the client's dosage, administration schedule, number of injections to be administered during the prior authorization period, requested units per injection, and the dosage calculation must be submitted in Section C of the Special Medical Prior Authorization (SMPA) Request Form under Statement of Medical Necessity.

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.102 Plasminogen Human-tvmh (Ryplazim)

Plasminogen human-tvmh (Ryplazim) (procedure code J2998) is a benefit of Texas Medicaid and is limited to diagnosis code E8802.

6.103 Plazomicin

Plazomicin (procedure code J0291) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.104 Prademagene Zamikeracel (Zevaskyn)

Prademagene zamikeracel (Zevaskyn) (procedure code J3389) is a benefit of Texas Medicaid for clients with prior authorization.

Prademagene zamikeracel (Zevaskyn) is an autologous cell sheet-based gene therapy indicated to treat wounds in adult and pediatric clients with recessive dystrophic epidermolysis bullosa (RDEB).

6.104.1 Prior Authorization Requirements

6.104.1.1 Initial Requests

Prademagene zamikeracel (Zevaskyn) is indicated as a surgical topical application for treating wounds.

Prior authorization may be approved for 12 months for clients who:

- Are at least 6 years of age or older.
- Have a confirmed diagnosis of RDEB (diagnosis code Q812) that has been confirmed by biopsy and by genetic testing that detected biallelic mutations in the COL7A1 gene.
- Have chronic cutaneous stage 2 wounds that are adequate for treatment and:
  - Have been open/present for at least 6 months.
  - Have an area of ≥ 20 cm2.

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- Have not previously been treated with prademagene zamikeracel (Zevaskyn).
- Are not infected.

- Have a wound area that shows no current evidence or history of squamous cell carcinoma.
- Do not have severe hypersensitivity (i.e., anaphylaxis) to vancomycin or amikacin.

Authorization will not be approved for administration to wounds that have previously been treated with prademagene zamikeracel (Zevaskyn).

6.104.1.2 Recertification or Extension

For continued therapy, the client must meet the following requirements:

- Reauthorization for the same wound is not permitted. The client must meet the initial approval criteria if the request is for previously untreated or newly developed wounds.
- Absence of unacceptable toxicity from prademagene zamikeracel (Zevaskyn) (e.g., severe hypersensitivity reactions and development of new malignance).
- The client shows a positive response to treatment as defined by improvement (healing) of treated wound sites or reduction in skin infections.

6.104.2 Documentation Requirements

In addition to the documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

6.105 Ravulizumab-cwvz (Ultomiris)

Ravulizumab-cwvz (procedure code J1303) is a benefit of Texas Medicaid and is limited to the following diagnosis codes:

Diagnosis Codes							
D588	D5930	D5932	D5939	D594	D595	D598	G360
G7000	G7001						

6.106 Remestemcel-L-rknd (Ryoncil)

Remestemcel-L-rknd (Ryoncil) (procedure code J3402) is a benefit of Texas Medicaid with prior authorization.

Remestemcel-L-rknd (Ryoncil) is an allogeneic bone marrow-derived mesenchymal stromal cell (MSC) therapy approved to treat steroid-refractory acute graft versus host disease (SR-aGVHD) in pediatric clients who are 2 months of age or older.

6.106.1 Prior Authorization Requirements

6.106.1.1 Initial Requests

Remestemcel-L-rknd (Ryoncil) is an intravenous infusion which may be approved for clients who meet all of the following requirements:

- The client is at least 2 months of age or older.
- The client has a confirmed diagnosis of aGVHD (diagnosis code D89810) following an allogenic hematopoietic stem cell transplant.
- The client's aGVHD is steroid refractory, as documented by the following:

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- Progression of acute GVHD within three days of consecutive treatment with 2 mg/kg/day of methylprednisolone or equivalent.
- No signs of improvement within 7 days of therapy with 2mg/kg/day of methylprednisolone or equivalent treatment.

- The client has no known hypersensitivity to dimethyl sulfoxide or porcine and bovine proteins.

6.106.1.2 Re-certification or Extension

For renewal or continuation of therapy, the client must meet the following requirements:

- The client has received remestemcel-L-rknd (Ryoncil) for at least 28 days.
- The client has documentation of partial or mixed response to remestemcel-L-rknd (Ryoncil) treatment.
- The client is currently receiving or has received remestemcel-L-rknd (Ryoncil) without any serious or life-threatening reactions.

6.106.2 Documentation Requirements

In addition to documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.107 Remimazolam

Remimazolam (procedure code J2249) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.108 Retifanlimab-dlwr (Zynyz)

Retifanlimab-dlwr (procedure code J9345) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.109 Revakinagene taroretcel-lwey (Encelto)

Revakinagene taroretcel-lwey (Encelto) (procedure code J3403) is a benefit of Texas Medicaid with prior authorization.

Revakinagene taroretcel-lwey (Encelto) is an allogeneic encapsulated cell-based gene therapy indicated for the treatment of adults with idiopathic macular telangiectasia type 2 (MacTel).

6.109.1 Prior Authorization Requirements

6.109.1.1 Initial Requests

Revakinagene taroretcel-lwey (Encelto) is administered as an intravitreal implantation under aseptic conditions and is indicated for clients who meet all the following requirements:

- The client is 18 years of age or older.
- The client has a confirmed diagnosis of retinal telangiectasis in at least one eye (diagnosis codes H35071, H35072, H35073, or H35079).
- The client has type 2 MacTel in at least one eye.
- The client does not have neovascular or proliferative MacTel.
- The client has no ocular and/or periocular infections.
- The client has no known hypersensitivity to endothelial serum-free media (Endo-SFM).

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- The client has temporarily discontinued any antithrombotic medication prior to revakinagene taroretcel-lwey (Encelto) insertion surgery.
- The client has not previously received revakinagene taroretcel-lwey (Encelto) insertion.

Prior authorization is limited to one revakinagene taroretcel-lwey (Encelto) treatment per eye per lifetime.

Clients must be monitored for signs and symptoms of vision loss, infectious endophthalmitis, and retinal tear or detachment.

6.109.1.2 Re-certification or Extension

Re-authorization of revakinagene taroretcel-lwey (Encelto) is not permitted for previously treated eyes.

If the request is for treatment of an eye that has not previously received an ocular implant, the client must meet the approval criteria listed in the prior authorization requirement section.

6.109.2 Documentation Requirements

In addition to documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.110 Rilonacept (Arcalyst)

Rilonacept (procedure code J2793) is a benefit of Texas Medicaid for clients who are 12 years of age or older.

6.111 Risperidone

Risperidone (Perseris) (procedure code J2798) and (Uzedy) (procedure code J2799) are benefits of Texas Medicaid for clients who are 18 years of age or older.

6.112 Rituximab-Abbs, (Truxima)

Rituximab-abbs (Truxima) (procedure code Q5115) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.113 Romosozumab

Romosozumab (procedure code J3111) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.114 Ronzanolixizum-noli (Rystiggo)

Ronzanolixizum-noli (procedure code J9333) is a benefit of Texas Medicaid for clients who are 18 years of age or older and is restricted to diagnosis codes G7000 and G7001.

6.115 Sickle Cell Disease Gene Therapy

Exagamglogene autotemcel (Casgevy) is an autologous genome edited hematopoietic stem cell-based gene therapy indicated for the treatment of clients who are 12 years of age or older with one of the following:

- Sickle cell disease (SCD) with recurrent vaso-occlusive crises, or
- Transfusion-dependent ß-thalassemia

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Exagamglogene autotemcel (Casgevy) (procedure code J3392) and lovotibeglogene autotemcel (Lyfgenia) (procedure code J3394) are benefits of Texas Medicaid with prior authorization. Prior authorization is approved for a duration of 12 months.

Exagamglogene autotemcel (Casgevy) (procedure code J3392) is limited to one transfusion treatment per lifetime.

Lovotibeglogene autotemcel (Lyfgenia) is an autologous hematopoietic stem cell-based gene therapy indicated for the treatment of clients who are 12 years of age or older with sickle cell disease and a history of vaso-occlusive events with at least four vaso-occlusive events in the past 24 months or currently receiving chronic transfusion therapy for recurrent vaso-occlusive events.

Lovotibeglogene autotemcel lovotibeglogene autotemcel (Lyfgenia) (procedure code J3394) is limited to one transfusion treatment per lifetime.

6.115.1 Prior Authorization Requirements

Exagamglogene Autotemcel (Casgevy)

Prior authorization requests for exagamglogene autotemcel (Casgevy) and lovotibeglogene autotemcel (Lyfgenia) must be submitted using the Special Medical Prior Authorization (SMPA) Request Form.

Exagamglogene autotemcel (Casgevy) is a one-time infusion therapy indicated for the treatment of clients for whom autologous hematopoietic stem cell transplantation is appropriate and who meet all the following criteria:

- The client is 12 years of age or older and has been diagnosed with sickle cell disease.
- The client has a diagnosis of sickle cell disease as confirmed by genetic testing with recurrent vaso-occlusive crises, with at least two vaso-occlusive crisis events per year in the past 2 years, as documented with one of the following diagnosis codes or provider attestation:

Diagnosis Codes							
D5700	D5701	D5702	D5703	D5704	D5709	D571	D5720
D57211	D57212	D57213	D57214	D57218	D57219	D5740	D57411
D57412	D57413	D57414	D57418	D57419	D5742	D57431	D57432
D57433	D57434	D57438	D57439	D5744	D57451	D57452	D57453
D57454	D57458	D57459	D5780	D57811	D57812	D57813	D57814
D57818	D57819						

- The client has inadequate response to hydroxyurea or crizanlizumab.
- The client is 12 years of age or older and has been diagnosed with transfusion-dependent ß-thalassemia, and the following additional criteria must be met:
  - Genetic testing confirms the client's diagnosis of transfusion-dependent ß-thalassemia, as documented with diagnosis code D561 or D565.
  - The client has a history of requiring at least 100 mL/kg/year or ten units/year of red blood cell (RBC) transfusions in the past 24 months.
- The client has not previously received allogeneic or autologous hematopoietic stem cell transplantation.
- The client has not previously received exagamglogene autotemcel (Casgevy) or any other gene therapy.
- The client has a confirmed negative serum pregnancy test.
- The client does not have active HIV-1, HIV-2, HBV, or HCV.

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- The client does not have advanced liver or chronic kidney disease.
- For transfusion-dependent ß-thalassemia diagnosis, prescriber attestation will be required to discontinue iron chelators at least 7 days prior to initiation of myeloablative conditioning.

For diagnosis of sickle cell disease, the prescriber attestation is required for the following:

- Hydroxyurea is discontinued at least eight weeks before mobilization and conditioning.
- Crizanlizumab is discontinued at least eight weeks before mobilization or conditioning.
- Iron chelators are discontinued at least seven days before initiation of myeloablative conditioning.

Monitoring parameters for exagamglogene autotemcel (Casgevy) are as follows:

- Monitor for bleeding and conduct frequent platelet counts until platelet engraftment and platelet recovery are achieved.
- Monitor absolute neutrophil counts until engraftment has been achieved.

Lovotibeglogene autotemcel (Lyfgenia)

Lovotibeglogene autotemcel (Lyfgenia) is a one-time infusion therapy indicated for the treatment of clients for whom autologous hematopoietic stem cell transplantation is appropriate and who meets the following requirements:

- The client is 12 years of age or older at the expected time of gene therapy administration.
- The client has a diagnosis of sickle cell disease confirmed by genetic testing and a history of vaso-occlusive events, with at least four vaso-occlusive events in the past 24 months, or currently receiving chronic transfusion therapy for recurrent vaso-occlusive events, as documented with one of the following diagnosis codes or provider attestation:

Diagnosis Codes							
D5700	D5701	D5702	D5703	D5704	D5709	D571	D5720
D57211	D57212	D57213	D57214	D57218	D57219	D5740	D57411
D57412	D57413	D57414	D57418	D57419	D5742	D57431	D57432
D57433	D57434	D57438	D57439	D5744	D57451	D57452	D57453
D57454	D57458	D57459	D5780	D57811	D57812	D57813	D57814
D57818	D57819						

- The client has not previously received allogeneic or autologous hematopoietic stem cell transplantation.
- The client has inadequate response or contraindication to hydroxyurea per the healthcare provider's discretion.
- The client has not previously received lovotibeglogene autotemcel (Lyfgenia) or any other gene therapy.
- The client has a confirmed negative serum pregnancy test and is not breastfeeding.
- The client has confirmed negative serology test for HIV-1 or HIV-2.
- The client does not have advanced liver or chronic kidney disease.
- Prescribers must attest and document the following:
  - Hydroxyurea is discontinued two months before mobilization and two days before conditioning.

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- Anti-retroviral medication is discontinued at least one month before mobilization and until all cycles of apheresis are completed.
- Iron chelators are discontinued at least seven days before initiation of myeloablative conditioning.

Monitoring parameters for lovotibeglogene autotemcel (Lyfgenia) are as follows:

- Monitor for evidence of malignancy through complete blood counts at least every six months and through integration site analysis at month 6, month 12, and as warranted.
- Monitor for thrombocytopenia and bleeding.
- Monitor neutrophil counts until engraftment has been achieved.

6.115.2 Documentation Requirements

In addition to documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.116 Secukinumab (Cosentyx)

Secukinumab (Cosentyx) (procedure code J3247) is a benefit of Texas Medicaid for clients who are 18 years of age or older and is restricted to the following diagnosis codes:

Diagnosis Codes							
L400	L401	L402	L403	L404	L405	L4050	L4051
L4052	L4053	L4054	L4059	L408	L409	M0880	M450
M451	M452	M453	M454	M455	M456	M457	M458
M459	M4680	M4681	M4682	M4683	M4684	M4685	M4686
M4687	M4688	M4689					

6.117 Sirolimus Protein-bound Particles (Fyarro)

Sirolimus protein-bound particles (Fyarro) (procedure code J9331) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.118 Spesolimab-sbzo (Spevigo)

Spesolimab-sbzo (Spevigo) (procedure code J1747) is a benefit of Texas Medicaid for clients who are 12 years of age or older and restricted to diagnosis code L401.

6.119 Sutimlimab-jome (Enjaymo)

Sutimlimab-jome (Enjaymo) (procedure code J1302) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.120 Sumatriptan succinate (Imitrex)

Procedure code J3030 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes							
G43001	G43009	G43011	G43019	G43101	G43109	G43111	G43119
G43401	G43409	G43411	G43419	G43501	G43509	G43511	G43519
G43601	G43609	G43611	G43619	G43701	G43709	G43711	G43719

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Diagnosis Codes							
G43801	G43809	G43811	G43819	G43821	G43829	G43831	G43839
G43901	G43909	G43911	G43919	G43A0	G43A1	G43B0	G43B1
G43C0	G43C1	G43D0	G43D1				

6.121 * Blastic Plasmacytoid Dendritic Cell Neoplasm Therapy (Elzonris and Decnupaz)

[Revised] Tagraxofusp-erzs (Elzonris) and pivekimab sunirine-pvzy (Decnupaz) are indicated to treat blastic plasmacytoid dendritic cell neoplasm (BPDCN). Tagraxofusp-erzs (Elzonris) is a CD 123-directed cytotoxin while pivekimab sunirine-pvzy (Decnupaz) is a CD 123-directed antibody and alkylating agent conjugate indicated to treat BPDCN.

[Revised] Tagraxofusp-erzs (Elzonris) (procedure code J9269) and pivekimab sunirine-pvzy (Decnupaz) (procedure code C9313) are benefits of Texas Medicaid with prior authorization.

6.121.1 * Prior Authorization Requirements

[Revised] Prior authorization is required for tagraxofusp-erzs (Elzonris) (procedure code J9269) and pivekimab sunirine-pvzy (Decnupaz) (procedure code C9313), and may be approved for a duration of every 12 months.

Prior authorization approval for tagraxofusp-erzs (Elzonris) infusion will be considered once all of the following criteria are met for initial therapy:

- [Revised] Client is 2 years of age or older
- Client has a diagnosis of blastic plasmacytoid dendritic cell neoplasm (diagnosis code C8640) excluding, acute promyelocytic leukemia (APL, FAB, M3)
- Client has a CD-123 positive/expressing disease
- Client has adequate serum albumin level and baseline organ function, including cardiac, renal, and hepatic function prior to each course of therapy:
  - Baseline serum albumin level of 3.2 g/dl or greater
  - Left ventricular ejection fraction (LVEF) of 40% or greater
  - Serum creatinine (Scr) of 1.5 mg/dl or less
  - Bilirubin level of 1.5 mg/dl or less

[Revised] Prior authorization approval for pivekimab sunirine-pvzy (Decnupaz) therapy will be considered once all of the following criteria are met for initial therapy:

- [Revised] Client is 18 years of age or older
- [Revised] Client has a diagnosis of blastic plasmacytoid dendritic cell neoplasm excluding acute promyelocytic leukemia (APL, FAB, M3) (diagnosis code C8640)
- [Revised] Client has a CD-123 positive/expressing disease
- [Revised] Client does not have moderate-to-severe hepatic impairment. Baseline aspartate amino-transferase (AST), alanine aminotransferase (ALT), and total bilirubin must be obtained and reviewed prior to treatment with pivekimab sunirine-pvzy (Decnupaz)
- [Revised] Pivekimab sunirine-pvzy (Decnupaz) may cause hepatotoxicity, including veno-occlusive disease (VOD), a severe form of hepatotoxicity.
  - [Revised] The client's hepatic function must be monitored prior to each course of therapy to mitigate the risk of severe or fatal VOD.

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  - [Revised] Treatment with pivekimab sunirinepvzy (Decnupaz) should be delayed with liver test elevations and permanently discontinued therapy in clients who experience VOD
- [Revised] Prescriber attests to closely monitor for signs and symptoms of VOD including elevations in liver tests, hepatomegaly, rapid weight gain, and ascites
- For renewal or continuation therapy, the client must meet all of the following criteria:
  - Client continues to meet initial approval criteria
  - [Revised] Client has previously received treatment with tagraxofusp-erzs (Elzonris) or pivekimab sunirine-pvzy (Decnupaz) with absence of adverse drug reactions or drug toxicity
  - Client has a positive clinical response demonstrated by disease stabilization

Refer to: Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

6.122 Talquetamab-tgvs (Talvey)

Talquetamab-tgvs (procedure code J3055) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.123 Tarlatamab-dlle (Imdelltra)

Tarlatamab-dlle (Imdelltra) is a bispecific delta-like ligand 3 (DLL3)-directed CD3 T-cell engager indicated for the treatment of adult clients with extensive stage small cell lung cancer (ES-SCLC) with disease progression on or after platinum-based chemotherapy.

Tarlatamab-dlle (Imdelltra) (procedure code J9026) is a benefit of Texas Medicaid with prior authorization.

Tarlatamab-dlle (Imdelltra) infusion is to be administered by a qualified healthcare professional in a healthcare setting with appropriate medical support.

6.123.1 Initial Requests

Tarlatamab-dlle (Imdelltra) is an intravenous infusion indicated for the treatment of a client who meets the following requirements:

- The client is 18 years of age or older.
- The client has a confirmed diagnosis of extensive stage small cell lung cancer with one of the following diagnosis codes:

Diagnosis Codes							
C3400	C3401	C3402	C3410	C3411	C3412	C342	C3430
C3431	C3432	C3480	C3481	C3482	C3490	C3491	C3492

- The client has previously received platinum-based chemotherapy (e.g., cisplatin, or carboplatin).
- The client does not have a clinically significant active systemic infection.
- The prescriber attests to counseling female clients of childbearing age regarding the risk of embryo-fetal toxicity and counseling to prevent pregnancy during treatment period and two months after the last infusion of tarlatamab-dlle (Imdelltra) by using an effective method of contraception.

Providers should monitor the following parameters:

- Signs and symptoms of severe reactions such as cytokine release syndrome (CRS).
- Neurologic toxicity, including immune effector cell-associated neurotoxicity syndrome (ICANS).

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- Cytopenia including neutropenia, thrombocytopenia, and anemia. Perform complete blood counts before each tarlatamab-dlle (Imdelltra) treatment.
- Signs and symptoms of hepatotoxicity. Monitor liver enzymes and bilirubin before each tarlatamab-dlle (Imdelltra) treatment.

6.123.2 Recertification or Extension

For renewal or continuation therapy of tarlatamabdlle (Imdelltra), the client must meet the following requirements:

- The client continues to meet the requirements listed above and has been treated with tarlatamabdlle (Imdelltra) in the past.
- The client experienced positive clinical response to treatment, as documented by stabilization of disease, and/or decrease in tumor size or spread.
- The client has not experienced any unacceptable, clinically significant adverse reactions or toxicity (e.g., severe cytopenia, hepatotoxicity, neurotoxicity, etc.) while on tarlatamab-dlle (Imdelltra) therapy.

All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.124 Tebentafusp-tebn (Kimmtrak)

Tebentafusp-tebn (Kimmtrak) (procedure code J9274) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.125 Teclistamab-cqyv (Tecvayli)

Teclistamab-cqyv (Tecvayli) (procedure code J9380) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.126 Teplizumab-mzwv (Tzield)

Teplizumab-mzwv (Tzield) is a cluster of differentiation 3 (CD3)-directed antibody that is indicated to:

- Delay the onset of stage 3 type 1 diabetes (T1D) in adult and pediatric clients who are 1 year of age or older with stage 2 T1D.
- Delay the decline in endogenous insulin production in pediatric clients who are 8 through 17 years of age who have recently been diagnosed with stage 3 T1D.

Teplizumab-mzwv (Tzield) (procedure code J9381) is a benefit of Texas Medicaid with prior authorization.

Teplizumab-mzwv (Tzield) therapy may be approved for up to 14-day treatment duration when the client meets the following criteria:

- The request is to delay the onset of stage 3 T1D
  - The client is 1 year of age or older.
  - The client is given teplizumab-mzwv (Tzield) to delay the onset of stage 3 T1D. The use of teplizumab-mzwv (Tzield) is not approved in type 2 diabetes or any other stages of T1D other than stage 2 TID.
  - The client has a diagnosis of stage 2 T1D confirmed by documentation of at least two positive pancreatic islet autoantibodies:
    - Islet cell autoantibody (ICA)

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    - Insulinoma-associated antigen 2 autoantibody (IA-2A)
    - Insulin autoantibody (IAA)
    - Zinc transporter 8 autoantibody (ZnT8A)
    - Glutamic acid decarboxylase 65 (GAD) autoantibodies
  - Documentation of dysglycemia without overt hyperglycemia using oral glucose tolerance test (OGTT), or another appropriate test for dysglycemia may be used if OGTT is not available.
- The request is to delay the decline in endogenous insulin production in pediatric clients recently diagnosed with stage 3 T1D.
  - The client is 8 through 17 years of age
  - The client has a diagnosis of stage 3 T1D confirmed by the documentation of at least one positive pancreatic islet cell autoantibody:
    - Islet cell autoantibody (ICA)
    - Insulinoma-associated antigen 2 autoantibody (IA-2A)
    - Insulin autoantibody (IAA)
    - Zinc transporter 8 autoantibody (ZnT8A)
    - Glutamic acid decarboxylase 65 (GAD) autoantibodies
  - The client has residual beta cell function, as indicated by peak stimulated C-peptide > 0.2 pmol/mL on a mixed-meal tolerance test (MMTT) or alternative method if appropriate and MMTT is not available.
- The clinical history does not suggest that the client has type 2 diabetes.
- The prescriber must obtain and assess a complete blood count and liver enzyme tests prior to the initiation of treatment with teplizumab-mzwv (Tzield) because the use of teplizumab-mzwv (Tzield) is not recommended in clients with certain lab abnormalities.
- The prescriber must assess client's history of chronic infection and monitor for any signs of active serious infection while on teplizumab-mzwv (Tzield). If a serious infection develops, teplizumab-mzwv (Tzield) therapy should be discontinued.

6.127 Teprotumumab-trbw (Tepezza)

Teprotumumab-trbw (Tepezza) (procedure code J3241) is a benefit of Texas Medicaid and prior authorization is required. Teprotumumab-trbw (Tepezza) is indicated for the treatment of thyroid eye disease (TED) regardless of TED activity or duration.

6.127.1 Prior Authorization Requirements

Prior authorization requests for procedure code J3241 must be submitted with a Special Medical Prior Authorization (SMPA) Request Form.

The client must meet all of the following requirements for approval of Teprotumumab-trbw (Tepezza):

- The client has a diagnosis of Graves' disease associated with TED.
- The client is euthyroid, or the client has either mild hypothyroidism or mild hyperthyroidism.
- The client has no history of prior surgical intervention for TED and does not plan to have surgical treatment while on Teprotumumab-trbw (Tepezza).
- The client may not exceed the course of eight total infusions per lifetime.

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6.127.2 Exclusions

Teprotumumab-trbw (Tepezza) should not be used in pregnancy as it may potentially lead to fetal loss. Females of reproductive potential should use effective contraception prior to initiation, during treatment with Teprotumumab-trbw (Tepezza) and for 6 months after the last dose of Teprotumumab-trbw (Tepezza).

6.128 Thyrotropin alpha for injection (Thyrogen)

Thyrotropin alpha for injection (Thyrogen) (procedure code J3240) is a benefit of Texas Medicaid and is limited to the following diagnosis codes:

Diagnosis Codes							
C323	C73	D020	D093	D098	D380	D440	D442
D449	D497	E010	E011	E012	E040	E042	E048
E049	E0500	E0520	Z85850				

6.129 Tildrakizumab (Ilumya)

Tildrakizumab (procedure code J3245) is a benefit of Texas Medicaid for clients who are 18 years of age or older, and is limited to diagnosis code L400.

6.130 Tisotumab Vedotin-tftv

Tisotumab Vedotin-tftv (procedure code J9273) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.131 Tocilizumab-aazg (Tyenne)

Tocilizumab-aazg (Tyenne) (procedure code Q5135) is a benefit of Texas Medicaid for clients who are 2 years of age or older, and is limited to the following diagnosis codes:

Diagnosis Codes							
M0500	M05011	M05012	M05019	M05021	M05022	M05029	M05031
M05032	M05039	M05041	M05042	M05049	M05050	M05052	M05059
M05061	M05062	M05069	M05071	M05072	M05079	M0509	M0510
M05111	M05112	M05119	M05121	M05122	M05129	M05131	M05132
M05139	M05141	M05142	M05149	M05151	M05152	M05159	M05161
M05162	M05169	M05171	M05172	M05179	M0519	M0520	M05211
M05212	M05219	M05221	M05222	M05229	M05231	M05232	M05239
M05241	M05242	M05249	M05251	M05252	M05259	M05261	M05262
M05269	M05271	M05272	M05279	M0529	M0530	M05311	M05312
M05319	M05321	M05322	M05329	M05331	M05332	M05339	M05341
M05342	M05349	M05351	M05352	M05359	M05361	M05362	M05369
M05371	M05372	M05379	M0539	M0540	M05411	M05412	M05419
M05421	M05422	M05429	M05431	M05432	M05439	M05441	M05442
M05449	M05451	M05452	M05459	M05461	M05462	M05469	M05471
M05472	M05479	M0549	M0550	M05511	M05512	M05519	M05521
M05522	M05529	M05531	M05532	M05539	M05541	M05542	M05549
M05551	M05552	M05559	M05561	M05562	M05569	M05571	M05572

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Diagnosis Codes							
M05579	M0559	M0560	M05611	M05612	M05619	M05621	M05622
M05629	M05631	M05632	M05639	M05641	M05642	M05649	M05651
M05652	M05659	M05661	M05662	M05669	M05671	M05672	M05679
M0569	M0570	M05711	M05712	M05719	M05721	M05722	M05729
M05731	M05732	M05739	M05741	M05742	M05749	M05751	M05752
M05759	M05761	M05762	M05769	M05771	M05772	M05779	M0579
M057A	M0580	M05811	M05812	M05819	M05821	M05822	M05829
M05831	M05832	M05839	M05841	M05842	M05849	M05851	M05852
M05859	M05861	M05862	M05869	M05871	M05872	M05879	M0589
M058A	M059	M05A	M0600	M06011	M06012	M06019	M06021
M06022	M06029	M06031	M06032	M06039	M06041	M06042	M06049
M06051	M06052	M06059	M06061	M06062	M06069	M06071	M06072
M06079	M0609	M060A	M0680	M06811	M06812	M06819	M06821
M06822	M06829	M06831	M06832	M06839	M06841	M06842	M06849
M06851	M06852	M06859	M06861	M06862	M06869	M06871	M06872
M06879	M0689	M068A	M069	M0820	M08211	M08212	M08219
M08221	M08222	M08229	M08231	M08232	M08239	M08241	M08242
M08249	M08251	M08252	M08259	M08261	M08262	M08269	M08271
M08272	M08279	M0829	M082A	M083	M315	M316	R7681

6.132 Tocilizumab-bavi (Tofidence)

Tocilizumab-bavi (Tofidence) (procedure code Q5133) is a benefit of Texas Medicaid and is limited to the following diagnosis codes:

Diagnosis Codes							
M0510	M05111	M05112	M05119	M05121	M05122	M05129	M05131
M05132	M05139	M05141	M05142	M05149	M05151	M05152	M05159
M05161	M05162	M05169	M05171	M05172	M05179	M0519	M0520
M05211	M05212	M05219	M05221	M05222	M05229	M05231	M05232
M05239	M05241	M05242	M05249	M05251	M05252	M05259	M05261
M05262	M05269	M05271	M05272	M05279	M0529	M0530	M05311
M05312	M05319	M05321	M05322	M05329	M05331	M05332	M05339
M05341	M05342	M05349	M05351	M05352	M05359	M05361	M05362
M05369	M05371	M05372	M05379	M0539	M0540	M05411	M05412
M05419	M05421	M05422	M05429	M05431	M05432	M05439	M05441
M05442	M05449	M05451	M05452	M05459	M05461	M05462	M05469
M05471	M05472	M05479	M0549	M0550	M05511	M05512	M05519
M05521	M05522	M05529	M05531	M05532	M05539	M05541	M05542
M05549	M05551	M05552	M05559	M05561	M05562	M05569	M05571
M05572	M05579	M0559	M0560	M05611	M05612	M05619	M05621
M05622	M05629	M05631	M05632	M05639	M05641	M05642	M05649

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Diagnosis Codes							
M05651	M05652	M05659	M05661	M05662	M005669	M05671	M05672
M05679	M0569	M0570	M05711	M05712	M05719	M05721	M05722
M05729	M05731	M05732	M05739	M05741	M05742	M05749	M05751
M05752	M05759	M05761	M05762	M05769	M05771	M05772	M05779
M0579	M057A	M0580	M05811	M05812	M05819	M05821	M05822
M05829	M05831	M05832	M05839	M05841	M05842	M05849	M05851
M05852	M05859	M05861	M05862	M05869	M05871	M05872	M05879
M0589	M058A	M059	M05A	M0600	M06011	M06012	M06019
M06021	M06022	M06029	M06031	M06032	M06039	M06041	M06042
M06049	M06051	M06052	M06059	M06061	M06062	M06069	M06071
M06072	M06079	M0609	M060A	M0680	M06811	M06812	M06819
M06821	M06822	M06829	M06831	M06832	M06839	M06841	M06842
M06849	M06851	M06852	M06859	M06861	M06862	M06869	M06871
M06872	M06879	M0689	M068A	M069	M0800	M0820	M08211
M08212	M08219	M08221	M08222	M08229	M08231	M08232	M08239
M08241	M08242	M08249	M08251	M08252	M08259	M08261	M08262
M08269	M08271	M08272	M08279	M0829	M082A	M083	M0880
M0890	R7681						

6.133 Toripalimab-tpzi

Toripalimab-tpzi (procedure code J3263) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.134 Trastuzumab

Procedure code J9355 is a benefit of Texas Medicaid. Reimbursement for this drug is considered when it is used as a single agent for the treatment of clients who have metastatic breast cancer whose tumors overexpress the Her-2 protein and who have received one or more chemotherapy regimens for their metastatic disease. Trastuzumab may also be reimbursed when:

- Used in combination with paclitaxel for the treatment of clients who have metastatic breast cancer whose tumors overexpress the Her-2 protein and who have not received chemotherapy for their metastatic disease.
- Used as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel for the adjuvant treatment of clients who have Her-2-overexpressing, node-positive breast cancer.

Trastuzumab is a benefit for clients whose tumors have Her-2 protein overexpression.

When billing for the test used to determine whether a client overexpresses the Her-2 protein, use procedure code 83950. Diagnosis of overexpression of the Her-2 protein must be made before Texas Medicaid will consider reimbursement for trastuzumab. This test may be reimbursed only once in a client's lifetime to the same provider. An additional test by the same provider requires documentation to support the medical necessity.

6.135 Travoprost

Travoprost (procedure code J7355) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

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6.136 Tremelimumab-actl (Imjudo)

Tremelimumab-actl (Imjudo) (procedure code J9347) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.137 Treosulfan (Grafapex)

Treosulfan (Grafapex) (procedure code J0614) is a benefit of Texas Medicaid with prior authorization.

Treosulfan (Grafapex) is an alkylating drug indicated for use in combination with fludarabine as a preparative regimen for allogeneic hematopoietic stem cell transplantation (HSCT) in adult and pediatric clients who are 1 year of age or older with acute myeloid leukemia (AML) or myelodysplastic syndrome (MDS).

6.137.1 Prior Authorization Requirements

Treosulfan (Grafapex) is an intravenous infusion, given on three consecutive days in conjunction with fludarabine prior to hematopoietic stem cell infusion. It is indicated for clients who meet the following requirements:

- The client is 1 year of age or older.
- The client has a confirmed diagnosis of one of the following:
  - Acute myeloid leukemia (diagnosis code C9200)
  - Myelodysplastic syndrome (diagnosis code D469)
- The client is undergoing allogeneic hematopoietic stem cell transplantation.
- Fludarabine must be administered in conjunction with treosulfan (Grafapex) as a preparative regimen for allogeneic HSCT.
- The prescriber attests to counseling female clients of childbearing age regarding the use of an effective method of contraception to prevent pregnancy during treatment and up to six months after the last dose of therapy. Male clients with female partners of reproductive potential should also be counseled.

The required monitoring parameters following treosulfan (Grafapex) are:

- Monitor hematologic laboratory parameters, as treosulfan (Grafapex) can cause severe and prolonged myelosuppression.
- Monitor for signs of neurological adverse reactions (e.g., seizures).
- Monitor for extravasation and tissue necrosis.
- Monitor for infections, anemia, thrombocytopenia, and secondary malignancies.

In addition to the documentation requirements outlined in the Prior Authorization Requirements section, all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

6.138 Triamcinolone Acetonide

Procedure code J3304 is a benefit of Texas Medicaid and is restricted to the following diagnosis codes:

Diagnosis Codes							
M170	M1711	M1712	M172	M1731	M1732	M174	M175
M1909	M1919	M1929					

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6.139 Trilaciclib (Cosela)

Trilaciclib (procedure code J1448) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.140 Ublituximab-xiiy (Briumvi)

Ublituximab-xiiy (Briumvi) (procedure code J2329) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.141 Valrubicin sterile solution for intravesical instillation (Valstar)

Procedure code J9357 valrubicin sterile solution for intravesical instillation (Valstar), is a benefit for clients with the diagnosis of bladder cancer in situ who have been treated unsuccessfully with BCG therapy and have an unacceptable morbidity or mortality risk if immediate cystectomy should be performed. Documentation of diagnosis and treatment must be submitted with the claim.

6.142 Vasopressin

Vasopressin (procedure codes J2598, J2599, and J2601) is a benefit of Texas Medicaid for clients who are 18 years of age or older.

6.143 Vitamin B12 (Cyanocobalamin) Injections

Vitamin B12 injections (procedure code J3420) are a benefit of Texas Medicaid. Vitamin B12 injections should only be considered for clients with conditions that are refractory to, or have a contraindication to, oral therapy.

6.144 Voretigene neparvovec-rzyl (Luxturna)

Voretigene neparvovec-rzyl (Luxturna) is an adeno-associated virus vector-based gene therapy indicated for the treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy, who have viable retinal cells in each eye as determined by the treating physician.

Luxturna (procedure code J3398) is a benefit of Texas Medicaid for clients who are 1 year through 65 years of age with prior authorization.

Voretigene neparvovec-rzyl (Luxturna) must be prescribed and administered by a retinal surgeon at an ocular gene therapy treatment center with experience performing intraocular surgery.

6.144.1 Prior Authorization Requirements

Prior authorization is not required for the physician services associated with administration of Luxturna. Physician services include the procedural costs and the associated supplies for administration of the medication.

Prior authorization is required for voretigene neparvovec-rzyl (Luxturna) (procedure code J3398).

For situations in which voretigene neparvovec-rzyl (Luxturna) is being dispensed by a pharmacy via white bagging, the prescribing provider must provide the dispensing DME pharmacy the authorization approval number. The dispensing DME pharmacy may not request prior authorization.

The DME Pharmacy provider billing for voretigene neparvovec-rzyl (Luxturna) will be responsible for coordinating with the rendering provider to obtain the prior authorization request approval number.

The requesting provider (physician or hospital) may coordinate with the DME Pharmacy provider for the initial request for voretigene neparvovec-rzyl (Luxturna). DME Pharmacy providers may assist in providing necessary information, such as their NPI number, fax number, and business address, to the requesting provider. However, the Special Medical Prior Authorization (SMPA) form must be signed, dated, and submitted by the Medicaid-enrolled requesting provider, not the DME Pharmacy provider.

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The dispensing pharmacy must submit the authorization approval number when billing for the drug. Reimbursement for dispensing of the drug by the pharmacy may not occur unless an approved prior authorization for voretigene neparvovec-rzyl (Luxturna) is in place.

Refer to: Subsection 11.5.1, "Pharmacy Delivery Method for Clinician-Administered Drugs" in this handbook for additional information on the "white bagging" delivery method.

Subsection 2.1.2, "Prior Authorization Requests" in this handbook for additional prior authorization information.

Prior authorization request for Luxturna injections will be considered when all of the following criteria are met:

- Client is 1 year of age through 65 years of age
- A documented diagnosis of a confirmed biallelic RPE65 mutation-associated retinal dystrophy (e.g., Leber's congenital amaurosis subtype 2, retinitis pigmentosa, or early onset severe retinal dystrophy)
- Genetic testing documenting biallelic mutations of the RPE65 gene
- Systemic corticosteroids equivalent to prednisone 1 mg/kg/day are administered for a total of 7 days, starting 3 days before administration of voretigene neparvovec-rzyl to each eye and followed by a tapering dose
- Client has viable retinal cells in each eye as determined by the treating physician and assessed in the previous 6 months. Verification of viable retinal cells must be documented and evident by one of the following:
- An area of retina within the posterior pole of greater than 100 μm thickness shown on optimal coherence tomography (OCT)
- Greater than or equal to 3 disc areas of retina without atrophy or pigmentary degeneration within the posterior pole
    - Remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent
- Prescribed and administered by retinal surgeon at an ocular gene therapy treatment center with experience performing intraocular surgery
- Patient has not previously received RPE65 gene therapy in intended eye
- Injection of the second eye must be administered at least 6 days after the first eye
- Have not had intraocular surgery within 6 months in either eye indicated for treatment

Benefit not to exceed more than 1 injection per eye per lifetime.

Authorization is valid for a period of 6 months from approval.

All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

6.144.2 Exclusions

Luxturna is not a benefit for patients who have previously received RPE65 gene therapy and who do not have viable retinal cells in each eye as determined by the treating physician.

6.145 Zopapogene Imadenovec-drba (Papzimeos)

Zopapogene imadenovec-drba (Papzimeos) (procedure code J3404) is a benefit of Texas Medicaid for clients with prior authorization.

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Zopapogene imadenovec-drba (Papzimeos) is a non-replicating adenoviral vector-based immunotherapy indicated to treat adults with recurrent respiratory papillomatosis.

6.145.1 Prior Authorization Requirements

6.145.1.1 6.142.1.1 Initial Requests

Zopapogene imadenovec-drba (Papzimeos) is a subcutaneous injection, and the initial prior authorization will be approved for 6 months for clients who meet the following requirements:

- The client is 18 years of age or older.
- The client has a confirmed diagnosis of recurrent respiratory papillomatosis (diagnosis code D141).
- The client has documented human papillomavirus (HPV) serotype 6 or 11.
- The prescriber must perform a surgical debulking of visible papilloma prior to the initiation of zopapogene imadenovec-drba (Papzimeos) treatment (Day 1) to establish minimal residual disease.
- The prescriber attests to remove visible papilloma prior to the third and fourth zopapogene imadenovec-drba (Papzimeos) administration to maintain minimal residual disease during treatment.

Authorization will be issued for no more than one treatment course (i.e., four doses).

Monitor the client for signs and symptoms of thrombotic events, including shortness of breath, chest pain, leg swelling, persistent abdominal pain, or neurological symptoms such as severe or persistent headache or blurred vision.

6.145.1.2 Documentation Requirements

In addition to the documentation requirements outlined in this section, all services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

7 * Separate Reimbursement of Certain Inpatient HCCADs

Inpatient high-cost clinician-administered drugs (HCCADs) are drugs or biologics that HHSC has approved to be "carved out" of the All-Patient Refined Diagnosis Related Group (APR-DRG) and can be billed on an outpatient claim.

This section allows for the use of specialty pharmacy billing for the HCCAD if it is available for the drug or bill for the HCCAD on a separate outpatient claim.

Refer to: Section 6, "Outpatient Drugs—Benefits and Limitations" in this handbook for the prior authorization criteria for the HCCADs.

The section below contains the list of HCCADs and procedure codes approved by HHSC:

HCCADs	[Revised] Procedure Codes
Abecma	Q2055
Aucatzyl	Q2058
Breyanzi	Q2054
Carvykti	Q2056
Casgevy	J3392
Elevidys	J1413
Hemgenix	J1411
Itvisma	J3405

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HCCADs	[Revised] Procedure Codes
Kebilidi	J3590
Kymriah	Q2042
Lenmeldy	J3391
Lyfgenia	J3394
Omisirge	J3406
Rethymic	J3590
Skysona	J3387
Tecartus	Q2053
Tecelra	Q2057
Yescarta	Q2041
Zevaskyn	J3389
Zolgensma	J3399
Zynteglo	J3393

Refer to: Subsection 9.2, "HCCADs Claims Processing Requirements" in this handbook" for claims processing requirements.

8 Cell and Gene Therapy Access Model (CGT)

The CGT Access Model is a Centers for Medicare & Medicaid Services (CMS) led multi-year initiative focusing on potentially lifesaving gene therapies for sickle cell disease.

Unique to this model, clients have access to fertility preservation services that otherwise are not a covered Texas Medicaid benefit. The drug manufacturers will cover the cost of these services.

Medications

In alignment with CMS, only the following gene therapies are part of the CGT Access Model:

- Lyfgenia by bluebird bio, Inc.
- Casgevy by Vertex Pharmaceuticals, Inc.

The CGT Access Model is only for the treatment of sickle cell disease (beta-thalassemia indication is not included).

As part of the CGT Access Model, the prior authorizations for the gene therapy and related care (i.e., genetic and laboratory testing, prescription) are authorized until the end of the original authorization period regardless of whether the client transitions between fee-for-service and managed care or from amongst MCOs. Additionally, the client must have access to the same qualified treatment center that administered the medication for at least one year after receiving their gene therapy infusion.

Eligibility

Clients who are eligible to participate must meet the following conditions:

- Be actively enrolled in Texas Medicaid and have Medicaid as their primary insurance
- Meet the clinical prior authorization criteria outlined in section "6.115 Sickle Cell Disease Gene Therapy" in this handbook.

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Billing

Providers submitting a claim under the CGT Access Model must:

- Be a member of the CMS Designated Registry through the Center for International Blood and Marrow Transplant Research (CIBMTR) prior to administering the gene therapy.
- Participate in the study related to this model; providers will receive study information directly from CIBMTR.
- Adhere to billing requirements outlined in section "7 * Separate Reimbursement of Certain Inpatient HCCADs" in this handbook and subsection "9.2 HCCADs Claims Processing Requirements" in this handbook for claims submission guidelines.
- Submit the invoice of the actual acquisition cost of the drug.

Resources

CGT Access Model:

- CMS: Cell and Gene Therapy Access Model
- CMS: Improved Access to Gene Therapy for Sickle Cell Disease: Maya's Care Journey
- CMS: CMS Expands Access to Lifesaving Gene Therapies Through Innovative State Agreements

For information and enrollment information related to additional client support in navigating through the client's journey, including the fertility preservation services, see:

- Lyfgenia: my bluebird support
- Casgevy: Vertex Connects

For fee-for-service, providers may contact the following:

- TMHP: Provider Enrollment
- TMHP: Prior Authorization

9 Claims Filing Information

Claims for clinician-administered drugs 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 them.

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 and itemized statements are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

9.1 JW Modifier Claims Filing Instructions

Providers must not use the JW modifier for medications manufactured in a multi-dose vial format.

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Providers must choose the most appropriate vial size(s) required to prepare a dose to minimize the discarded portion of the vial payable.

Claims considered for reimbursement must not exceed the package size of the vial used for preparation of the dose. Providers must not bill for vial contents overfill.

Providers must not use the JW modifier when the actual dose of the drug or biological administered is less than the billing unit.

Example: *One billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7mg dose is administered to a client while 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would process for payment of the total 10mg of drug administered and discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.*

Reimbursement for JW modifier claims is only available for drugs covered in an outpatient setting.

Inpatient and diagnostic radiopharmaceuticals claims are not eligible for reimbursement, and may not include the JW modifier.

Coverage is for "buy and bill" providers only. Specialty pharmacies billing through the medical benefit must not submit claims with a JW modifier because they are unaware of how much the provider administered or discarded.

Federally Qualified Health Center (FQHC) and Rural Healthcare Clinic RHC) are not eligible to bill with the JW modifier because these providers do not bill for the coverage of drugs or biologicals separately.

Critical Access Hospitals (CAH) are eligible to bill with the JW modifier because these providers bill for the coverage of drugs or biologicals separately.

The JW modifier is not allowed for medications prepared in an institutional setting via "batch processing or bulk productions" methods. An example of a batch processing method is when a hospital or repackaging facility produces multiple non-patient specific doses of medications in advance of anticipated use. These preparations are labeled and distributed with client specific information only when orders are received. Because these doses may be recycled for other client use, they are not eligible.

Providers may utilize automatic systems to calculate dose and discard amounts. However, providers must continue to document the exact usage/discard accurately.

Providers must enter the dose administered (used portion) line item detail of the CAD and also enter the dose discarded (unused portion) line item detail of the CAD on the same claim. The dose discarded (unused portion) line item detail must include the JW modifier to be considered for reimbursement. When billing for reimbursement of wastage on an outpatient claim, the HCPCS and Current Procedural Terminology (CPT) code should always be provided along with the revenue code.

9.2 HCCADs Claims Processing Requirements

The following special requirements apply when billing the HCCAD on a separate outpatient claim.

Providers must claim separate payment for the HCCAD on an outpatient claim. Payment for the HCCAD must not be bundled with any other service.

The claim for the HCCAD must be separate from any facility or institutional claim the hospital submits for all other hospital services delivered to the member during the same visit. The associated inpatient or outpatient charges with the same date(s) of service are billed separately and remain part of the APR-DRG.

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The date of administration of the drug should be used on the HCCAD outpatient claim along with the member's name and other required information. The HCCAD claim must include:

- The NDC qualifier of N4 (paper claims only).
- The appropriate 11-digit National Drug Code (NDC) and corresponding HCPCS code for the drug.
- The number of units of the drug administered to the member that is covered by the claim.
- The NDC unit of measurement. There are five allowed values: F2, GR, ML, UN, or ME.

Drugs administered in an inpatient setting do not qualify for 340B discounts.

9.2.1 * Claims Submissions for HCCADs Covered Under Procedure Code J3590

Hospitals that have prior authorization can submit a separate outpatient claim for HCCADs when the drug is provided in an inpatient setting. In addition to the criteria listed in section 9.2, HCCADs Claims Processing Requirements, providers must submit modifier U3 on a fee-for service (FFS) outpatient claim so that TMHP can easily identify the HCCAD under (procedure code J3590) for claims, and reimburse them appropriately for the following drugs:

- Rethymic
- Kebilidi

Note: *Providers should not submit these HCCADs on the related inpatient services claim.*

Providers can refer to the current National Drug Codes fee schedule on the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

10 Pharmacy Benefit

The Texas Drug Code Index, or formulary (or list of available drugs), includes non-legend (over-the counter) drugs. Additionally, certain supplies and select vitamin and mineral products are also available as a pharmacy benefit. Some drugs are subject to one or both types of prior authorization, clinical and non-preferred. VDP does not reimburse claims for nutritional products (enteral or parenteral), medical supplies, or equipment other than a limited set of home health supplies.

The PDL is arranged by drug therapeutic class, and contains a subset of many, but not all, drugs that are on the Medicaid formulary. Most drugs are identified as preferred or non-preferred. Drugs listed on the PDL as preferred or not listed at all are available without prior authorization unless there is a clinical prior authorization associated with that drug. For more information about prior authorization, refer to Subsection 13, "Pharmacy Prior Authorization" in this handbook.

10.1 Drug and Product Search

The Drug and Product Searches are online tools available to health-care providers to help clients get access to medications.

Users can search by either brand or generic name of the drug or product, the 11-digit national drug code (NDC), the PDL drug class, or HCPCS description (for products).

Detailed filters allow searches as follows:

- By program:
  - Medicaid
  - CHIP
  - CSHCN Services Program

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  - HTW Program
  - HTW Plus Program
  - KHC Program (e.g., CHIP, CSHCN, HTW, and KHC)
- By prior authorization status:
  - PDL prior authorization
  - Clinical prior authorization
- By drug types:
  - Family planning
  - Diabetic supplies
  - Injectable drugs
  - LARCs
  - Over-the-counter (OTC)
  - Drugs requiring 90% utilization before refilling (refer to section 10.4)
- By product types:
  - Flu vaccines
  - Mosquito repellents
  - COVID-19 vaccines

Refer to: The Drug Search and Product Search on the VDP website for more information.

10.1.1 Epocrates

The Texas Medicaid formulary and Preferred Drug List are available on the Epocrates drug information system. Epocrates (epocrates.com) is the publisher of mobile device software applications designed to provide information about drugs to doctors and other health care professionals.

Once registered, providers can utilize Epocrates Rx, the free drug reference, and search for brand, generic, or over-the-counter medicines. Providers can select the "Texas Medicaid" formulary option, allowing searches by drug name to find products identified as preferred or non-preferred or are subject to clinical prior authorization criteria. In addition to listing a drug's preferred status, Epocrates includes drug monographs, dosing information, and warnings.

Epocrates does not mirror the HHSC designations differentiated by dosage form. In these situations, the designation includes an explanatory message.

10.2 Drug Shortages

HHSC encourages prescribing providers to notify HHSC about potential drug shortages impacting prescribing choice and pharmacy claim processing using the Drug Shortage Notification and Expedited Formulary or Preferred Drug List Request (HHS Form 1315).

Significant drug shortages affecting multiple pharmacies and distributors can have a continuing adverse impact on people enrolled in Medicaid if not resolved promptly. The process ensures notification of alternatives to the shorted drug, the timeline of the shortage, and the drug's availability for use.

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10.3 Hepatitis C Direct-Acting Antiviral Treatment Products

The Texas Health and Human Services Commission (HHSC) launched a public health initiative called Texas Medicaid HepCure to reduce the rate of Hepatitis C virus (HCV) in Texas. No HCV medication is required to be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist. All providers with prescriptive authority can prescribe this treatment to their clients with HCV.

HHSC allows prescribers to write prescriptions for the entire course of therapy for DAAs, and clients do not need to request additional refills throughout their treatment duration. Prescribers may choose to write a prescription for the entire treatment cycle or have the client return for further testing if warranted. This applies to all Hepatitis C DAA medications.

10.3.1 Background on Hepatitis C

Hepatitis C is a liver infection caused by HCV. It spreads through contact with blood from an infected person. For some people, hepatitis C is a short-term illness that resolves spontaneously, but it becomes a chronic infection for most people who become infected with HCV. Chronic HCV can result in serious, even life-threatening, health problems like cirrhosis and liver cancer.

People with HCV often have no symptoms and do not feel sick. When symptoms appear, they often are a sign of advanced liver disease. The number of people unknowingly living with undiagnosed HCV infection is why broad population-based HCV screening is important. Screening, testing and treatment can save and prolong life.

DAA medications use molecules that target specific nonstructural proteins of the virus which results in disruption of viral replication and infection. They are oral medications taken once per day for several weeks. With cure rates above 90%, these drugs can virtually eliminate the disease. The medications can be prescribed using simplified treatment algorithms for most clients and do not require specialized clinical oversight or management.

10.3.2 HCV Screening and Testing

The Centers for Disease Control and Prevention (CDC) recommends that all adults who are 18 years of age or older be screened for HCV at least once in a lifetime. They also recommend that people with certain risk factors, including people who inject drugs, be tested regularly. The US Preventative Services Task Force recommends screening for Hepatitis C infection in adults who are 18 through 79 years of age and gives a “B” recommendation (moderate certainty of substantial net benefit).

Screening for HCV involves measuring antibodies to HCV in a client’s serum. A reactive or positive test (detection of the antibody) is not a disease diagnosis; it only indicates that a person was previously exposed to the virus. If the antibody test is reactive, a nucleic acid test (also known as a polymerase chain reaction [PCR] test) for HCV ribonucleic acid (RNA) is needed to determine whether the client currently has active HCV infection. Often, the antibody test and the RNA test can be performed on a single blood draw, with a positive antibody test automatically reflexing to the HCV RNA test. The client can be prescribed HCV treatment if the HCV RNA test is positive. In most instances, a simplified HCV treatment algorithm can be followed.

10.3.3 Treatment Coverage

After confirmatory testing, individuals may not have previously received treatment for Hepatitis C. HHSC encourages Medicaid providers to evaluate their clients at risk for Hepatitis C or previously ineligible for HCV treatment to assess if they would benefit from treatment.

Prior authorization is required for PDL non-preferred agents.

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10.3.4 Follow-Up After Treatment

Clients who have received treatment should be tested for HCV RNA 12 weeks (or longer) after treatment completion. Undetectable or unquantifiable HCV RNA 12 weeks or longer after treatment completion is defined as a sustained virologic response (SVR) consistent with the cure of HCV infection.

10.3.5 Pregnant Clients

The CDC recommends that all pregnant clients should be screened for HCV during each pregnancy, regardless of age. This will aid providers in identifying HCV-infected pregnant clients, which can lead to treatment for the birthing client during the postpartum period. It can also help identify infants with perinatal exposure who should receive testing at a pediatric visit. There are currently no approved curative treatments available for pregnant clients or children who are 3 years of age or younger, but curative treatments are available for non-pregnant clients and for children who are 3 years of age or older.

10.3.6 Resources for Providers

HCV DAAs are safe, associated with high rates of cure, and have few side effects and contraindications. Some HCV clients may need to have their treatment managed by a specialist, such as those with hepatitis B virus or HIV co-infection, those who previously failed HCV treatment, or those with liver cancer or who have had a liver transplant. However, most cases of HCV can be treated by primary care physicians or advanced practice providers. Providers may find the following resources helpful, and can also visit the Hepatitis C Treatment page for more information on Texas Medicaid HepCure and Hepatitis C:

- CDC Resources:
  - Recommended Testing Sequence for Identifying Current HCV Infection: www.cdc.gov/hepatitis/hcv/pdfs/hcv_flow.pdf
  - Testing Recommendations for HCV infection: www.cdc.gov/hepatitis-c/hcp/diagnosis-testing/
  - Hepatitis C Questions and Answers for Health Professionals: www.cdc.gov/hepatitis-c/hcp/clinical-overview/
- Prescriber Resources: www.hcv.com/resources
- Resources from the American Association for the Study of Liver Diseases: www.hcvguidelines.org
- Texas Hepatitis C Report Card: stateofhepc.org/states/texas/

10.4 Home Health Supplies

Pharmacies enrolled with VDP can dispense a limited set of home health supplies that are commonly found in a pharmacy to clients enrolled in traditional Medicaid. These supplies are also available to clients enrolled in Medicaid managed care, provided the dispensing pharmacy is contracted by the client's health plan.

The list of supplies that can be dispensed at a pharmacy and information about the provisions of these supplies for clients enrolled in traditional Medicaid can be found on the VDP Product Search page. Users can search by product NDC or name or the HCPCS description.

Providers should contact the appropriate health plan or pharmacy benefit manager for more information about providing these supplies to clients enrolled in managed care.

10.5 Long-Acting Reversible Contraception Products

Long-acting reversible contraception (LARC) products are available to clients through either a Medicaid or HTW pharmacy or medical benefit.

The list of LARC drugs dispensed at a pharmacy can be found on the VDP Drug Search page. Users can select the "LARC" check-box for a list of all drugs.

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Providers can obtain LARC products with no upfront cost by submitting a completed and signed prescription request form to certain specialty pharmacies. The specialty pharmacy will dispense the LARC product by shipping it to the practice address in care of the client and bill Medicaid or HTW for the product. Providers can only bill for product administration at the time of service. LARC products obtained by providers from specialty pharmacies must be returned if unused and unopened.

10.5.1 Product Billing

The specialty pharmacy bills Medicaid or HTW for LARC products when obtained from a specialty pharmacy. Providers will continue to bill Medicaid or HTW for insertion of the LARC product. Providers may only bill for the LARC product if it was obtained through the buy-and-bill process.

For clients enrolled in traditional Medicaid (fee-for-service (FFS)) or HTW, providers bill HHSC for the insertion of the LARC product using procedure code 58300.

For clients enrolled in Medicaid managed care, providers bill the patient's managed care organization for the insertion of the LARC product. Contact the patient's MCO for specific billing instructions.

10.5.2 Specialty Pharmacy Participation

Providers do not need to enroll with specialty pharmacies to obtain LARC products. Any provider currently enrolled with Medicaid or HTW may prescribe and obtain a LARC product and bill Medicaid or HTW for insertion of the LARC product. The participating pharmacies ship statewide.

Prescribing providers should identify whether the patient is enrolled in traditional Medicaid or managed care. For clients enrolled in managed care, the provider's office should coordinate with the managed care organization (MCO) to determine which pharmacy should receive the prescription because the MCO may be contracted with a single specialty pharmacy. The name, phone number, and national provider identifier (NPI) is provided for each specialty pharmacy is listed in the "Manufacturer Information" section.

10.5.3 Product Returns and Abandoned Units

Manufacturers offer abandoned unit return programs that allow a provider to return an abandoned LARC product. An "abandoned unit" is an unused and unopened product that was shipped by a participating specialty pharmacy with a prescription label that includes the name of the patient. In order to be returnable, the LARC product should be in its original packaging.

10.5.4 Manufacturer Information

10.5.4.1 Bayer (Kyleena, Mirena, and Skyla)

10.5.4.1.1 Specialty Pharmacy Participation

Products are available from CVS CarePlus Specialty Pharmacy or Walgreens Specialty Pharmacy, both shipping statewide.

Walgreens Specialty Pharmacy
Frisco, TX
1-800-424-9002
NPI 1851463087

CVS Caremark Specialty Pharmacy
Fort Worth, TX
817-336-7281
NPI 1366551848

10.5.4.1.2 Obtaining Products

Providers use Bayer's Specialty Pharmacy Prescription Request Form. This form is available on the VDP website at https://www.txvendordrug.com/resources/forms.

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Complete the Bayer's Specialty Pharmacy Prescription Request Form as follows:

- Enter the patient and prescriber information, including the patient's pharmacy drug benefit and medical insurance information and copies of the patient's pharmacy benefit and medical insurance cards.
- Complete the prescribing information and keep a copy for future use.
- Identify the drug to be administered in the prescription section, including the appropriate diagnosis code, and sign the prescription. Advanced Practice Registered Nurses, Physician Assistants, and Nurse Practitioners should identify who their collaborative agreement is with to write prescriptions, if necessary
- Have the patient read and sign the "Patient Authorization" section of the form.
- Fax the form, including the "Patient Authorization" section, to the pharmacy.
- The pharmacy will call the patient to confirm the patient's intent to receive an intrauterine device (IUD). This is done to limit potentially abandoned IUD units. The pharmacy will not mail the IUD to the provider until confirmation from the patient is received.

10.5.4.1.3 Returning Products

Providers may return abandoned units. The box must be sealed and have been abandoned for at least 60 days (2 months) from the dispensing date but no more than 210 days (7 months) past the fill date. Only LARC products obtained through a specialty pharmacy can be returned through this program.

To return abandoned units complete the Bayer Abandoned Unit Program Return Form. This form is available on the VDP website at https://www.txvendordrug.com/resources/forms.

The Bayer Abandoned Unit Program Return Form may be submitted by mail or fax as follows:

- Fax the form to the dispensing specialty pharmacy for verification.
- Wait for an authorization number and return mailing label, and then
- Confirm the specialty pharmacy identification number matches the ID number listed on the return authorization form.
- Package the unit in one of the cardboard boxes the drug was initially shipped in or a large envelope.
- Mail the unit to the specialty pharmacy.

10.5.4.2 Organon (Nexplanon)

10.5.4.2.1 Specialty Pharmacy Participation

Nexplanon is available from CVS CarePlus Specialty Pharmacy or Accredo Specialty Pharmacy, both of which ship statewide.

CVS Caremark Specialty Pharmacy
Fort Worth, TX
817-336-7281
NPI 1366551848

Accredo Specialty Pharmacy
Irving, TX
972-929-6800
NPI 1073569034

10.5.4.2.2 Obtaining Products

Providers use Organon's Nexplanon Direct Service Request Form. Request the form from Organon Customer Support Center for Nexplanon (CSCN) at 1-844-639-4321.

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Complete the CSCN Direct Service Request Form as follows:

- At the top of the first page of the form, check the "Prescription Order" box and select a specialty pharmacy.
- Complete the patient and prescriber information including the patient's pharmacy drug benefit and medical insurance information. Include copies of the patient's insurance card and prescription drug card.
- Have the patient read and sign the "Patient Authorization" section.
- Ensure the physician signs both the Dispense as Written and prescriber signature lines, and the appropriate diagnosis code is selected.
- Fax the completed form to the CSCN at 1-844-232-2618.
- The CSCN will forward the prescription to the specialty pharmacy you selected after confirming the benefits of the patient.

10.5.4.2.3 Returning Products

Providers may return an abandoned unit. The Nexplanon box must be sealed and been abandoned for at least 120 days (4 months) from date of dispense but no more than 180 days (6 months) past the fill date.

Complete the Organon Abandoned Unit Program Return Form. This form is available on the VDP website at https://www.txvendordrug.com/resources/forms.

The Organon Abandoned Unit Program Return Form may be submitted by mail or fax as follows:

- Fax the form to the specialty pharmacy for verification.
- Wait to receive the return identification number from the specialty pharmacy and return mailing label and instructions, which will be provided by C3i, Organon's third-party processor.
- Confirm the specialty pharmacy return identification number matches the ID number listed in the return mailing label provided by C3i.
- Package the unit in the box in which the Nexplanon was originally shipped or other appropriately sized shipping box or envelope.
- Mail the unit along with the Organon Abandoned Unit Program for Nexplanon Return Form to Cardinal Health 3PL. A pre-paid shipping label and address will be provided by C3i.

Only LARC products obtained through a specialty pharmacy can be returned through this program.

10.5.4.3 Cooper Surgical (Paragard)

10.5.4.3.1 Specialty Pharmacy Participation

Paragard is available from the following specialty pharmacy, which ships statewide:

Biologics by McKesson Specialty Pharmacy
Cary, NC 27513
1-888-275-8596
NPI 1487640314

10.5.4.3.2 Obtaining Products

To obtain products providers should use the Cooper Surgical Patient Authorization Form and Patient Referral Form:

- Patients should complete the Patient Authorization Form and return to the provider.

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- Providers should ensure the box next to "PARAGARD T 380A Qty: 1" is checked on the Teva Patient Authorization Form and Patient Referral Form.
- Forms may be returned to the Specialty Pharmacy by fax to 1-855-215-5315 for Biologics by McKesson or fax to 1-212-988-4501 for City Drugs. Upon receipt of your completed forms, Cooper Surgical will send you written confirmation by fax.

10.5.4.3.3 Returning Products

The original Paragard box must be sealed and have been abandoned at least 90 days since it was shipped.

The following will occur ninety days following shipment:

- Paragard will follow-up with your office to confirm the product was placed into the intended Medicaid client.
- If the product was not placed, the Paragard Specialist will obtain your email address to send you the return shipping label.
- Place the original unused and unopened Paragard unit and original packaging with affixed prescription label into a shipping box. You can reuse the original shipping box.
- Print the return shipping label and ship the unused and unopened Paragard unit back to Paragard as soon as possible.
- For additional questions regarding Cooper Surgical Abandoned Unit Return program contact Paragard at 1-877-727-2427.

10.5.4.3.4 Loss of Client Eligibility

If the client was eligible for Medicaid or HTW on the date of service when the LARC product was prescribed and ordered, but the client loses eligibility before the LARC product is inserted, the provider is not required to return the LARC product. If the client is no longer eligible for Medicaid or HTW, the provider may insert the LARC device, but reimbursement for all care and services provided must be resolved between the provider and the client.

If a provider accepts a client as a private pay client, the provider must advise the client she is accepted as a private pay client at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure the client signs written notification so there is no question how the client was accepted.

10.5.4.3.5 Questions

Contact the specialty pharmacy for questions related to obtaining LARC products. Further questions may be directed to the client's health plan or the TMHP provider help line for FFS Medicaid or HTW clients at 1-800-925-9126.

10.6 Mosquito Repellent Benefit

HHSC covers mosquito repellent year-round for the prevention of the Zika virus.

A list of products is available through the VDP Product Search page. Users can search by product name, the 11-digit National Drug Code (NDC), or click the "mosquito repellent" checkbox to view all products.

Clients that are eligible for the benefit include the following demographics:

- Females who are 10 through 55 years of age
- Pregnant females of any age
- Males who are 14 years of age and older

HHSC requires a prescription for all clients.

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10.7 Palivizumab (Synagis)

Palivizumab is available to physicians for administration to clients in Medicaid and the CSHCN Services Program through VDP. This enables physicians to have palivizumab shipped directly to their office from a network pharmacy, and not purchase the drug.

Physicians who obtain palivizumab through VDP may not submit claims to TMHP for the drug. The administering provider may submit a claim to TMHP for an injection administration fee and any medically necessary office-based evaluation and management service provided at time of injection.

10.7.1 Schedule

The following sections provide information about the forms used for prior authorization requests.

Refer to: The Synagis page on the VDP website for the current season's schedule.

10.7.2 Forms

Note: *Palivizumab is also available for clients enrolled in the Children with Special Health Care Needs (CSHCN) Services Program. Providers can refer to the CSHCN Services Program Provider Manual for details.*

10.7.2.1 Managed Care

Medicaid managed care and CHIP require the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits (Texas Department of Insurance Form NOFR002). Prescribing providers should contact the MCO for prior authorization requirements and forms. MCOs may require additional information in addition to the MCO-specific addendum form. The MCO's form will reflect the appropriate MCO contact information and reconsideration request process.

10.7.2.2 Traditional Medicaid

The prescribing provider must send the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits (TDI NOFR002), the Palivizumab (Synagis) Standard Prior Authorization Request (HHS 1321), the prescription for Synagis, and any supporting information to the Medicaid-enrolled pharmacy. Pharmacy staff will submit the form to the Texas Prior Authorization Call Center.

10.8 Vitamin and Mineral Products

HHSC-enrolled pharmacies with VDP can dispense vitamin and mineral products to clients who are 20 years of age and younger and enrolled in traditional Medicaid. These products are also available to clients enrolled in Medicaid managed care, if the dispensing pharmacy is contracted with the client's health plan.

To expedite pharmacy claim processing for vitamin and mineral products, prescribing providers are encouraged to include the diagnosis on the prescription.

The list of products that can be dispensed at a pharmacy and information about the provision of these products to clients enrolled in fee-for-service can be found on the VDP Product Search page. Users can search by product NDC or name or the HCPCS description.

For clients enrolled in Medicaid managed care or CHIP, claims are submitted to the clients' health plans. Pharmacy staff must work with the health plan's pharmacy benefit manager to determine the billing requirements, reimbursement rates, and coverage limitations for these products.

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11 Prescribing Information

The federal Patient Protection and Affordable Care Act and the Code of Federal Regulations Title 42 §455.410(b) require all physicians or other professionals who order, refer, or prescribe drugs, supplies and services for a recipient of traditional Medicaid, CHIP, CSHCN, and HTW Program to be enrolled as participating Medicaid providers.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information.

11.1 Tamper-Resistant Prescription Pads

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

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

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

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

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

Refer to: The *VDP Pharmacy Provider Procedure Manual* on the VDP website.

11.2 Prescription Refills and Expirations

Medicaid prescriptions for non-controlled substances are valid for one year from the date written and up to 11 refills if authorized by prescriber.

Medicaid prescriptions for controlled substances in Schedules III, IV, and V are valid for six months from the date written and up to five refills if authorized by prescriber provider. Controlled substance prescriptions written by advanced practice registered nurses and physicians assistants are valid for 90 days.

Medicaid prescriptions for Schedule II drugs cannot be refilled and must be dispensed within 21 days of the date on which the prescription was written.

Prescriptions for Schedule II drugs may be written as multiples of three for a total of a 90 day supply subject to federal and state law.

Refer to: The *VDP Pharmacy Provider Procedure Manual* on the VDP website.

Pharmacy Laws and Rules page of the Texas State Board of Pharmacy (TSBP) website for rules about issuance of identical sets of Schedule II prescriptions.

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11.3 Prescription Monitoring of Controlled Substances

The Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act requires states to have a qualified prescription drug monitoring program. The SUPPORT Act also requires certain Medicaid providers to check beneficiaries' prescription drug history before prescribing or dispensing controlled substances.

The Texas Prescription Monitoring Program (PMP) collects and monitors prescription data for all Schedule II, III, IV and V controlled substances dispensed by a pharmacy in Texas or to a Texas resident from a pharmacy located in another state. The PMP also provides a venue for monitoring patient prescription history for practitioners and the ordering of Schedule II Texas Official Prescription Forms.

Prescribers are required to check a Medicaid member's PMP history before prescribing Schedule II, III, IV, and V controlled substances.

Pharmacies that dispense Schedule II, III, IV, and V drugs are required to report the information directly to the Texas State Board of Pharmacy's contracted vendor. Prescription data is reported by the prescriber's federal Drug Enforcement Administration (DEA) number. Prescribers and pharmacies are required by statute to have a valid, active DEA numbers in order to possess, administer, prescribe or dispense controlled substances.

Refer to: The Texas Prescription Monitoring Program page of TSBP website.

11.4 Requirements for Early Refills

A refill is considered too soon, or early, if the client has not used at least 75 percent of the previous fill of the medication.

For clients enrolled in traditional Medicaid or the CSHCN Services Program, a refill for certain controlled substances is considered too soon if the client has not used at least 90 percent of the previous fill of the medication.

Note: *Some drugs, such as attention deficit hyperactivity disorder drugs and certain seizure medications, are excluded from this change.*

To identify drugs that require 90 percent utilization, refer to the VDP Drug Search and select the "90% Utilization" filter. The returned results will include only those drugs that meet this requirement.

Refer to: The VDP Drug Search on the VDP website for more information.

Justifications for early refills include, but are not limited to, the following:

- A verifiable dosage increase
- An anticipated prolonged absence from the state

If a client requests an early refill of a drug, the pharmacy must contact VDP to request an override of the early refill restriction. Prescribing providers may be asked to verify the reason for the early refill by the dispensing pharmacy or VDP staff.

Note: *Providers who are members of Medicaid managed care plans should contact the appropriate health plan or pharmacy benefits manager for specific requirements and processes related to dispensing early refills.*

11.5 Clinician-Administered Drugs

All Texas Medicaid providers must submit a rebate-eligible NDC for professional or outpatient claims submitted to TMHP with a clinician-administered drug procedure code.

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The NDC is an 11-digit number on the package or container from which the medication is administered. Providers must enter identifier N4 before the NDC code. The NDC unit and the NDC unit of measure must be entered on all professional or outpatient claims that are submitted to TMHP and Medicaid managed care plans.

Clinician-administered drugs that do not have a rebate-eligible NDC will not be reimbursed by Texas Medicaid.

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for additional information on claim filing using NDC.

The VDP CAD Search for more information.

11.5.1 Pharmacy Delivery Method for Clinician-Administered Drugs

Providers administering clinician-administered drugs in an outpatient setting for clients enrolled in Medicaid (both traditional and managed care) can send a prescription to a pharmacy and wait for the drug to be shipped or mailed to their office. This delivery method is called "white-bagging."

Providers should use the following steps for this delivery method:

1) The treating provider identifies that the client is enrolled in Medicaid.
2) The treating provider or treating provider's agent sends a prescription to a Texas Medicaid-enrolled pharmacy and obtains any necessary prior authorizations.
3) If any prior authorization is approved, the dispensing pharmacy fills the prescription and overnight ships an individual dose of the medication, in the client's name, directly to the treating provider.
4) The treating provider administers the medication in the office setting. The provider bills for an administration fee and any medically necessary service provided at time of administration. The provider should not bill Medicaid for the drug.

The pharmacy contacts the provider each month, prior to dispensing any refills, to ensure that the client received all previously dispensed medication. Auto-refills are not allowed.

These medications cannot be used on any other client and cannot be returned to the pharmacy for credit.

Exception: *Unused long-acting reversible contraceptives may be returned in certain circumstances.*

Note: *Physicians who use this delivery method will not have to buy the clinician-administered drug, therefore, the physician is allowed to administer the drug and should only bill for the administration of the drug.*

11.6 Opioid Limitations

For many people, substance use disorder starts after initially receiving opioid prescriptions for an episode of acute pain. To encourage the appropriate use of opioids and reduce the over-prescribing of opioids, Texas Medicaid has implemented the requirements in this section.

11.6.1 Affected Clients

The requirements in this section do not apply to clients who are:

- Receiving hospice care or palliative care
- Being treated for cancer
- Residing in a long-term care facility
- Residing in a facility in which residents receive opioid substitution therapy for the treatment of opioid use disorder (OUD).

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The requirements also do not apply to other clients that HHSC elects to exempt based on an objective, confirmable physical pathology known to cause severe chronic pain that is not ameliorated by other therapies and for which opioid treatment is appropriate (e.g., sickle cell disease). If diagnoses are not available in the medical data, prescribers can request exemptions on a case-by-case basis through the pharmacy prior authorization process.

11.6.2 Morphine Milligram Equivalents

Morphine milligram equivalents (MME) per day is used to compare the potency of one opioid to another. The clinical decision for the MME per day recommendations varies depending on the person's opioid use. Additionally, the Centers for Disease Control and Prevention (CDC) recommends starting opioid treatment with an immediate-release/short-acting formulation at the lowest effective dose instead of an extended-release/long-acting formulation.

A client is considered "opioid naive" if the client has taken opioids for a duration that is less than or equal to seven days in the last 60 days. For clients who are opioid naive, providers must submit a one-time prior authorization request for:

- An opioid prescription that exceeds a ten-day supply.
- A prescription for a long-acting opioid formulation.
- A claim or combination of claims in which the total daily dose of opioids exceeds 90.

The one-time requirement for prior authorization does not apply to subsequent claims because the member will no longer be opioid naive. The duration of the prior authorization is equal to the days' supply of the claim.

For clients who are not opioid naïve, prior authorization is required for opioid prescriptions if the total daily dose of opioids exceeds 90 MME. For those patients who may require a tapering plan, providers would determine the development and management of a patient specific course of therapy to help manage withdrawal symptoms. A prescriber may request a tapering plan through the pharmacy prior authorization process on a case-by-case basis. Prior authorization approvals last for six-months.

11.6.3 Days' Supply Limit

Opioid prescriptions for the treatment of acute pain are rarely required for more than ten days. To reduce the risk of addiction and the diversion of unused opioids, opioid prescriptions for clients who are opioid naïve are limited to a maximum ten-day supply without prior authorization.

11.6.4 Fee-For-Service Three Prescription Limit

Prescriptions for opioids to treat acute pain for clients who are 21 years of age and older are exempt from the three-prescription-per-month limit for members in fee-for-service.

12 Patient Information

12.1 Medicaid Drug Benefits

Clients enrolled in traditional Medicaid are limited to three prescriptions per month with the following exceptions:

- Clients enrolled in waiver programs such as Community Living Assistance (CLASS) and Community-Based Alternatives (CBA)
- Texas Health Steps (THSteps)-eligible clients (clients who are 20 years of age and younger)
- Clients in skilled nursing facilities

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The following categories of drugs do not count against the three prescription per month limit:

- Family planning drugs and supplies
- Smoking cessation drugs
- Insulin syringes

Note: *Prescriptions for family planning drugs and limited home health supplies are not subject to the three-prescription limit.*

Though TMHP reimburses family planning agencies and physicians for family planning drugs and supplies, the following family planning drugs and supplies are also available through the VDP and are not subject to the three-prescription limit:

- Oral contraceptives
- Long-acting injectable contraceptives
- Vaginal ring
- Hormone patch
- Certain drugs used to treat sexually transmitted diseases (STDs)

12.2 Cost Avoidance Coordination of Benefits

Cost avoidance coordination of benefits for pharmacy claims ensures compliance with CMS regulations. Under federal rules, Medicaid agencies must be the payer of last resort. The cost avoidance model checks for other known insurance at point of sale, preventing Medicaid from paying a claim until the pharmacy attempts to obtain payment from the client's primary third party insurance.

12.3 Medicaid Children's Services Comprehensive Care Program

Medically-necessary drugs and supplies that are not covered by the VDP may be available to children and adolescents (birth through 20 years of age) through the Medicaid Comprehensive Care Program (CCP). Drugs and supplies not covered could include, as examples, some over-the-counter drugs, nutritional products, diapers, and disposable or expendable medical supplies.

The Prior Authorization fax number is 1-512-514-4212.

Refer to: Subsection 2.8.1.1, "Pharmacies (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about pharmacy enrollment in CCP.

12.4 Pharmacy Lock-In

Clients enrolled in traditional Medicaid can be "locked-in" to a specific primary care pharmacy. Those clients will have "Lock-in" identified on the face of their Your Texas Benefits Medicaid card. Clients who are not "locked-in" to a specific pharmacy may obtain their drugs or supplies from any enrolled Medicaid pharmacy.

Refer to: Subsection 4.3.2, "Client Lock-in Program" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information about lock-in limitations.

Family planning services are excluded from lock-in limitation.

12.5 Free Delivery of Medicaid Prescriptions

Many Medicaid pharmacies offer free delivery of prescriptions to clients enrolled in Medicaid.

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To find out which pharmacies offer delivery services:

- Refer clients enrolled in traditional Medicaid to the VDP Pharmacy Search. Click the "Delivers" indicator on the search. The returned results will include only those pharmacies that provide a delivery service. These HHSC-enrolled pharmacies have certified their delivery services meet the minimum conditions for the payment of the delivery fee. These certified delivery pharmacies are reimbursed a delivery fee that is included in the medication dispensing formula.
- Refer clients enrolled in Medicaid managed care to their respective health plan. Each health plan develops its own participating pharmacy network for the delivery service.

Deliveries are made to client's home and not institutions, such as nursing homes. Delivery service is not applicable for mail-order prescriptions and not is available for over-the-counter drugs.

Refer to: The VDP Pharmacy Search on the VDP website.

12.6 Medication Synchronization

12.6.1 Overview

Medication Synchronization establishes processes for early refills in order to align the filling or refilling of multiple medications for a client with chronic illnesses.

The Texas Insurance Code §1369(j) allows a client enrolled in Medicaid, their prescribing physician, or the dispensing pharmacist to initiate the medication synchronization request. This process allows for clients to pick up all their medication on a single day each month versus requiring clients to make multiple pharmacy visits to obtain different prescription medications with different refill dates.

12.6.2 Eligible Medications

A drug is eligible for medication synchronization if it meets the following conditions:

- It is listed on the Medicaid, CHIP, KHC or CSHCN formulary.
- It is used for treatment and management of chronic illnesses.
- It is a formulation or dosage form that can be effectively dispensed in a medication synchronization protocol.
- It must meet all prior authorization criteria applicable to the medication on the date the synchronization request is made. This includes clinical prior authorizations, non-preferred prior authorizations, and drug utilization review edits.
- The original prescription must have refills.

Exception: *The prescription could be new but the drug is categorized with the same Generic Code Number (GCN) class, and if the pharmacy uses the override code, the claim will pay. Having available refills is not required.*

A claim cannot be synchronized if it is a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

12.6.3 Chronic Illness

Medications eligible for synchronization must be used to treat chronic illnesses. A chronic illness is defined as an illness or physical condition that is:

- Reasonably expected to continue for an uninterrupted period of at least three months, and
- Controlled, but not cured by medical treatment. This includes drugs used to treat mental health conditions and substance use.

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12.6.4 Traditional Medicaid Claims Processing

A synchronized claim will count as one of the three prescriptions Medicaid will pay if a client is limited.

12.6.5 Medicaid Managed Care and CHIP Claims Processing

Each health plan has an HHSC-approved process for medication synchronization for clients eligible for Medicaid or CHIP. In CHIP, cost sharing or co-payment amounts will be prorated. Dispensing fees will not be prorated.

Pharmacy staff should contact the client's health plan for medication synchronization requirements using the contact information on the MCO Search page.

Refer to: The VDP MCO Search on the VDP website.

13 Pharmacy Prior Authorization

Some Medicaid drugs are subject to one or both types of prior authorization, clinical and non-preferred.

13.1 Clinical Prior Authorization

Clinical prior authorizations utilize evidence-based clinical criteria and nationally recognized peer-reviewed information. These prior authorizations may apply to an individual drug or a drug class on the formulary, including some preferred and non-preferred drugs. There are specific clinical prior authorizations that all health plans are required to perform. Usage of all other clinical prior authorizations will vary between health plans and at the discretion of each health plan.

Some clinical prior authorizations require prescribing providers to submit forms for clients enrolled in traditional Medicaid. Refer to each form's instruction page linked below for submission requirements and instructions. Prescribing providers must submit each form below with the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits (TDI Form NOFR002). and submit by fax to the Texas Prior Authorization Call Center at 866-469-8590.

Health plans may require prior authorization for these drugs. Providers should contact the appropriate health plan for specific requirements and forms.

Drug Name	Number
Cystic Fibrosis Treatment Agents (Kalydeco, Orkambi, and Symdeko)	HHS Form 1338
Increlex	HHS Form 1357
Phosphate Binders	HHS Form 1348
Synagis Refer to: Subsection 10.7, "Palivizumab (Synagis)" in this section for information about Synagis prior authorizations.	HHS Form 1321
Xyrem	HHS Form 1356

Refer to: The Clinical Prior Authorization Assistance Chart is available on the VDP website https://www.txvendordrug.com/sites/default/files/docs/cpa-assistance-chart.pdf. It identifies each health plans prior authorization and how those authorizations relate to the authorizations used for traditional Medicaid claim processing. The chart is updated quarterly.

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13.2 Non-preferred Prior Authorization

The PDL is arranged by drug therapeutic class and contains a subset of many, but not all, drugs that are on the Medicaid formulary. Drugs are identified as preferred or non-preferred on the PDL. Drugs listed on the PDL as preferred, or those not listed at all, are available without PDL prior authorization. Drugs identified as non-preferred on the PDL require a PDL prior authorization.

Refer to: Medicaid health plans are required to adhere to the Texas Medicaid Preferred Drug List.

Note: *CHIP does not have a PDL.*

Refer to: The PDL Prior Authorization Criteria Guide that explains the criteria that are used to evaluate the PDL prior authorization requests.

13.3 Obtaining Prior Authorization

Prior authorization for clients enrolled in traditional Medicaid is requested through the Texas Prior Authorization Call Center.

The Texas Prior Authorization Call Center accepts prior authorization requests by phone at 1-877-PA-TEXAS (1-877-728-3927) (Monday through Friday, between 7:00 a.m. to 7:00 p.m., Central time) or online through the VDP Provider Portal. Online submissions are only available for non-preferred prior authorization requests. The prescriber can submit both clinical and non-preferred prior authorization requests online.

Refer to: The VDP Provider Portal Registration User Manual and the VDP Provider Portal User Manual.

The VDP Prescriber Prior Authorization Manual.

Note: *Pharmacists cannot obtain prior authorization for medications. If the client arrives at the pharmacy without prior authorization for a non-preferred drug and/or a drug requiring clinical prior authorization, the pharmacist will alert the provider's office and ask the provider to get prior authorization.*

13.4 Prior Authorization Reconsideration

The prescribing provider may request reconsideration if the prior authorization request is denied.

13.4.1 Managed Care

Prescribing providers should refer to the VDP MCO Search to find each MCO's prior authorization call center to learn about their reconsideration or appeal processes.

13.4.2 Fee-for-service Medicaid

The Texas Prior Authorization Call Center will notify prescribing providers of their right to request a reconsideration of the decision rendered. Providers should complete the Medicaid Fee-for-Service Prior Authorization Reconsideration Request (HHS Form 1322) and submit it to the Texas Prior Authorization Call Center. Refer to the form's instruction page for requirements and submission instructions. Providers may also include supporting documentation with their form submission, including:

- Medication documentation, such as the patient's medical records or lab results supporting the medical reason for the treatment
- Peer-reviewed literature supporting the safety, efficacy, and rationale for using the medication outside the current Medicaid criteria, if applicable

The Texas Prior Authorization Call Center will mail a copy of the reconsideration determinations to the requesting provider and client. The client's letter will include the HHSC prior authorization appeal process if the reconsideration request is denied.

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13.5 72-Hour Emergency Supply

Federal and Texas law allows for a 72-hour emergency supply of a prescribed drug to be provided when a medication is needed without delay and prior authorization is not available. This rule applies to non-preferred drugs on the PDL and any drug that is affected by a clinical prior authorization.

Drugs not on the PDL may also be subject to clinical prior authorization.

14 Retrospective Drug Utilization Reviews

Retrospective DUR provides for the ongoing periodic examination of claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribing providers, pharmacists, and people associated with specific drugs or groups of drugs.

The retrospective review also allows for active and ongoing educational outreach in the form of letters or face-to-face discussions to educate prescribing providers on common drug therapy problems with the aim of improving prescribing or dispensing practices.

The Texas Drug Utilization Review Board reviews and recommends interventions for traditional Medicaid claims. A fixed-number of interventions are performed each calendar year. MCOs are required to create and perform interventions and education of their population.

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PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human Services

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES HANDBOOK

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1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

The information in this handbook is intended for therapy services for clients of all ages. Therapy services include occupational therapy (OT), physical therapy (PT), and speech therapy (ST). The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these therapies.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

All providers are required to report suspected child abuse and neglect, as outlined in subsection 1.7, "Provider Responsibilities" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2 Enrollment

Refer to: Subsection 1.7.18, "Physical, Occupational, and Speech Therapy Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for enrollment information.

3 Managed Care Organization (MCO) Clients Who Transition to Medicaid Fee-For-Service (FFS)

When client's transition from an MCO to FFS, providers can request previously approved authorizations be transferred from the MCO to FFS for Comprehensive Care Program (CCP) services, OT, PT, and ST.

3.1 Submission Guidelines

The following submission time frames apply for providers that request to transfer previously approved MCO authorizations for PT, OT, and ST services:

- TMHP will consider the reimbursement of claims for services that were rendered on or after the MCO's disenrollment date only when the provider submits a request to TMHP to transfer the previously approved authorization for PT, OT, and ST services.

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- The request to TMHP must be received on or before the end date of the previously approved MCO authorization. Any requests submitted after the MCO's authorization end date will have to meet the regular submission guidelines for the specific service type.

3.2 Documentation Requirements

All of the requests to transfer the authorizations from the MCO to FFS must include:

- A copy of the previously approved authorization letter.
- All of the documentation that was sent in the original authorization request, including any orders by the prescribing provider that were used to determine the start of care. TMHP will accept the prescribing provider orders as the required documentation for the requested services.
- The completed CCP prior authorization form, Special Medical Prior Authorization (SMPA) form, Home Health Plan of Care, or Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form whichever is applicable for the requested service. The form must include the dates of service and quantities that are being requested from TMHP, and they must match the dates of service and quantities that were approved in the original MCO authorization. It is not necessary to obtain signatures or dates on the forms if they are submitted to TMHP for the purpose of transferring an authorization from an MCO to FFS Medicaid.

  Note: *Authorizations for services transferred from an MCO to FFS Medicaid are subject to retrospective review.*

TMHP will verify the client's eligibility, the dates of service, and the quantities requested. TMHP will process reimbursement claims as follows:

- Claims for services that were rendered before the date on which the transfer request was received will be denied as a late submission, and the provider will be notified of their administrative appeal rights through the Health and Human Services Commission (HHSC).
- Claims for services that were rendered on or after the date of receipt use the required information from the transferred authorization and will be processed as if the request was received in a timely manner.

If a request to transfer an MCO authorization is submitted after the end date of the MCO authorization or the provider does not have an authorization letter from the MCO, TMHP will process the request to transfer the authorization based on established TMHP authorization submission guidelines for PT, OT, and ST services.

All new requests for rendered services must meet the documentation requirements.

3.3 New Services and Extension of Services

For new services that occur after the client's MCO disenrollment change date, the provider is responsible for submitting all TMHP required paperwork and meeting all established submission guidelines for prior authorization.

Requests for the extension of services that occur after the MCO disenrollment change date must include all of the paperwork that is required by TMHP and meet all established submission guidelines for prior authorization.

3.4 Loss of Eligibility

If an MCO disenrolled a client and the client also loses Medicaid eligibility, providers must anticipate, if and when Medicaid eligibility is restored, that the client will initially be considered a Medicaid FFS client and will have a retroactive eligibility period.

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All requests for services that require prior authorization and that occur during the client's retroactive eligibility period, must be submitted to TMHP following the process that is outlined in subsection 5.1.1, "Prior Authorization Requests for Clients with Retroactive Eligibility" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*).

If a client is retroactively disenrolled by an MCO, all of the services that are rendered by the provider during this retroactive disenrollment period (specifically from the date on which the client was eligible for FFS to the date of the client's MCO eligibility change) will be denied by TMHP, and the provider will be notified of their administrative appeal rights.

TMHP may consider services for the MCO transition beginning on the date of the client's MCO eligibility change date and going forward. TMHP uses the MCO transition process for the submission of paperwork and the processing of provider requests.

4 Therapy Services Overview

Physical, occupational and speech therapy services must be medically necessary to the treatment of the individual's chronic or acute need. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, all of the following conditions must be met:

- The services requested must be considered under the accepted standards of practice to be a specific and effective treatment for the patient's condition.
- The services requested must be of a level of complexity or the patient's condition must be such that the services required can only be effectively performed by or under the supervision of a licensed occupational therapist, physical therapist, or speech-language pathologist, and requires the skills and judgment of the licensed therapist to perform education and training.
- Functional goals refer to a series of behaviors or skills that allow the client to achieve an outcome relevant to his/her health, safety, or independence within the context of everyday environments. Functional goals must be specific to the client, objectively measurable within a specified time frame, attainable in relation to the client's prognosis or developmental delay, relevant to client and family, and based on a medical need.
- For clients who are 20 years of age and younger, the following conditions must be met:
  - The goals of the requested services to be provided are directed at improving, adapting, restoring, or maintaining functions which have been lost or impaired due to a recent illness, injury, loss of body part or congenital abnormality or as a result of developmental delay or the presence of a chronic medical condition.
  - Testing must establish a client with developmental delays meets the medical necessity criteria as defined in subsection 5.3, "Developmental Delay Criteria" in this handbook for chronic therapy services.
  - Evidence of care coordination with the prescribed pediatric extended care center (PPECC) provider, when the client receives therapy services in a PPECC setting.
- For clients who are 21 years of age and older, the following conditions must be met:
  - The goals of the requested services to be provided are directed at improving, adapting or restoring functions which have been lost or impaired due to a recent illness, injury, loss of body part and restore client's function to within normal activities of daily living (ADL).
  - There must be reasonable expectation that therapy will result in a meaningful or practical improvement in the client's ability to function within a reasonable and predictable time period.

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Medical necessity criteria for therapy services provided in the home must be based on the supporting documentation of the medical need and the appropriateness of the equipment, service, or supply prescribed by the prescribing provider for the treatment of the individual.

The therapy service must be related to the client's medical condition, rather than primarily for the convenience of the client or provider.

Frequency must always be commensurate with the client's medical and skilled therapy needs, level of disability (for clients who are 20 years of age and younger), and standards of practice; it is not for the convenience of the client or the responsible caregivers.

The following apply:

- Treatment plans and plans of care developed must include not only the initial frequency (high, moderate or low) but the expected changes of frequency throughout the duration period requested based on the client's anticipated therapy treatment needs.
- An example of a tapered down frequency request initiated with a high frequency is: 3 times a week for 2 weeks, 2 times a week for 2 weeks, 1 time a week for 2 weeks, 1 time every other week).

Refer to: Subsection 4.6, "Frequency and Duration Criteria for PT, OT, and ST Services" in this handbook for the frequency prior authorization criteria.

Therapy services are limited to one evaluation, re-evaluation or treatment up to the limits outlined in this handbook for each therapy discipline per date of service.

4.1 Physical Therapy

The practice of physical therapy includes:

- Measurement or testing of the function of the musculoskeletal, or neurological, system.
- Rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, or birth defect.
- Treatment, consultative, educational, or advisory services to reduce the incidence or severity of disability or pain to enable, train, or retrain a person to perform the independent skills and activities of daily living.

Texas Medicaid limits physical therapy to the skilled treatment of clients who have acute or acute exacerbation of chronic disorders or chronic medical condition of the musculoskeletal and neuromuscular systems. Physical therapy may be provided by a prescribing provider or physical therapist within their licensed scope of practice.

4.2 Occupational Therapy

The practice of occupational therapy includes:

- Evaluation and treatment of a person whose ability to perform the tasks of living is threatened or impaired by developmental deficits, sensory impairment, physical injury, or illness.
- Using therapeutic goal-directed activities to:
  - Evaluate, prevent, or correct physical dysfunction.
  - Maximize function in a person's life.
- Applying therapeutic goal-directed activities in treating patients on an individual basis, in groups, or through social systems, by means of direct or monitored treatment or consultation.

Texas Medicaid limits occupational therapy to the skilled treatment of clients whose ability to function in life roles is impaired. Occupational therapy may be provided by a prescribing provider or occupational therapist within their licensed scope of practice.

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Occupational therapy uses purposeful activities to obtain or regain skills needed for activities of daily living (ADL) and/or functional skills needed for daily life lost through acute medical condition, acute exacerbation of a medical condition, or chronic medical condition related to injury, disease, or other medical causes. ADLs are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming, and mobility.

4.3 Speech Therapy

Speech therapy is a benefit of Texas Medicaid for the treatment of chronic (for clients who are 20 years of age and younger), acute, or acute exacerbations of pathological or traumatic conditions of the head or neck, which affect speech production, speech communication and oral motor, feeding and swallowing disorders. Speech therapy may be provided by a prescribing provider or speech language pathologist within their licensed scope of practice.

Speech-language pathologists treat speech sound and motor speech disorders, stuttering, voice disorders, aphasia and other language impairments, cognitive disorders, social communication disorders and swallowing (dysphagia) deficits.

Speech therapy is designed to ameliorate, restore, or rehabilitate speech language communication and swallowing disorders that have been lost or damaged as a result of a chronic, acute or acute exacerbation of a medical condition due to a recent injury, disease or other medical conditions, or congenital anomalies or injuries.

4.3.1 Types of Communication Disorders

There are three types of communication disorders:

- Language Disorders—Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, and syntax), content and meaning of language (pragmatics) and/or the perception/processing of language. Language disorders may involve one, all or a combination of the above components.
- Speech Production Disorders—Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production Disorders may involve one, all or a combination of these components of the speech production system. An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal and/or apraxia, dysarthria.
- Oral Motor/Swallowing/Feeding Disorders—Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

4.4 Co-Treatment

Co-treatment is defined as two different therapy disciplines performing therapy on the same client at the same time by a licensed therapist as defined in this handbook for each therapy discipline, and rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners and State Board of Examiners for Speech-Language Pathology and Audiology.

Co-treatment may be a benefit when it is medically necessary for the client to receive therapy from two different therapy disciplines at the same time. The therapy performed requires the expertise of two different disciplines (i.e., licensed physical therapist, licensed occupational therapist, or licensed speech-language pathologist), to perform the therapy safely and effectively to reach the client's goals as determined by the approved plan of care, signed and dated by the client's prescribing provider.

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When performing co-treatment, a primary therapist must be designated by the two performing therapists. Only the primary performing therapist may bill for the therapy services rendered. The secondary therapist will not be reimbursed for assisting a designated primary performing therapist.

The following co-treatment documentation requirements must be maintained in the client's medical records as follows:

- Medical necessity for the individual therapy services must be justified before performing co-treatment.
- Documentation supports co-treatment goals and how co-treatment will help the therapist achieve the therapist's goals for the client, for each therapy discipline.
- An explanation of why the client requires and will receive multi-disciplinary team care, defined as at least two therapy disciplines (physical, occupational, or speech therapy) during the same therapy session.

Retrospective review may be performed to ensure documentation supports that the medical necessity of the co-treatment performed and that the billing was appropriate for the services provided by the designated primary-performing therapist.

4.5 Telehealth Services

Providers must defer to the needs of the person receiving services, allowing the mode of service delivery (synchronous audiovisual or in-person) to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

Evaluation, reevaluation, and treatment of some PT, OT, and ST services may be provided by synchronous audiovisual technology.

Telehealth services for OT, PT or ST by synchronous audiovisual technology are allowed for specific procedure codes if clinically appropriate as determined by the practitioner, per standard of care, safe, agreed to by the person receiving services or by the legally authorized representative (LAR), and in compliance with each discipline's rules.

The following procedure codes may be provided by synchronous audiovisual technology:

- Physical Therapy Evaluations- Low, Moderate, and High Complexity and re-evaluation (procedure codes 97161, 97162, 97163, 97164)
- Occupational Therapy Evaluation– Low, Moderate, and High Complexity and re-evaluation (procedure codes 97165, 97166, 97167, 97168)
- PT or OT Services (individual or group) (procedure codes 97110, 97112, 97116, 97150, 97530, 97535, 97750, 97537)
- Community reintegration (procedure code 97537) may be provided if the person receiving services is currently receiving other therapeutic procedure codes and may not be billed separately.
- Speech Evaluations and re-evaluations (procedure codes 92521, 92522, 92523, 92524, 92610, S9152)
- ST (individual or group) services (procedure codes 92507, 92508, 92526)
- The provider should obtain informed consent for treatment from the patient, patient's parent, or the patient's legal guardian prior to rendering a telehealth service. Verbal consent is permissible and should be documented in the client's medical record.
- Services delivered by synchronous audiovisual technology may require participation of a caregiver or parent to assist with the treatment.

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- Therapy assistants may deliver services and receive supervision by synchronous audiovisual technology within limits outlined in each discipline's rules. Providers should refer to state practice rules and national guidelines regarding supervision requirements for each discipline.
- Providers must use modifier 95 to indicate remote delivery. Providers are reminded to use the required modifiers GP, GO, and GN on all claims for physical, occupational, or speech therapy treatment

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth documentation requirements including requirements for informed consent.

Note: *Telehealth services must adhere to documentation, privacy and security requirements as outlined in this handbook and those in theTelecommunication Services Handbook (Vol. 2, Provider Handbooks).*

4.5.1 Group Therapy

Group therapy consists of simultaneous treatment to two or more clients who may or may not be doing the same activities. If the therapist is dividing attention among the clients, providing only brief, intermittent personal contact, or giving the same instructions to two or more clients at the same time, the treatment is recognized as group therapy. The prescribing provider or therapist involved in group therapy services must be in constant attendance, but one-on-one client contact is not required.

The following requirements must be met in order to meet the Texas Medicaid criteria for group therapy:

- Prescribing provider's prescription for group therapy.
- Performance by or under the general supervision of a qualified licensed therapist as defined by licensure requirements.
- The licensed therapist involved in group therapy services must be in constant attendance (in the same room) and active in the therapy.
- Each client participating in the group must have an individualized treatment plan for group treatment, including interventions and short-and long-term goals and measurable outcomes.

Texas Medicaid does not limit the number of clients who can participate in a group therapy session. Providers are subject to certification and licensure board standards regarding group therapy.

4.5.1.1 Group Therapy Documentation Requirements

The following documentation must be maintained in the client's medical record:

- Prescribing provider's prescription for group therapy.
- Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals.
- Name and signature of licensed therapist providing supervision over the group therapy session.
- Specific treatment techniques utilized during the group therapy session and how the techniques will restore function.
- Start and stop times for each session.
- Group therapy setting or location.

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- Number of clients in the group.

The client's medical record must be made available upon request.

4.6 Frequency and Duration Criteria for PT, OT, and ST Services

Frequency must always be commensurate with the client's medical and skilled therapy needs, level of disability and standards of practice; it is not for the convenience of the client or the responsible adult.

Exceptions to therapy limitations may be covered if the medically necessary criteria are met for the following:

- Presentation of new acute condition
- Therapist intervention is critical to the realistic rehabilitative/restorative goal, provided documentation proving medical necessity is received.

When therapy is initiated, the therapist must provide education and training of the client and responsible caregivers, by developing and instructing them in a home treatment program to promote effective carryover of the therapy program and management of safety issues.

Providers may request high, moderate, or low frequencies on the Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Form by indicating 3, 2, or 1 time per week respectively. Providers may request low or maintenance level by requesting 1, 2, or 3 times per month. Additional documentation is required when requesting a frequency of 3 times a week or more.

> ***Note:*** *The reference to "maintenance" in the above statement is applicable to clients who are 20 years of age and younger.*

4.6.1 High Frequency

High frequency (3 times per week) can only be considered for a limited duration (approximately 4 weeks or less) or as otherwise requested by the prescribing provider with documentation of medical need to achieve an identified new skill or recover function lost due to surgery, illness, trauma, acute medical condition, or acute exacerbation of a medical condition, with well-defined specific, achievable goals within the intensive period requested.

Therapy provided three times a week may be considered for 2 or more of these exceptional situations:

- The client has a medical condition that is rapidly changing.
- The client has a potential for rapid progress (e.g., excellent prognosis for skill acquisition) or rapid decline or loss of functional skill (e.g., serious illness, recent surgery).
- The client's therapy plan and home program require frequent modification by the licensed therapist.

On a case-by-case basis, a high frequency requested for a short-term period (4 weeks or less) which does not meet the above criteria may be considered with all of the following documentation:

- Letter of medical need from the prescribing provider documenting the client's rehabilitation potential for achieving the goals identified,
- Therapy summary documenting all of the following:
  - Purpose of the high frequency requested (e.g., close to achieving a milestone)
  - Identification of the functional skill which will be achieved with high frequency therapy
  - Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved.

A higher frequency (4 or more times per week) may be considered on a case-by-case basis with clinical documentation supporting why 3 times a week will not meet the client's medical needs.

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4.6.2 Moderate Frequency

Therapy provided two times a week may be considered when documentation shows one or more of the following:

- The client is making very good functional progress toward goals.
- The client is in a critical period to gain new skills or restore function or is at risk of regression.
- The licensed therapist needs to adjust the client's therapy plan and home program weekly or more often than weekly based on the client's progress and medical needs.
- The client has complex needs requiring ongoing education of the responsible adult.

4.6.3 Low Frequency

Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:

- The client is making progress toward the client's goals, but the progress has slowed, or documentation shows the client is at risk of deterioration due to the client's development or medical condition.
- The licensed therapist is required to adjust the client's therapy plan and home program weekly to every other week based on the client's progress.
- Every other week therapy is supported for clients whose medical condition is stable, they are making progress, and it is anticipated the client will not regress with every other week therapy.

Note: *As the client's medical need for therapy decreases, it is expected that the therapy frequency will decrease as well.*

4.6.4 Maintenance Level/Prevent Deterioration

For clients who are 20 years of age and younger only, this frequency level (e.g., every other week, monthly, every 3 months) is used when the therapy plan changes very slowly, the home program is at a level that may be managed by the client or the responsible adult, or the therapy plan requires infrequent updates by the skilled therapist. A maintenance level or preventive level of therapy services may be considered when a client requires skilled therapy for ongoing periodic assessments and consultations and the client meets one of the following criteria:

- Progress has slowed or stopped, but documentation supports that ongoing skilled therapy is required to maintain the progress made or prevent deterioration.
- The submitted documentation shows that the client may be making limited progress toward goals or that goal attainment is extremely slow.
- Factors are identified that inhibit the client's ability to achieve established goals (e.g., the client cannot participate in therapy sessions due to behavior issues or issues with anxiety).
- Documentation shows the client and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the client's needs.

4.6.5 Requesting Therapy Services

Providers may request physical, occupational, or speech therapy services frequency by week for one or more visits per week, or by month for 1, 2, or 3 visits per month.

- A week includes the day of the week on which the prior authorization period begins and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday.

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- The number of therapy services authorized for a week or month must be contained in that prior authorization period.
- Services billed, in excess of those authorized are subject to recoupment.

Missed visits may be made up within the authorization period as long as total number of visits or units authorized does not exceed the amount authorized. Provider should document reason for visits outside of the weekly or monthly frequency in the client's medical record.

4.7 Criteria for Discontinuation of Therapy

Discontinuation of therapy may be considered in one or more of the following situations:

- Client no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care.
- Client has returned to baseline function.
- Client can continue therapy with a home treatment program and deficits no longer require a skilled therapy intervention and, for clients who are 20 years of age and younger only, maintain status.
- Client has adapted to impairment with assistive equipment or devices.
- Client is able to perform ADLs with minimal to no assistance from caregiver.
- Client has achieved maximum functional benefit from therapy in progress or will no longer benefit from additional therapy.
- Client is unable to participate in the treatment plan or plan of care due to medical, psychological, or social complications; and responsible adult has had instruction on the home treatment program and the skills of a therapist are not needed to provide or supervise the service.
- Testing shows client no longer has a developmental delay.
- Plateau in response to therapy/lack of progress towards therapy goals. Indication for therapeutic pause in treatments or, for those under age 21, transition to chronic status and maintenance therapy.
- Non-compliance due to poor attendance and with client or responsible adult, non-compliance with therapy and home treatment program.

4.8 Exclusions (Non-covered Services)

The following services are not a benefit of Texas Medicaid:

- Speech therapy provided in the home to adult clients who are 21 years of age and older
- Therapy services that are provided after the client has reached the maximum level of improvement or is now functioning within normal limits
- Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition
- Separate reimbursement for VitalStim therapy for dysphagia. VitalStim must be a component of a comprehensive feeding treatment plan to be considered a benefit.
- Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached, which no longer require the skills of a therapist to provide or oversee
- Therapy services related to activities for the general good and welfare of clients who are not considered medically necessary because they do not require the skills of a therapist, such as:
    - General exercises to promote overall fitness and flexibility or improve athletic performance

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  - Activities to provide diversion or general motivation
  - Supervised exercise for weight loss
- Treatment solely for the instruction of other agency or professional personnel in the client's physical, occupational or speech therapy program
- Emotional support, adjustment to extended hospitalization and/or disability, and behavioral readjustment
- Therapy prescribed primarily as an adjunct to psychotherapy
- Treatments not supported by medically peer-reviewed literature, including but not limited to investigational treatments such as sensory integration, vestibular rehabilitation for the treatment of attention deficit hyperactivity disorder, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, low-energy neuro-feedback, and the Wilbarger brushing protocol.
- Therapy not expected to result in practical functional improvements in the client's level of functioning
- Treatments that do not require the skills of a licensed therapist to perform in the absence of complicating factors (i.e., massage, general range of motion exercises, repetitive gait, activities and exercises that can be practiced by the client on their own or with a responsible adult's assistance)
- The therapy requested is for general conditioning or fitness, or for educational, recreational or work-related activities that do not require the skills of a therapist
- Equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided
- Therapy services provided by a licensed therapist who is the client's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage)

Auxiliary personnel (aide, orderly, student, or technician) may participate in physical therapy, occupational therapy, or speech therapy sessions when they are appropriately supervised according to each therapy discipline's scope of practice and provider licensure requirements. Providers may not bill Texas Medicaid for therapy services provided solely by auxiliary personnel

Auxiliary personnel, a licensed therapy assistant, and a licensed speech-language pathology intern (Clinical Fellow) are not eligible to enroll as therapist providers in Texas Medicaid.

4.8.1 Telehealth Exclusions

Texas Medicaid does not reimburse for PT, OT, or ST delivered through synchronous telephone (audio-only) technology. Certain procedure codes are not reimbursable for any telehealth service delivery. The following procedure codes must be provided in-person:

Procedure codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97113	97124	97140	97542	97760	97761	97763
97799									

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5 Children's Therapy Services Clients birth through 20 years of age

5.1 Services, Benefits, and Limitations

This section addresses acute and chronic physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services for clients who are 20 years of age or younger. This section does not address freestanding inpatient rehabilitation services.

Unless otherwise specified, "days" refers to calendar days.

PT, OT, and ST are benefits of Texas Medicaid in Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs) for clients who are 20 years of age or younger.

Note: *CORF and ORF services provided at schools, homes, daycare facilities, or any other non-Medicare approved ORF or CORF facility is not a covered Comprehensive Care Program (CCP) benefit.*

Services provided to a client on school premises are only permitted when delivered before or after school hours. The only PT, OT, and ST services that can be delivered during school hours are therapy services provided by school districts as School Health and Related Services (SHARS).

Clients who are eligible for PT, OT, and ST through the public school system (SHARS), may only receive additional therapy through Medicaid if medical necessity criteria is met as outlined in this handbook.

Refer to: Subsection 2.9, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for the specific guidelines for therapy services that are provided through Early Childhood Intervention (ECI).

Section 2.1.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about therapy services provided through SHARS.

Therapy services must be performed by one of the following: a licensed physical therapist, licensed occupational therapist, licensed speech-language pathologist, a prescribing provider within their scope of practice, or one of the following under the supervision of a licensed therapist of the specific discipline:

- Licensed therapy assistant
- Licensed speech-language pathology intern (Clinical Fellow)

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of therapy services on behalf of the client's prescribing provider when the prescribing provider delegates this authority to the APRN or PA.*

PT, OT, and ST services are provided in one of the following places of service by setting and provider:

Place of Service	Provider Types
Office	Physician, physical/occupational therapy group, independently enrolled therapist, podiatrist, SHARS and ECI
Home	Home health agency, independently enrolled therapist, physical/occupational therapy group, ECI, SHARS
Outpatient	Physician: podiatrist, outpatient hospital/clinic, outpatient rehabilitation center (includes comprehensive outpatient rehabilitation facility [CORF]/outpatient rehabilitation facility [ORF]) PPECC: home health agency, independently enrolled therapist, physical/occupational therapy group, ECI
Other	ECI, SHARS, independently enrolled therapist, home health agency, and physical/occupational therapy group

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In determining whether a service requires the skill of a licensed physical and occupational therapist or speech language pathologist, consideration must be given to the inherent complexity of the service, the condition of the client, the accepted standards of medical and therapy practice guidelines, with consideration of the following:

- If the service could be performed by the average nonmedical person, the absence of a competent person (such as a family member or medical assistant) to perform it does not cause it to be a skilled therapy service.
- If the nature of a service is such that it can be safely and effectively performed by the average nonmedical person without direct supervision of a licensed therapist, the services cannot be regarded as skilled therapy.

Refer to: Subsection 2.1, "CCP Overview" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about CCP.

5.1.1 Acute PT, OT, and ST Services

Acute PT, OT, and ST services are benefits of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition.

Treatments are expected to significantly improve, restore or develop physical functions diminished or lost as a result of a recent trauma, illness, injury, disease, surgery, or change in medical condition, in a reasonable and generally predictable period of time (60 days), based on the prescribing provider's and therapist's assessment of the client's restorative potential.

Note: *Recent is defined as occurring within the past 90 days of the prescribing provider's evaluation of condition.*

Treatments are directed towards restoration of or compensation for lost function.

Services do not duplicate those provided concurrently by any other therapy.

Services must meet acceptable standards of medical practice and be specific and effective treatment for the client's condition.

Services are provided within the provider's scope of practice, as defined by state law.

Acute is defined as an illness or trauma with a rapid onset and short duration.

A medical condition is considered chronic when 120 days have passed from the start of therapy or the condition is no longer expected to resolve or may be slowly progressive over an indefinite period of time.

With documentation of medical need physical, occupational, and speech therapy may continue for a maximum of 120 days for an acute medical condition or an acute exacerbation of a chronic medical condition.

Once the client's condition is no longer considered acute, continued therapy for a chronic condition will only be considered for clients who are 20 years of age or younger.

5.1.2 Chronic Services

Chronic physical, occupational, and speech therapy services are benefits of Texas Medicaid for the medically necessary treatment of chronic medical conditions and developmental delay when a medical need is established for the developmental delay as indicated in this handbook. All eligible clients who are birth through 20 years of age may continue to receive all medically necessary therapy services, with documentation proving medical necessity.

The goals of the services provided are directed at maintaining, improving, adapting, or restoring functions which have been lost or impaired due to a recent illness, injury, loss of body part, congenital abnormality, degenerative disease, or developmental delay.

Services do not duplicate those provided concurrently by any other therapy.

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Services must meet acceptable standards of medical practice and be specific and effective treatment for the client's condition.

Services are provided within the provider's scope of practice, as defined by state law.

Treatment for chronic medical conditions and developmental delay will only be considered for clients who are birth through 20 years of age.

5.2 Authorization Requirements for PT, OT, and ST Services

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

Providers must list all relevant procedure codes on the Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form when requesting prior authorization for therapy services.

Therapy services performed in the acute care inpatient setting do not require prior authorization.

Coverage periods do not coincide necessarily with calendar weeks or months, but cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization period.

5.2.1 Initial Evaluation and Considerations for Prior Authorization for Treatment

Initial evaluations do not require prior authorization (procedure codes 92521, 92522, 92523, 92524, 92610, 97161, 97162, 97163, 97165, 97166, and 97167); however, documentation kept in the client's record must include a signed and dated prescribing provider's order for the evaluation, support a medical need for the therapy evaluation, and be available when requested.

A therapy evaluation is considered current when it is performed within 60 days before the prior authorization request is received.

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization requirements documentation through fax or mail, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To complete the prior authorization process electronically, the provider must complete and submit the prior authorization requirements documentation through any approved electronic method, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To avoid unnecessary denials, the prescribing provider must provide correct and complete information, including documentation of medical necessity for the service(s) requested. The prescribing provider must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

Therapy services, regardless of place or provider, occurring after the initial evaluation, require prior authorization. PT, OT, or ST services may be prior authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client's daycare facility or the client's school.

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5.2.1.1 Initial Evaluation for Acute and Chronic Therapy Services

For acute therapy services, i.e. acute services billed with an AT modifier, prior authorization requests may not exceed a 60 day period per each request. After two 60 day authorized periods, any continued requests for therapy services must be considered under the chronic sections of this handbook.

For chronic therapy services, prior authorization may be granted for up to 180 days with documentation of medical necessity and additional prior authorizations.

Initial prior authorization (PA) requests must be received no later than five business days from the date therapy treatments are initiated. Requests received after the five-business-day period will be denied for dates of service that occurred before the date that the PA request was received.

All of the following documentation is required when submitting an initial request for therapy services initiated after the completion of the evaluation for acute or chronic services:

- A completed Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form signed and dated by both the therapist and by the prescribing provider is required. When the request form is unsigned by the prescribing provider, it must be accompanied by a signed and dated written order or prescription or a documented verbal order delineating the prescribed therapy services.
- The prescribing provider must certify that the Texas Health Steps (THSteps) checkup is current or that a developmental screening has been performed within the last 60 days. Signature of prescribing provider on PA form will attest that this service has been provided. If prescribing provider provides verbal order or written order separate from PA form, staff member who conveys the verbal or written order must communicate that prescribing provider attests that THSteps checkup is current or that a developmental screening has been performed within the last 60 days.
- For acute services: Documentation from the prescribing provider that a visit for the acute or acute exacerbation of the medical condition requiring therapy has occurred within the last 90 days.
- Evaluation and Treatment Plan or Plan of Care (POC) with all of the following required elements:
  - Client's medical history and background
  - All medical diagnoses related to the client's condition
  - Date of onset of the client's condition requiring therapy or exacerbation date as applicable
  - Date of evaluation
  - Time in and time out
  - Baseline objective measurements based on standardized testing performed or other standard assessment tools

Refer to: Subsection 5.3, "Developmental Delay Criteria" in this handbook for information about chronic services.

  - Safety risks
  - Client-specific, measurable short and long-term functional goals within the length of time the service is requested
  - Interpretation of the results of the evaluation, including recommendations for therapy amount, frequency per week and duration of services
  - Therapy treatment plan/POC to include specific modalities and treatments planned
  - Documentation of client's primary language
  - Documentation of client's age and date of birth
  - Adaptive equipment or assistive devices, as applicable

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- Prognosis for improvement
- Requested dates of service for planned treatments after the completion of the evaluation
- Responsible adult's expected involvement in client's treatment
- History of prior therapy and referrals as applicable
- Signature and date of treating therapist

5.2.2 Additional Evaluation and Documentation Requirements for Speech Therapy

Additional evaluation and documentation requirements for speech therapy include one or more of the following:

- Language evaluations—Oral-peripheral speech mechanism examination and formal or informal assessment of hearing, articulation, voice and fluency skills;
- Speech production (voice)—Formal screening of language skills, and formal or informal assessment of hearing, voice and fluency skills;
- Speech production (fluency and articulation)—Formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills;
- Oral Motor/Swallowing/Feeding—In addition to formal screening of language skills, formal or informal assessment of hearing, voice, and fluency skills, if swallowing problems and/or signs of aspiration are noted, then a statement indicating that a referral has been made to the client's prescribing provider to consider a video fluoroscopic swallow study must be included.

5.2.2.1 Bilingual Testing Requirements

Bilingual and multilingual speakers are frequently misclassified as developmentally delayed. Equivalent proficiency in both languages should not be expected.

Criterion-referenced assessment tools can be used to identify and evaluate a client's strengths and weaknesses, as opposed to norm-referenced testing, which assesses an individual relative to a group.

When possible, use culturally and linguistically adapted test equivalents in both languages to compare potential deficits and include in the documentation. The therapist will show the highest score of the two languages to determine whether the child qualifies and which language will be used for the child's therapy. Testing for all subsequent re-evaluations should only be conducted in the language used in therapy.

5.2.3 Written and Verbal Orders

For new authorizations and recertifications of therapies, if the submitted request form is not signed and dated by the prescribing provider, the request must be accompanied by a verbal or written order.

The request form or written or verbal order must be signed and dated within the 60-day period before the initiation of services. A prescribing provider's order to evaluate and treat is acceptable for the evaluation or re-evaluation, but is not acceptable for the therapy treatment. The therapy treatment order must contain the prescribing provider's ordered frequency, duration, and affirmation that the client's THSteps checkup is current or that a developmental screening has been performed within the last 60 days.

The documentation for a verbal order must meet the following criteria:

- It must be signed and dated by the licensed professional who by state and federal law may take a verbal order.
- It must have the name and credentials of the licensed professional who took the order and who is responsible for furnishing or supervising the ordered services.

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- The verbal order must include the date on which the verbal order was taken.
- The verbal order must include the services, frequency, and duration that was prescribed by the ordering provider.

5.2.4 Requests for Recertification—Acute Therapy Services

A recertification for prior authorization of acute therapy services may be considered up to a maximum of 60 day increments, when services continue to meet authorization criteria. Re-evaluation codes (procedure codes 97164, 97168, and S9152) require authorization for acute therapy services and must be submitted with the recertification request. Therapy for clients who are birth through 20 years of age who do not meet the acute therapy services criteria may be considered for chronic therapy services.

Recertification for an acute or acute exacerbation of medical conditions includes a progress summary and a Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Form.

A complete recertification request must be received no earlier than 30 days before the current authorization period expires. Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

Prior authorization for recertification requests may be considered for increments up to 60 days for each therapy service request, with documentation supporting the medical necessity including all of the following:

- Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Form or electronic equivalent signed and dated by the therapist and signed and dated by the prescribing provider. When the request form is unsigned by the prescribing provider, it must be accompanied by a written order or prescription or a verbal order for the prescribed therapy services.
- A progress summary (see progress summary documentation requirements), and
- A revised treatment plan or plan of care for the recertification dates of service requested, including all of the following:
    - Date therapy services started
    - Changes in the treatment plan, the rationale and the requested change in frequency of visits for changing the plan
    - Documentation of reasons continued therapy services are medically needed
    - Documentation of client's participation in treatment, as well as client or responsible adult's participation or adherence with a home treatment program
    - New treatment plan or plan of care for the recertification dates of service requested
    - Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable
    - Adaptive equipment or assistive devices, as applicable
    - Prognosis with clearly established discharge criteria
- Documentation of consults with other professionals and services or referrals made and coordination of service when applicable (e.g., for school aged clients, documentation of the coordination of care and referrals made for school therapies).
- The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

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A progress summary, which may be contained in the last treatment note, must be included with the recertification request and contains all of the following:

- Date therapy started
- Date the summary completed
- Time period (dates of service) covered by the summary
- Client's medical and treatment diagnoses
- A summary of client's response to therapy and current treatment plan, to include:
  - Documentation of any issues limiting the client's progress
  - Documentation of objective measures of functional progress related to each treatment goal established on the initial evaluation
  - An assessment of the client's therapy prognosis and overall functional progress
  - Documentation of client's participation in treatment as well as client or responsible adult's participation or adherence with a home treatment program
  - Updated or new functional and measurable short and long-term treatment goals with time frames, as applicable
  - Documentation of client's continued need for therapy
  - Clearly established discharge criteria
  - Documentation of consults with other professionals and services or coordination of service when applicable.
- The progress summary must be signed and dated by the therapist responsible for the therapy services.

5.2.5 Requests for Recertification - Chronic Therapy Services

5.2.5.1 Re-evaluation (every 180 days)

A re-evaluation is a comprehensive evaluation and must take place every 180 days and contains all the elements of an initial evaluation, including affirmation that the client's THSteps checkup is current or that a developmental screening was performed by the prescribing provider within the last 60 days. It may be used to make a determination whether or not skilled therapy is medically necessary, or when determining the effectiveness of the current plan, or when the current plan requires significant modification and revision of the interventions and goals due to changes in the client's medical status or lack of progress with the current treatment. A re-evaluation requires authorization and must be submitted with the recertification request (procedure codes 97164, 97168, and S9152).

Routine reassessments that occur during each treatment session or visit or for a progress report required for an extension of services or discharge summary are not considered a comprehensive re-evaluation.

Tests used must be norm-referenced, standardized, and specific to the therapy provided.

Refer to: Subsection 5.3, "Developmental Delay Criteria" in this handbook for information about documentation about developmental delay criteria.

A recertification request may be considered when services will be medically needed after the previously approved authorization period ends.

A complete request must be received no earlier than 30 days before the current authorization period expires.

Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the request is received.

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A re-evaluation may occur as early as 60 days prior to the end of the current authorization period.

A therapy re-evaluation is considered current when it is performed within 60 days before the current authorization period expires.

The re-evaluation must occur within 30 days of the signed and dated order from the referring provider.

Prior authorization for recertification requests may be considered for increments up to 180 days for each request with documentation supporting the medical necessity including all of the following:

- Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form or electronic equivalent signed and dated by the therapist and by the prescribing provider. When the request form is unsigned by the prescribing provider, it must be accompanied by a written order or prescription or a verbal order for the prescribed therapy services.
- A re-evaluation must include a revised treatment plan or plan of care including all of the following:
  - Documentation that the THSteps checkup is current or that a developmental screening was performed by the prescribing provider within the last 60 days

    Note: *Additional documentation is not necessary if the prescribing provider signs the Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form.*
  - Date therapy services started
  - Changes in the treatment plan, the rationale, and the requested change in frequency of visits
  - Documentation of reasons continued therapy services are medically needed
  - Documentation of developmental delay

Refer to: Subsection 5.3, "Developmental Delay Criteria" in this handbook for information about documentation about developmental delay criteria.

  - Documentation of client's participation in treatment, as well as client or responsible adult's participation or adherence with a home treatment program
  - New treatment plan or POC for the recertification dates of service requested
  - Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable. Previous authorization period's goals and progress must be included.
  - Prognosis with clearly established discharge criteria. The discharge plan must reflect realistic expectations from the episode of therapy.
  - Documentation of consults with other professionals and services or referrals made and coordination of service when applicable (e.g., for school aged clients, documentation of the coordination of care and referrals made for school therapies)
  - The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

5.2.6 Requests for Revisions to Existing Prior Authorizations or Recertification for Acute and Chronic Therapy Services

A revision to an existing authorization/recertification must be documented in the client's record when significant changes occur in the frequency or treatment plan. When frequency is increased, or services requiring separate authorization are added, a request for revision must be submitted for prior authorization.

Requests for revisions must be received no later than five business days from the date the revised therapy treatments are initiated. Requests for revisions received after the five business day period will be denied for dates of service that occurred before the date the request was received.

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A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revision must be submitted with the following documentation:

- Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form, including the date the revision was initiated, signed and dated by the therapist and signed and dated by the prescribing provider. When the request form is not signed and dated by the prescribing provider, it must be accompanied by a written order or prescription or a verbal order for the prescribed services.
- Progress summary for acute services indicating the medical rationale for the change requested, and
- Updated treatment plan or POC addressing all the elements of the previous plan and addressing all revisions to the services planned, including updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable. Previous authorization period's goals and progress must be included.
- The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

5.2.7 Change of Therapy Provider

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider outside the current group or agency, they must start a new request for authorization and submit all documentation required for an initial evaluation, and also the following:

- A change-of-therapy provider letter, signed by the client or responsible adult
- The letter must document the date that the client ended therapy (effective date of change) with the previous provider, or last date of service
- The name of the new provider and previous provider

When a provider or client discontinues therapy during an existing prior authorization period and the client requests services through a new provider located within the same enrolled group of providers or within a group of independently enrolled providers collaboratively working together, the new provider can use the same evaluation and plan of care.

The authorization period will not change when the provider changes.

5.2.8 Treatment Note

The following documentation must be kept on file by the treating provider and be available when requested:

- Client's name
- Date of service
- Time in and out of each therapy session
- Objectives addressed (should coincide with plan of care) and progress noted, if applicable
- A description of specific therapy services provided and the activities rendered during each therapy session, along with a form of measurement.
- Assessments of client's progress or lack of progress
- Treatment notes must be legible
- Therapy providers must sign each date of entry with full signature and credentials

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All documentation for evaluations, re-evaluations, progress summaries, treatment notes, and discharge summaries must show client's name, date of service, time in and time out of each therapy session.

Note: *Documentation requirements for a telehealth service are the same as what is required for an in-person visit and must accurately reflect the services rendered. Additionally, documentation must identify the means of delivery when provided by telehealth.*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth services documentation requirements.

5.3 Developmental Delay Criteria

To establish a developmental delay, all of the following criteria must be met:

- Tests used must be norm-referenced, standardized, and specific to the therapy provided.
- Retesting with norm-referenced standardized test tools for re-evaluations must occur every 180 days. Tests must be age appropriate for the child being tested and providers must use the same testing instrument as used in the initial evaluation. If reuse of the initial testing instrument is not appropriate, i.e. due to change in client status or restricted age range of the testing tool, provider should explain the reason for the change.
- Eligibility for therapy will be based upon a score that falls 1.5 standard deviations (SD) or more below the mean in at least one subtest area of composite score on a norm-referenced, standardized test. Raw scores must be reported along with score reflecting SD from mean.
- When the client's test score is less than 1.5 SD below the mean, a criterion-referenced test along with informed evidenced-based clinical opinion must be included to support the medical necessity of services and will be sent to physician review to determine medical necessity.
- If a child cannot complete norm-referenced standardized assessments, then a functional description of the child's abilities and deficits must be included. Measurable functional short and long term goals will be considered along with test results. Documentation of the reason a standardized test could not be used must be included in the evaluation.

Specific developmental delay criteria requirements for speech diagnoses are as follows:

- Language—at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
- Articulation—at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
- Apraxia—at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
- Fluency—at least one norm-referenced, standardized test with good reliability, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
- Voice—a medical evaluation is required for eligibility and based on medical referral
- Oral Motor/Swallowing/Feeding—an in-depth, functional profile of oral motor structures and function

If the client's test score is less than 1.5 SD below the mean, additional documentation supporting the client's medical need for therapy will be considered and the request will be sent to physician review to determine medical necessity.

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Additional speech therapy visits or sessions may be considered for moderate speech language, articulation, voice and dysphagia developmental delays when documentation submitted supports medical necessity as delineated in the frequency criteria in this handbook.

5.4 Age Adjustment for Children Born Prematurely

Age is adjusted for children born before 37 weeks gestation and is based on a 40-week term. The developmental age must be measured against the adjusted age rather than chronological age until the child is 24 months old. The age adjustment cannot exceed 16 weeks.

5.5 PT, OT, and ST Procedure Codes

PT, OT, and ST treatment procedure codes are either time-based and billable in units or untimed and billable per daily encounter.

5.5.1 Timed PT and OT Treatment Procedure Codes

All time-based PT and OT treatment procedure codes are cumulatively limited to one hour per date of service per discipline (4 units).

The following time-based PT and OT treatment procedure codes must be billed in 15 minute increments and are limited to a combined total of 2 units (thirty minutes) per date of service per discipline:

Procedure Codes	
97034	97035

The following time-based PT and OT treatment procedure code must be billed in 15 minute increments, is limited to a combined total of 3 units (45 minutes) per date of service per discipline, and is not payable in the home or other setting:

Procedure Codes
97036

The following time-based PT and OT treatment procedure codes must be billed in 15 minute increments and are limited to a combined total of 4 units (one hour) per date of service per discipline:

Procedure Codes									
97032	97033	97110	97112	97113	97116	97124	97140	97530	97535
97537	97542	97750	97760	97761	97763				

Note: *Procedure code 97113 is not payable to home health agencies.*

5.5.2 Untimed PT and OT Treatment Procedure Codes

The following supervised modality PT and OT treatment procedure codes are limited to once per date of service per procedure code and must be delivered on the same date of service as one or more time-based PT and OT procedure codes and are subject to CMS NCCI relationships:

Procedure Codes							
97012	97014	97016	97018	97022	97024	97026	97028

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The following PT and OT group therapy treatment procedure code is limited to once per date of service:

Procedure Codes
97150

Separate prior authorization is required for medically necessary therapeutic procedures not addressed by procedure codes outlined in this handbook.

The following procedure code requires supporting documentation indicating why an unlisted procedure code is required and is limited to once per date of service:

Procedure Codes
97799

If the therapy treatment services that are billed exceed one hour (four units per day), the claim will be denied, and it may be appealed. On appeal, the provider must meet the following conditions:

- The appeal must document the prior authorization period week or month for the date of service appealed.
- The appeal must include an attestation that the provider has billed all therapy services for the week or month in question.

For clients who are 20 years of age and younger, when physical or occupational group therapy is administered, providers can bill procedure code 97150 for each member of the group.

A client may receive therapy in more than one discipline (physical, occupational, or speech) in more than one setting (outpatient, office or home setting) in one day.

5.5.3 ST Treatment Procedure Codes

Individual speech treatment is limited to one encounter per date of service any provider. Only one of the following individual speech treatment procedure codes will be reimbursed per date of service:

Procedure Codes	
92507	92526

An encounter for speech therapy individual treatment is defined as face-to-face time with the patient and/or caregiver for a length of time compliant with nationally recognized professional speech-language pathology standards for a typical session.

The following group speech therapy procedure code is limited to once per date of service:

Procedure Codes
92508

5.5.4 PT, OT, and ST Evaluation and Re-evaluation Codes

Evaluation and re-evaluation procedure codes in the following table are untimed:

Procedure Codes									
92521	92522	92523	92524	92610	97161	97162	97163	97164	97165
97166	97167	97168	S9152						

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5.5.5 PT, OT, and ST Reimbursement Guidelines

If a therapy evaluation or re-evaluation procedure code and like therapy procedure code are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

Therapy services provided in the nursing home setting are limited to the nursing facility because these services must be made available to nursing home residents on an "as needed" basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources. Nursing home facilities should refrain from admitting clients who need goal directed therapy if the facility is unable to provide these services.

Procedure codes for PT, OT, and ST evaluations are payable once every three years to the same rendering provider.

For acute services, PT, OT, and ST re-evaluations may be reimbursed once every 60 days to any provider when a recertification of services is planned.

For chronic services, PT, OT, and ST re-evaluations are reimbursed once every 180 days to any provider when a recertification of services is planned.

Additional PT, OT, or ST evaluations or re-evaluations exceeding the limits outlined in this handbook may be considered for with documentation of one of the following:

- A significant change in the client's medical condition as documented in the plan of care or treatment plan
- A change of provider has occurred and a change of provider letter is submitted with the appeal.
- The re-evaluation is required for recertification of an existing authorization.

The following procedure codes are billable for telehealth services:

Procedure Codes									
92507	92508	92521	92522	92523	92524	92526	92610	97110	97112
97116	97150	97161	97162	97163	97164	97165	97166	97167	97168
97530	97535	97750	97537	S9152					

Therapy services may be billed when rendered in a PPECC even if the provider would typically be restricted to a home setting. Home health providers rendering therapy services in a PPECC must include the PPECC's NPI number on their institutional claim form, in addition to their own NPI. Therapy providers who bill using a professional claim form must include the PPECC name and NPI number on the claim and indicate outpatient hospital as the place of service. The therapy provider and PPECC must have a written agreement for each client related to the provision of therapy services provided at the PPECC. The written agreement must address responsibilities of both parties, and how the parties will coordinate related to the client's plan of care. The written agreement must be maintained in the client's medical record.

A modifier must be used to indicate when treatment services have been rendered by a licensed therapist/ prescribing provider or a therapy assistant under supervision of a licensed therapist. Providers must use modifier 95 for services delivered by synchronous audiovisual technology.

The following modifiers are not required for evaluation or re-evaluation codes because those services may not be rendered by therapy assistants.

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Modifier	Description
UB	Services delivered by a licensed therapy assistant under supervision of a licensed therapist
U5	Services delivered by a licensed therapist or physician

5.5.6 Therapy Co-Treatment

Claims for co-treatment services must be submitted with modifier U3:

Modifier	Description
U3	Therapy Co-Treatment Modifier

Claims for telehealth must be submitted with modifier 95:

Modifier	Description
95	Services delivered by synchronous audiovisual technology

6 Adult Services

6.1 Services, Benefits, and Limitations

Unless otherwise specified, "days" refers to calendar days.

Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services are benefits of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition for clients who are 21 years of age and older.

Treatments are expected to significantly improve, restore, or develop physical functions diminished or lost as a result of a recent trauma, illness, injury, disease, surgery, or change in medical condition, in a reasonable and generally predictable period of time (60 days), based on the prescribing provider's and therapist's assessment of the client's restorative potential.

Note: *Recent is defined as occurring within the past 90 days of the prescribing provider's evaluation of condition.*

Treatments are directed towards restoration of or compensation for lost function.

Services do not duplicate those provided concurrently by any other therapy.

Services must meet acceptable standards of medical practice and be specific and effective treatment for the client's condition.

Services are provided within the provider's scope of practice, as defined by state law.

Acute is defined as an illness or trauma with a rapid onset and short duration.

Adult therapy services are limited to a maximum of 120 days per identified acute medical condition or acute exacerbation of a chronic medical condition requiring therapy or whenever the maximum benefit from therapy has been achieved, whichever comes first.

A medical condition is considered chronic when 120 days have passed from the start of therapy, or the condition is no longer expected to resolve or may be slowly progressive over an indefinite period of time.

Physical and occupational therapy services for acute conditions are benefits of Texas Medicaid for adult clients in the office, outpatient, and home settings.

Speech therapy services for acute conditions are benefits of Texas Medicaid for adult clients in the office and outpatient setting only.

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Therapy services must be performed by one of the following:

- Licensed physical therapist
- Licensed occupational therapist
- Licensed speech-language pathologist
- Physician within their scope of practice

Therapy services may also be performed by one of the following under the supervision of a licensed therapist of the specific discipline:

- Licensed therapy assistant
- Licensed speech-language pathology intern (Clinical Fellow)

6.1.1 Adult Acute Therapy Place of Service

PT and OT providers render acute therapy services for adult clients who are 21 years of age and older in one of the following places of service:

Place of Service	Provider types
Office	Physician; podiatrist; independently enrolled therapist; physical/occupational therapy group
Home	Home health agency; independently enrolled physical therapist; and physical/occupational therapy group
Outpatient	Physician; podiatrist; outpatient hospital/clinic
Other	Independently enrolled therapist; home health agency; physical/occupational therapy group

ST providers render acute therapy services for adult clients who are 21 years of age and older in one of the following places of service:

Place of Service	Provider types
Office	Physician; independently enrolled speech-language pathologist
Outpatient	Physician; outpatient hospital/clinic

In determining whether a service requires the skill of a licensed therapist, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and therapy practice guidelines.

If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a skilled therapy service.

If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed therapist, the services cannot be regarded as skilled therapy.

6.2 Authorization Requirements for Outpatient and Home Health —PT, OT, and ST Services

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

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Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

Coverage periods do not coincide necessarily with calendar weeks or months, but cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization period.

6.2.1 Initial Evaluation and Considerations for Prior Authorization for Treatment

Initial evaluations do not require prior authorization (procedure codes 92521, 92522, 92523, 92524, 92610, 97161, 97162, 97163, 97165, 97166, and 97167); however, documentation kept in the client's record must include a signed and dated prescribing provider's order for the evaluation, support a medical need for the therapy evaluation and be available when requested.

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization requirements documentation through fax or mail, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To complete the prior authorization process electronically, the provider must complete and submit the prior authorization requirements documentation through any approved electronic method, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment, supplies, and services requested and is subject to retrospective review. The prescribing provider must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

Therapy services, regardless of place or provider, occurring after the initial evaluation, require prior authorization. Prior authorization requests may not exceed a 60 day period.

Prior authorization (PA) requests must be received no later than five business days from the date therapy treatments following the evaluation are initiated. Requests received after the five-business-day period will be denied for dates of service that occurred before the date that the PA request is received.

6.2.1.1 Documentation

All of the following documentation is required when submitting an initial request for therapy services initiated after the completion of the evaluation:

- A completed Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form signed and dated by the therapist and signed and dated by the prescribing provider is required). When the request form is unsigned by the prescribing provider, it must be accompanied by a signed and dated written order, or prescription, or a documented verbal order delineating the prescribed therapy services.
- Documentation of the acute or acute exacerbation of the medical condition requiring therapy. Evaluation and Treatment Plan or Plan of Care (POC) with all of the following required elements:
  - Client's medical history and background
  - All medical diagnoses related to the client's condition
  - Date of onset of the client's condition requiring therapy, or exacerbation date as applicable
  - Date of evaluation

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- Baseline objective measurements documented based on any testing performed
- Explanation of how identified limitations impair the overall function of the client
- Safety risks
- Client-specific, measurable short and long-term functional goals within the length of service time requested
- Interpretation of the results of the evaluation, including recommendations for therapy amount, frequency per week and duration of services
- When a client also receives PPECC services, indicate if therapy services will be delivered in a PPECC setting, the amount, frequency, and duration of the therapy services to be delivered in a PPECC setting in contrast with other locations (e.g., the home)
- Therapy treatment plan/POC to include specific modalities and treatments planned
- Documentation of client's primary language
- Documentation of client's age and date of birth
- Adaptive equipment or assistive devices, as applicable
- Prognosis for improvement
- Time in and time out on evaluation
- Requested dates of service for planned treatments after the completion of the evaluation
- Responsible adult's expected involvement in client's treatment
- History of prior therapy and referrals as applicable
- Signature and date of treating therapist

Additional requirements for speech therapy include one or more of the following:

- Language evaluations—oral-peripheral speech mechanism examination and formal or informal assessment of hearing, articulation, voice and fluency skills.
- Speech production (voice)—formal screening of language skills, and formal or informal assessment of hearing, voice and fluency skills.
- Speech production (fluency)—formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills.
- Oral Motor/Swallowing/Feeding—If swallowing problems and/or signs of aspiration are noted, then include a statement indicating that a referral for a video fluoroscopic swallow study has been made; formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills.

6.2.2 Written and Verbal Orders

For new authorizations and recertifications of therapies, if the submitted request form is not signed and dated by the prescribing provider, the request must be accompanied by a verbal or written order.

The request form or written or verbal order must be signed and dated within the 60-day period before the initiation of services. A prescribing provider's order to evaluate and treat is acceptable for the evaluation or re-evaluation, but is not acceptable for the therapy treatment. The therapy treatment order must contain the prescribing provider's ordered frequency and duration.

The documentation for a verbal order must meet the following criteria:

- It must be signed and dated by the licensed professional who by state and federal law may take a verbal order.

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- It must have the name and credentials of the licensed professional who took the order and who is responsible for furnishing or supervising the ordered services.
- The verbal order must include the date on which the verbal order was taken.
- The verbal order must include the services and the frequency and duration that was prescribed by the ordering provider.

6.2.3 Requests for Recertification-Up to an Additional 60 days for Acute Services

A recertification request may be considered when services will be medically needed after the previously approved authorization period ends.

Re-evaluation codes (procedure codes 97164, 97168, and S9152) require prior authorization and must be submitted with the recertification request. Required documentation for recertifications includes a progress summary and Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form.

A complete recertification request must be received no earlier than 30 days before the current authorization period expires. Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

One recertification request may be considered for an additional 60 days for each therapy service request with documentation supporting the medical necessity including all of the following:

- Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form or electronic equivalent signed and dated by the therapist and signed and dated by the ordering provider. When the request form is unsigned by the provider, it must be accompanied by a written order or prescription or a verbal order for the prescribed therapy services.
- A progress summary (see progress summary documentation requirements), and
- An updated treatment plan or POC for the recertification dates of service requested, including all of the following:
  - Date therapy services started
  - Changes in the treatment plan, the rationale and the requested change in frequency of visits for changing the plan
  - Documentation of reasons continued therapy services are medically needed
  - Documentation of client's participation in treatment, as well as client and responsible adult's participation or adherence with a home treatment program
  - Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable
  - Adaptive equipment or assistive devices, as applicable
  - Prognosis with clearly established discharge criteria
  - Documentation of consults with other professionals and services or referrals made and coordination of service when applicable
  - The updated treatment plan or plan of care must be signed and dated by the therapist responsible for the therapy services.

A progress summary which may be contained in the last treatment note, must be included with the recertification request and contains all of the following:

- Date therapy started

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- Date the summary completed
- Time period (dates of service) covered by the summary
- Client's medical and treatment diagnoses
- A summary of client's response to therapy and current treatment plan, to include:
  - Documentation of any issues limiting the client's progress
  - Documentation of objective measures of functional progress related to each treatment goal established on the initial evaluation
  - An assessment of the client's therapy prognosis and overall functional progress
  - Documentation of client's participation in treatment as well as client and responsible adult's participation or adherence with a home treatment program
  - Updated or new functional and measurable short and long-term treatment goals with time frames, as applicable
  - Documentation of client's continued need for therapy
  - Clearly established discharge criteria
  - Documentation of consults with other professionals and services or coordination of service when applicable.
- The progress summary must be signed and dated by the therapist responsible for the therapy services.

6.2.4 Requests for Revisions to Existing Prior Authorization or Recertification

A revision to an existing authorization/recertification must be documented in the client's record when significant changes occur in the frequency or treatment plan. When the frequency is increased or services requiring separate authorization are added, a request for revision must be submitted for prior authorization.

Requests for revisions must be received no later than five business days from the date the revised therapy treatments are initiated.

Requests for revisions received after the five business day period will be denied for dates of service that occurred before the date the request was received.

- A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.
- Requests for revision must be submitted with the following documentation:
  - Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form, including the date the revision was initiated, signed, and dated by the therapist and signed and dated by the prescribing provider. When the request form is not signed and dated by the prescribing provider, it must be accompanied by a written order or prescription or a verbal order for the prescribed services.
  - Progress summary including the medical rationale for the change requested, and
- Updated treatment plan or POC addressing all the elements of the previous plan and addressing all revisions to the services planned, including updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable. Previous authorization period's goals and progress must be included.
- The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

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6.2.5 Change of Therapy Provider

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider outside the current group or agency, they must start a new request for authorization and submit all documentation required for an initial evaluation, and also all of the following:

- A change-of-therapy provider letter signed by the client or responsible adult,
- The letter must document the date that the client ended therapy (effective date of change) with the previous provider, or last date of service,
- The name of the new provider and previous provider

When a provider or client discontinues therapy during an existing prior authorization period and the client requests services through a new provider located within the same enrolled group of providers or within a group of independently enrolled providers collaboratively working together, the new provider can use the same evaluation and plan of care.

The authorization period will not change when the provider changes.

6.2.6 Treatment Note

The following documentation must be kept on file by the treating provider and available when requested:

- Client's name
- Date of service
- Time in and out of each therapy session
- Objectives addressed (should coincide with plan of care) and progress noted, if applicable
- A description of specific therapy services provided and the activities rendered during each therapy session, along with a form of measurement.
- Assessments of client's progress or lack of progress
- Treatment notes must be legible
- Therapy providers must sign each date of entry with full signature and credentials

All documentation for evaluations, re-evaluations, progress summaries, treatment notes, and discharge summaries must show client's name, date of service, time in and time out for each therapy session.

Note: *Documentation requirements for a telehealth service are the same as what is required for an in-person visit and must accurately reflect the services rendered. Additionally, documentation must identify the means of delivery when provided by telehealth.*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth services documentation requirements.

6.3 PT, OT, and ST Procedure Codes

PT, OT, and ST treatment procedure codes are either time-based and billable in units or untimed and billable per daily encounter.

6.3.1 PT and OT Treatment Procedure Codes

All time-based PT and OT treatment procedure codes are cumulatively limited to one hour per date of service per discipline (4 units).

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The following time-based PT and OT treatment procedure codes must be billed in 15 minute increments and are limited to a combined total of 2 units (thirty minutes) per date of service per discipline:

Procedure Codes	
97034	97035

The following time-based PT and OT treatment procedure code must be billed in 15 minute increments, is limited to a combined total of 3 units (45 minutes) per date of service per discipline, and is not payable in the home or other setting:

Procedure Codes
97036

The following time-based PT and OT treatment procedure codes must be billed in 15 minute increments and are limited to a combined total of 4 units (one hour) per date of service per discipline:

Procedure Codes									
97032	97033	97110	97112	97113	97116	97124	97140	97530	97535
97537	97542	97750							

Note: *Procedure code 97113 is not payable to home health agencies.*

6.3.2 Untimed PT and OT Treatment Procedure Codes

The following supervised modality PT and OT treatment procedure codes are limited to once per date of service per procedure code and must be delivered on the same date of service as one or more time-based PT and OT procedure code(s) and are subject to CMS NCCI relationships:

Procedure Codes							
97012	97014	97016	97018	97022	97024	97026	97028

The following PT and OT group therapy treatment procedure code is limited to once per date of service:

Procedure Codes
97150

Separate prior authorization is required for medically necessary therapeutic procedures not addressed by procedure codes outlined in this handbook.

The following procedure code requires supporting documentation indicating why an unlisted procedure code is required and is limited to once per date of service:

Procedure Codes
97799

If the therapy treatment services that are billed exceed one hour (four units per day), the claim will be denied, and it may be appealed. On appeal, the provider must meet the following conditions:

- The appeal must document the prior authorization period week or month for the date of service appealed.

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- The appeal must include an attestation that the provider has billed all therapy services for the week or month in question.

For clients who are 21 years of age and older, when physical or occupational group therapy is administered, providers should bill procedure code 97150 for each member of the group.

A client may receive therapy in more than one discipline (physical, occupational, or speech) in the outpatient, office or home setting in one day.

6.3.3 ST Treatment Procedure Codes

Individual speech treatment is limited to one encounter per date of service any provider. Only one of the following individual speech treatment procedure codes will be reimbursed per date of service:

Procedure Codes	
92507	92526

An encounter for speech therapy individual treatment is defined as face-to-face time with the patient and/or caregiver for a length of time compliant with nationally recognized professional speech-language pathology standards for a typical session.

The following group speech therapy procedure code is limited to once per date of service:

Procedure Codes
92508

6.3.4 PT, OT, and ST Evaluation and Re-evaluation Procedure Codes

Evaluation and re-evaluation procedure codes in the following table are untimed:

Procedure Codes									
92521	92522	92523	92524	92610	97161	97162	97163	97164	97165
97166	97167	97168	S9152						

6.3.5 PT, OT, and ST Reimbursement Guidelines

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

Therapy services provided in the nursing home setting are limited to the nursing facility because these services must be made available to nursing home residents on an "as needed" basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources. Nursing home facilities should refrain from admitting clients who need goal directed therapy if the facility is unable to provide these services.

Procedure codes for PT, OT, ST evaluations are payable once every three years to the same rendering provider.

For acute services, PT, OT, ST re-evaluations may be reimbursed once every 60 days to any provider when a recertification of services is planned.

Additional PT, OT, or ST evaluations or re-evaluations exceeding the limits outlined in this handbook may be considered for reimbursement on appeal with documentation of one of the following:

- A significant change in the client's medical condition as documented in the plan of care or treatment plan,

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- A change of provider has occurred and a change of provider letter is submitted with the appeal.

The re-evaluation is required for recertification of an existing authorization.

The following procedure codes are billable for telehealth services:

Procedure Codes									
92507	92508	92521	92522	92523	92524	92526	92610	97110	97112
97116	97150	97161	97162	97163	97164	97165	97166	97167	97168
97530	97535	97750	97537	S9152					

A modifier must be used to indicate when treatment services have been rendered by a licensed therapist/ prescribing provider or a therapy assistant under supervision of a licensed therapist. Providers must use modifier 95 for services delivered by synchronous audiovisual technology.

The following modifiers are not required for evaluation or re-evaluation codes because those services may not be rendered by therapy assistants:

Modifier	Description
UB	Services delivered by a licensed therapy assistant under supervision of a licensed therapist
U5	Services delivered by a licensed therapist or physician

This modifier is to be utilized as indicated with all physical, occupational, and speech therapy treatment procedure codes.

Claims for co-treatment services must be submitted with modifier U3:

Modifier	Description
U3	Therapy Co-Treatment Modifier

Claims for telehealth must be submitted with modifier 95:

Modifier	Description
95	Services delivered by synchronous audiovisual technology

7 Claims Filing and Reimbursement

7.1 Claims Information

Therapy services must be submitted to TMHP in an approved electronic format or on a 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. Claims may be filed electronically in a CMS-1500 format as long as the nine-digit prior authorization number is reflected in the equivalent electronic field.

CORF and ORF providers must submit services in an approved electronic claims format or on the UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms. Revenue and Current Procedural Terminology (CPT) procedure codes are used when submitting claims for CORF and ORF services. The only POS is outpatient facility (POS 5).

When completing a CMS-1500 or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

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Refer to: Subsection 2.8, "Home Health Agency Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for additional claim information for Home Health agencies.

"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

7.2 Reimbursement/Billing Guidelines

Physical, occupational, and speech therapy services are reimbursed in accordance with 1 TAC § 355. See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

Therapy providers are reimbursed in accordance with 1 TAC §355.8085.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.4, "Claims Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee 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.

When there is a change of provider, or a change in the client's medical condition requiring therapy, a denied claim for a therapy (PT, OT, or ST) evaluation, re-evaluation or swallowing function evaluation that exceeded the limits outlined in this handbook may be considered on appeal for reimbursement with documentation of one of the following:

- A change in the client's medical condition or new therapy related diagnosis with date of onset documented in the plan of care or treatment plan
- A change of provider letter signed and dated by the client or responsible adult documenting all of the following:
  - The date the client ended therapy (effective date of change) with the previous provider
  - The name of the new provider and previous provider

7.2.1 Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units

Modifiers GP, GO, and GN are required on all claims except when billing evaluation and re-evaluation procedure codes. The AT modifier must be included on claims for acute therapy services.

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All claims for reimbursement of procedure codes paid in 15 minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to zero units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Time intervals for 1 through 8 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

7.3 Claims Resources

Providers may refer to the following sections or forms when filing claims:

Resource	Location
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
Appendix D: Acronym Dictionary	Appendix D (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Appendix A: State, Federal, and TMHP Contact Information (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)

7.4 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday-Friday from 7 a.m. to 7 p.m., Central Time.

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8 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form

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Radiology and Laboratory Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

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TEXAS
Health and Human Services

RADIOLOGY AND LABORATORY SERVICES HANDBOOK

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1 General Information

This information is intended for Texas Medicaid independent (freestanding) laboratories, radiological laboratories, and physiological laboratories.The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Independent Laboratory

The requirements in this section apply to all providers who bill laboratory services.

2.1 Enrollment

Providers must meet the following requirements and submit a complete application in order to enroll as independent (freestanding) laboratory providers:

- The provider must be actively enrolled in Medicare as an independent laboratory.
- The independent laboratory must be independent from a physician's office or hospital.
- The independent laboratory must meet staff, equipment, and testing capability standards for certification by the Health and Human Services Commission (HHSC).

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2.1.1 Clinical Laboratory Improvement Amendments (CLIA)

CLIA regulations set standards that are designed to improve quality in all laboratory testing and include specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing.

The regulations concern all laboratory testing that is used for the assessment of human health or the diagnosis, prevention, or treatment of disease. Under CLIA 88, all clinical laboratory providers (including those located in physicians' offices), regardless of location, size, or type of laboratory, must meet certain standards based on the complexity of the tests they perform.

Providers must hold the appropriate CLIA certificates to perform certain tests as indicated in this handbook. Providers that are certified only to perform waived tests must use modifier QW as indicated on the CMS website.

Refer to: The CLIA Regulations and Federal Register Documents page of the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov for the CLIA rules and regulations. The regulations are found at Title 42 Code of Federal Regulations, Part 493.

2.1.2 CLIA Requirements

To be eligible for reimbursement by Medicare and Medicaid, all providers that perform laboratory tests must do the following:

- Pay the applicable fee to CMS.
- Contact HHSC at 1-512-834-6650 to receive a CLIA registration or certification number. Submit CLIA applications to the following address:

  Health Facility Licensing and Certification Division
  HHSC
  1100 West 49th Street
  Austin, TX 78756

- CLIA updates can be submitted through a PEMS Maintenance-Licenses Transaction.

TMHP monitors claims that are submitted by clinical laboratory providers to verify that the clinical laboratory has a CLIA number on file. If the provider does not have a CLIA number on file with TMHP, the laboratory services claims may be denied.

2.2 Services, Benefits, Limitations, and Prior Authorization

Texas Medicaid only covers professional and technical services that an independent laboratory is certified by CLIA to perform.

Provider documentation must be maintained in the client's medical record and must delineate the medical need for administering the laboratory test.

The physician is responsible for providing to the performing laboratory the clinical diagnosis code that is associated with the individual test so that the performing laboratory may bill Texas Medicaid directly for the analysis of the specimen.

Refer to: The Current Procedural Terminology (CPT) manual for information regarding examples of laboratory codes. Correct use of CPT coding requires using the most specific laboratory code that matches the services provided, based on the code's description.

2.2.1 CLIA Certificates

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

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Refer to: The TMHP website Required CLIA Lab Certifications web page at https://www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

2.2.2 Laboratory Handling Fees and Reference Laboratories

2.2.2.1 Independent Laboratory Providers

An independent laboratory provider may be reimbursed for tests performed in the laboratory and for laboratory handling fees for tests that are forwarded to another laboratory (i.e., reference laboratory).

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may not bill for any laboratory tests.

An independent laboratory may only bill Texas Medicaid for tests referred to another independent or hospital laboratory if it performs at least one test that it is certified by CLIA to perform, and forwards a portion of the same specimen to the other laboratory to have one or more tests performed. The referring laboratory may then bill for tests it has performed on the specimen. When billing, the following information must be on the claim:

- Block 20: "Yes" box must be checked.
- Block 32: The name, address, and ZIP Code of the reference laboratory (i.e., the laboratory to which the specimen was referred).
- Block 24-J: The provider number of the reference laboratory must be included next to each procedure to be performed by the reference laboratory.

An independent laboratory that forwards a specimen to another laboratory (independent or hospital) may bill a handling fee (procedure code 99001) for collecting and forwarding the specimen to the other laboratory if the specimen is collected by routine venipuncture or catheterization.

2.2.2.2 Physician Providers

A physician may bill only one laboratory handling charge (procedure code 99000) per client visit when the specimen is collected by drawing a blood sample through venipuncture or collecting a urine specimen by catheterization, unless the specimen is divided and sent to different laboratories or there are different specimens collected and sent to different laboratories.

The claim must indicate the name and address of each laboratory where a specimen is sent for more than one laboratory handling charge to be paid.

Refer to: Subsection 9.2.42, "Laboratory Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about laboratory services reimbursed to physician providers.

2.2.2.3 Outpatient Hospital Providers

An outpatient hospital may be reimbursed for a laboratory handling charge (procedure code 99001) for each independent laboratory to where it sends specimens when the laboratory handling charge is not being billed through other methods.

2.2.2.4 Family Planning Laboratory Tests

Family planning agencies must use procedure code 99000 with a family planning diagnosis code to bill their laboratory handling charges for laboratory specimens sent out; modifier FP must be omitted. Providers may refer to the appropriate section in the provider manual for instructions for billing family planning services. As with procedure code 99000, only one handling fee may be charged for each laboratory to where the agency sends specimens, regardless of the number of specimens taken.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service.

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Refer to: Subsection 6.1, "Services, Benefits, Limitations, and Prior Authorization" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for the complete list of family planning diagnosis codes.

2.2.3 Nonclinical Laboratory Procedures

The reimbursement for nonclinical laboratory procedure codes can be found on the appropriate Texas Medicaid fee schedules on the TMHP website at www.tmhp.com.

2.2.4 Clinical Laboratory Procedures

The reimbursement for clinical laboratory procedures can be found on the appropriate Texas Medicaid fee schedule. Fee schedules are available on the TMHP website at www.tmhp.com.

2.2.4.1 Repeat Procedures

Modifier 91 should be used for repeat clinical diagnostic tests as follows:

- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider, regardless of the use of modifier 91, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures and services must be documented on appeal.

Providers may appeal claims that have been denied for documentation of time. Most procedure codes that initially required modifier 91 will continue to be audited for modifier 91.

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, including documentation of times for each repeated procedure.

2.2.5 Automated Laboratory Tests and Laboratory Paneling

The reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined with any other automated tests that are billed for the client for the same date of service. The Texas Medicaid allowable fee for the individual components of the complete laboratory panel will not exceed the automated test panel (ATP) fee for the total number of automated tests that are billed for the client for the same date of service.

When all of the components of the panel are performed, the complete panel procedure code must be billed. When only two or more components of the panel are performed, the individual procedure codes for each laboratory test performed may be billed.

2.2.5.1 Fee Calculations for Automated Tests and Laboratory Panels

Automated test and laboratory panel procedure codes may be reimbursed according to the appropriate ATP level payment based on the total number of automated tests that are performed on the same day for the same client.

Refer to: The "Clinical Laboratory, Automated Test Panels - Insert" Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for the ATP level payment for automated test and lab panel procedure codes.

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ATP Level Pricing

The amount that is allowed for each automated test and lab panel procedure code that is billed with the same date of service for the same client will be a percentage of the total ATP level payment. To calculate the automated test pricing, the following information is necessary:

- The number of automated tests that are billed for the client for the same date of service (including individual automated tests and all automated tests that are represented by the laboratory panels.) Procedure codes that are duplicated between panels are not counted more than once.
- The ATP pricing fee that corresponds to the number of automated tests that are billed for the client for the same date of service.
- The total billed amount for all automated test and laboratory panel procedure codes that are billed for the client for the same date of service.

The automated test pricing may be calculated as follows:

Step 1

A percentage for each automated test or lab panel detail is derived from dividing the billed amount (B/A) for each procedure by the total billed amount (TB/A) for all automated test and laboratory panel procedure codes with the same date of service for the same client.

Example:

Automated Test	B/A	Percentage
Detail 1 Automated Test	= $50.00	= 29%
Detail 2 Automated Test	= $25.00	= 14%
Detail 3 Lab Panel	= $100.00	= 57%
Detail 4 Clinical Lab Test	= $20.00	= 0%
	TB/A = $175.00	

Note: *The TB/A is for automated test and laboratory panel procedure codes (details 1, 2, and 3 only). Detail 4 is not included in the calculations for the automated tests because it is a clinical lab procedure code and may be reimbursed as indicated on the fee schedule.*

Calculations:

Detail 1	= 50.0 0 / 175.00	= .285714285714…	= 29%
Detail 2	= 25.00 / 175.00	= .142857142857…	= 14%
Detail 3	= 100.00 / 175.00	= .571428571428…	= 57%

Step 2

The detail allowed amount for each automated test (AT) procedure code will be the calculated percentage of the ATP level payment.

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Example:

Automated Test	Number of Automated Tests	Allowed Amount
Detail 1 Automated Test	= 1	= $3.10
Detail 2 Automated Test	= 1	= $1.55
Detail 3 Lab Panel	= 4	= $6.19
Detail 4 Clinical Lab Test	= 0	= Fee Schedule
	ATP = 6 = $10.84	

Note: *The total number of automated tests includes the individual automated test procedure codes and the number of automated tests that are represented by each panel procedure code that is billed. Automated tests that are duplicated between panels are not counted more than once.*

Calculations:

Detail 1	= 29% of 10.84	= (.285714285714…)X(10.84)	= $3.10
Detail 2	= 14% of 10.84	= (.142857142857…)X(10.84)	= $1.55
Detail 3	= 57% of 10.84	= (.571428571428…)X(10.84)	= $6.19
			$10.84

Note: *If a clinical laboratory procedure code is included in a panel, the fee schedule rate for the clinical laboratory procedure is added to the ATP rate, and the resulting sum is divided among the automated test and laboratory panel procedure codes that are billed for the date of service.*

The total allowed amount for all laboratory services that are billed for the client for the same date of service will represent the ATP level pricing combined with any clinical laboratory test fee schedule pricing.

2.2.6 Complete Blood Count (CBC)

A CBC and its components may be reimbursed by Texas Medicaid without prior authorization. The medical necessity for all laboratory services must be documented in the client's medical record, and the services must be referenced to an appropriate diagnosis code.

Texas Medicaid considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. CBC tests should be individualized and based on client history, clinical indications, or proposed therapy, and will not be reimbursed for screening purposes.

When related CBC procedure codes are billed for the same date of service by the same provider, the first procedure code will be reimbursed and all other procedure codes will be denied.

Reticulocyte procedure codes may be reimbursed in addition to the CBC, hemogram, differential analysis, and platelet procedure codes indicated above.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for CBC procedure codes that may be reimbursed.

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2.2.7 Drug Testing and Therapeutic Drug Assays

The following procedure codes for drug testing and therapeutic drug assays may be reimbursed by Texas Medicaid:

Procedure Codes									
80143	80150	80151	80155	80156	80157	80158	80159	80161	80162
80163	80164	80165	80167	80168	80169	80170	80171	80173	80175
80176	80177	80178^	80179	80180	80181	80183	80184	80185	80186
80188	80189	80190	80192	80193	80194	80195	80197	80198	80199
80200	80201	80202	80203	80204	80210	80299	80305^	80306	80307
80320	80321	80322	80323	80324	80325	80326	80327	80328	80329
80330	80331	80332	80333	80334	80335	80336	80337	80338	80339
80340	80341	80342	80343	80344	80345	80346	80347	80348	80349
80350	80351	80352	80353	80354	80355	80356	80357	80358	80359
80360	80361	80362	80363	80364	80365	80366	80367	80368	80369
80370	80371	80372	80373	80374	80375	80376	80377	G0480	G0481
G0482	G0483	G0659							
^ QW Modifier									

Note: *The procedure codes above do not require prior authorization.*

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

Procedure codes G0480, G0481, G0482, G0483, and G0659 are limited to once per day by any provider.

Chemistry procedure codes used for specimen validity testing (procedure codes 82540, 82550, 82552, 82553, 82554, 83986, and 84311) will be denied when submitted on the same date of service by the same provider, as procedure code G0480, G0481, G0482, G0483, or G0659.

The following CPT Drug Assay procedure codes will be denied when billed on the same date of service, by the same provider with the corresponding HCPCS Drug Assay procedure codes identified with an "X":

CPT Drug Assay Procedure Codes					
	G0480	**G0481**	**G0482**	**G0483**	**G0659**
80320	X		X	X	X
80321	X	X	X	X	
80323	X	X	X	X	X
80324	X	X	X	X	
80325	X				
80326	X	X	X	X	X
80327	X				
80328	X				
(X) The "80000" CPT procedure code will be denied if billed with the HCPCS "G" procedure code indicated with an "X." **(Blank) There is no relationship between the "80000" CPT procedure code and the HCPCS "G" procedure code. Both procedure codes may be reimbursed if billed with the same date of service.** **^QW Modifier**					

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CPT Drug Assay Procedure Codes					
80329	X		X	X	X
80330	X			X	
80332	X		X	X	
80333	X			X	X
80335	X				
80336	X				
80337	X		X	X	X
80338	X				X
80339	X				X
80342	X				X
80345	X				X
80358	X				X
80363	X				X
80365	X				X
80368	X				X
80369	X				X
80370	X				X
80375	X				X
80377	X				X

(X) The "80000" CPT procedure code will be denied if billed with the HCPCS "G" procedure code indicated with an "X."
(Blank) There is no relationship between the "80000" CPT procedure code and the HCPCS "G" procedure code. Both procedure codes may be reimbursed if billed with the same date of service.
^QW Modifier

2.2.7.1 Documentation Requirements

All services outlined in this section are subject to retrospective review. Documentation in the client's medical record must be maintained by the physician and support the medical necessity for the services provided.

2.2.8 Evocative and Suppression Testing

The following procedure codes for evocative and suppression testing may be reimbursed by Texas Medicaid:

Procedure codes									
80400	80402	80406	80408	80410	80412	80414	80415	80416	80417
80418	80420	80422	80424	80426	80428	80430	80432	80434	80435
80436	80438	80439							

Note: *The procedure codes above do not require prior authorization.*

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

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2.2.9 Hematology and Coagulation

The following hematology and coagulation procedure codes may be reimbursed by Texas Medicaid:

Procedure Codes									
85002	85004	85007	85008	85009	85013*	85014^	85018^	85025^	85027
85032	85041	85044	85045	85046	85048	85049	85055	85060	85097
85130	85170	85175	85210	85220	85230	85240	85244	85245	85246
85247	85250	85260	85270	85280	85290	85291	85292	85293	85300
85301	85302	85303	85305	85306	85307	85335	85337	85345	85347
85348	85360	85362	85366	85370	85378	85379	85380	85384	85385
85390	85396	85397	85400	85410	85415	85420	85421	85441	85445
85460	85461	85475	85520	85525	85530	85536	85540	85547	85549
85555	85557	85576^	85597	85598	85610^	85611	85612	85613	85635
85651*	85652	85660	85670	85675	85705	85730	85732	85810	85999
G0306	G0307								
*** CLIA Waived Test** **^ QW Modifier**									

Note: *The procedure codes above do not require prior authorization.*

The following procedure codes are limited to one per day by the same provider:

Procedure Codes						
85027	85347	85397	85520	85576^	85610^	85730
^ QW Modifier						

Procedure codes 85460 and 85461 may be reimbursed for female clients who are 10 through 55 years of age.

Procedure code 85004 will deny if billed on the same day by the same provider as procedure code 85007.

Procedure code 85660 is limited to once per lifetime, any provider. An additional test may be considered on appeal with documentation indicating the provider was unaware the client was tested previously or was unable to obtain client's medical records.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.10 Human Immunodeficiency Virus (HIV) Drug Resistance Testing

Standard treatment regimens for HIV therapy require a combination of three or more drugs. Standard therapy continues if a reduction in viral load is achieved. Incomplete virus suppression favors the development of a drug resistance and jeopardizes the success of future therapy. Testing for drug resistance as a prerequisite to further therapy is indicated under such circumstances.

To ensure accurate testing results, the client must be on appropriate antiretroviral therapy at the time of testing or have discontinued the drug regimen within the past four weeks.

Testing for antiretroviral drug resistance is indicated in certain clinical situations. These indications include any of the following:

- Individuals who have an initial (new onset) acute HIV infection, to determine if a drug-resistant viral strain was transmitted and to plan a drug regimen accordingly.

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- Individuals who have virological failure during antiretroviral therapy, laboratory results showing HIV RNA levels greater than 500 and less than 1,000 copies/ml.
- HIV-infected pregnant women before initiation of therapy.
- HIV-infected pregnant women entering pregnancy with HIV RNA levels at or below 400 copies/ml while the women are on therapy.

Documentation must be maintained in the client's medical record to support medical necessity for the HIV drug-resistance testing. Specific documentation requirements are dependent on the rationale for the testing. Documentation must include, but is not limited to, the date the drug regimen was initiated, the dosage and frequency of the prescribed medication, and laboratory tests that support all of the following:

- Acute HIV infection, with identification of the specific viral strain
- Virological failure during antiretroviral therapy with HIV RNA levels greater than 500 and less than 1,000 copies/ml
- Positive pregnancy results in an HIV positive female client
- HIV RNA levels of 400 copies/ml or less during pregnancy

HIV drug-resistance testing is not recommended when one of the following criteria is met:

- The drug regimen has been discontinued for more than four weeks
- The viral load is less than 500 copies/ml

Refer to: Subsection B.1.1, "Routine HIV Testing Procedure Codes" in "Appendix B: HIV/AIDS" (*Vol. 1, General Information*) for additional information about HIV testing laboratory procedures.

2.2.11 Microbiology

The following procedure codes may be reimbursed by Texas Medicaid:

Procedure Codes									
Microbiology									
86703	86790	86794	87003	87015	87040	87045	87046	87070	87071
87073	87075	87076	87077^	87081	87084	87086	87088	87101	87102
87103	87106	87107	87109	87110	87116	87118	87140	87143	87147
87149	87150	87152	87153	87158	87164	87166	87168	87169	87172
87176	87177	87181	87182	87184	87185	87186	87187+	87188	87190
87197	87205	87206	87207	87209	87210^	87220	87230	87250	87252
87253	87254	87255	87260	87265	87267	87269	87270	87271	87272
87273	87274	87275	87276	87278	87279	87280	87281	87283	87285
87290	87299	87300	87301	87305	87320	87324	87327	87328	87329
87332	87335	87336	87337	87338^	87340	87341	87350	87380	87385
87389^	87390	87391	87400^	87420^	87425	87427	87430^	87449^	87451
87467	87468	87469	87471	87472	87475	87476	87478	87480	87481
87482	87484	87485	87486	87487	87490	87491^	87492	87493	87494
87495	87496	87497	87498	87500	87501	87502^	87503+	87510	87511
+Add-on code **^QW Modifier**									

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Procedure Codes									
87512	87513	87516	87517	87520	87521^	87522	87523	87525	87526
87527	87528	87529	87530	87531	87532	87533	87534	87535	87536
87537	87538	87539	87540	87541	87542	87550	87551	87552	87555
87556	87557	87560	87561	87562	87563^	87564	87580	87581	87582
87590	87591^	87592	87593	87594	87631^	87632	87633^	87634^	87640
87641	87650	87651^	87652	87653	87660	87661	87662	87797	87798
87799	87800	87801^	87802	87803	87804^	87806^	87807^	87808^	87809^
87810	87812	87850	87880^	87899^	87900	87901	87902	87903	87904
87905	87906	87910	87912	87999	G0433^	G0499			
Molecular Testing									
87505	87506	87507	87623	87624	87625	87626	87627		
+Add-on code **^QW Modifier**									

Note: *The procedure codes above do not require prior authorization.*

The following procedure codes are limited to one per day by the same provider:

Procedure Codes									
86790	86794	87015	87046	87071	87075	87076	87077^	87081	87088
87101	87102	87106	87107	87140	87147	87149	87150	87152	87153
87154	87181	87182	87184	87185	87186	87188	87190	87206	87209
87210^	87252	87254	87300	87634^	87801^	87809^	87899^	87904	
^ QW Modifier									

Procedure code G0433 will be denied if billed on the same day by any provider as procedure code 86703.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.11.1 Zika Virus Testing

Procedure codes 86794 and 87662 may be used to bill for Zika virus testing.

Procedure code 87662 may be reimbursed up to two times on the same day by the same provider.

2.2.12 Organ or Disease-Oriented Panels

The following organ or disease-oriented panel procedure codes may be reimbursed by Texas Medicaid:

Procedure Codes									
80047^	80048^	80050	80051^	80053^	80055	80061^	80069^	80074	80076
80081									
^ QW Modifier									

Note: *The procedure codes above do not require prior authorization.*

Procedure codes 80055 and 80081 are limited to female clients who are 10 through 55 years of age. Only one service for procedure code 80055 or one service for procedure code 80081 will be reimbursed per pregnancy to the same provider.

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Procedure code 80061 is limited to once per rolling year, by any provider, when performed as part of a preventative care medical checkup.

The reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined; including any other automated tests billed for the client for the same date of service (DOS). The Texas Medicaid allowable fee for the individual components of the complete laboratory panel will not exceed the automated test panel (ATP) fee for the total number of automated tests that are billed for the client for the same DOS.

When all of the components of the panel are performed, the complete panel procedure code must be billed. When only two or more components of the panel are performed, the individual procedure codes for each laboratory test may be billed.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.13 Urinalysis and Chemistry

The following urinalysis and chemistry procedure codes may be reimbursed by Texas Medicaid for once per day:

Procedure Codes									
Urinalysis									
81000	81001	81002*	81003^	81005	81007^	81015	81020	81025*	81050
81099									
Chemistry									
82009	82010^	82013	82016	82017	82024	82030	82040^	82042	82043^
82044^	82045	82075	82077	82085	82088	82103	82104	82105	82106
82107	82108	82120^	82127	82128	82131	82135	82136	82139	82140
82143	82150^	82154	82157	82160	82163	82164	82166	82172	82175
82180	82190	82232	82239	82240	82247^	82248	82252	82261	82270*
82271^	82272*	82274^	82286	82300	82306	82308	82310^	82330^	82331
82340	82355	82360	82365	82370	82373	82374^	82375	82376	82378
82379	82380	82382	82383	82384	82387	82390	82397	82415	82435^
82436	82438	82441	82465^	82480	82482	82485	82495	82507	82523^
82525	82528	82530	82533	82540	82542	82550^	82552	82553	82554
82565^	82570^	82575	82585	82595	82600	82607	82608	82610	82615
82626	82627	82633	82634	82638	82642	82652	82653	82656	82657
82658	82664	82668	82670	82671	82672	82677	82679^	82681	82693
82696	82705	82710	82715	82725	82726	82728	82731	82735	82746
82747	82757	82759	82760	82775	82776	82784	82785	82787	82800
82803	82805	82810	82820	82930	82938	82941	82943	82945	82946
82947^	82948	82950^	82951^	82952^	82955	82960	82963	82965	82977^
82978	82979	82985^	83001^	83002^	83003	83009	83010	83012	83013
83014	83015	83018	83020	83021	83026*	83030	83033	83036^	83037^
83045	83050	83051	83060	83065	83068	83069	83070	83080	83088
***CLIA Waived test** **+Add-on code** **^ QW Modifier**									

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Procedure Codes									
83090	83150	83491	83497	83498	83500	83505	83516^	83518	83519
83520	83521	83525	83527	83528	83540	83550	83570	83582	83586
83593	83605^	83615	83625	83630	83631	83632	83633	83634	83655^
83661	83662	83663	83664	83670	83690	83695	83698	83700	83701
83704	83718^	83719	83721^	83722	83727	83735	83775	83785	83789
83825	83835	83857	83864	83872	83873	83874	83880^	83883	83884
83885	83915	83916	83918	83919	83921	83930	83935	83937	83945
83950	83951	83970	83986^	83992	83993	84030	84035	84060	84066
84075^	84078	84080	84081	84085	84087	84100	84105	84106	84110
84112	84119	84120	84126	84132^	84133	84134	84135	84138	84140
84143	84144	84145	84146	84150	84152	84153	84154	84155^	84156
84157	84160	84163	84165	84166	84181	84182	84202	84203	84206
84207	84210	84220	84228	84233	84234	84235	84238	84244	84252
84255	84260	84270	84275	84285	84295^	84300	84302	84305	84307
84311	84315	84375	84376	84377	84378	84379	84392	84402	84403
84425	84430	84431	84432	84436	84437	84439	84442	84443^	84445
84446	84449	84450^	84460^	84466	84478^	84479	84480	84481	84482
84484	84485	84488	84490	84510	84512	84520^	84525	84540	84545
84550^	84560	84577	84578	84580	84583	84585	84586	84588	84590
84591	84597	84600	84630	84681	84702	84703^	84704	84999	
Molecular Testing									
83006									
Ophthalmology and Optometry									
83861^									
***CLIA Waived test** **+Add-on code** **^ QW Modifier**									

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The TMHP website Required CLIA Lab Certifications web page at https://www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

Texas Medicaid limits reimbursement for the procedure codes listed in the table above to one per day without a modifier and one per day with a modifier when billed by the same provider.

Procedure code 84583 will be denied if it is billed on the same day by the same provider as procedure code 81000, 81001, 81002, 81003, 81005, or 81020.

Procedure codes 82013, 82105, 82106, 82677, 83080, 84163, and 84704 are limited to one per 210 days when billed by any provider.

Procedure code 83698 is limited to the following diagnosis codes:

Diagnosis Codes							
E1165	E119	E11A	E139	E7800	E78010	E78011	E78019

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Diagnosis Codes							
E781	E782	E783	E7841	E7849	E785	I2584	

Procedure code 83698 is limited to two per rolling year when billed by any provider. Claims submitted for procedure code 83698 that are in excess of two per year may be considered on appeal with documentation of any of the following:

- Medical necessity for the additional test.
- The provider was unable to obtain the previous records from a different provider.
- The provider was new to treating the client and was not aware the client had received the test.

Procedure codes 82757, 84066, 84152, and 84154 are limited to male clients.

Procedure codes 82120, 84135, and 84138 are limited to female clients.

The following procedure codes are restricted to females who are 10 through 55 years of age:

Procedure Codes									
81025*	82106	82143	82731	83632	83661	83662	83663	83664	84112
84163									
*CLIA waived tests									

Refer to: Subsection 9.2.26.8, "Helicobacter Pylori (H. pylori)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about limitations on procedure codes 83009, 83013, and 83014.

2.2.14 Additional Laboratory Services

2.2.14.1 Colorectal Cancer Screening

Refer to: Subsection 4.2.8, "Colorectal Cancer Screening" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 9.2.15.1.1, "Colorectal Cancer Screening" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.2 Cytopathology Studies

Refer to: Subsection 9.2.26.4, "Cytopathology Studies—Other Than Gynecological" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 6.14, "Pap Smear (Cytopathology Studies)" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.3 Helicobacter pylori Testing

Refer to: Subsection 9.2.26.8, "Helicobacter Pylori (H. pylori)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.4 Laboratory Services for Clients on Dialysis

Refer to: Subsection 7.2.7, "Laboratory and Radiology Services" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.5 Prognostic Breast and Gynecological Cancer Studies

Refer to: Subsection 7.2.7, "Laboratory and Radiology Services" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*).

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2.2.14.6 THSteps Outpatient Laboratory Services

Refer to: Subsection 4.3.12.6, "Laboratory Test" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.7 Authorization Requirements

Prior authorization is not required for most laboratory services. Providers may refer to the specific sections for those services that require authorizations.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including independent laboratory services. Independent laboratory services are subject to retrospective review and recoupment if documentation does not support the service billed.

Independent laboratory documentation must include the physician's signed and dated order for the laboratory tests. The specific tests ordered by the physician must be listed on the order. The test results must also be included in the documentation.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service using a family planning diagnosis code.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about Medicaid Title XIX Family Planning Services.

Subsection 6.1, "Services, Benefits, Limitations, and Prior Authorization" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about the Texas Women's Health Program.

A National Provider Identifier (NPI) is required for all claims. In addition, for paper claims, the NPI is required for the billing and performing provider only. All paper claims must be submitted with an NPI and taxonomy code for the billing and performing provider. All other provider fields on the claim forms require an NPI only.

Providers must submit independent laboratory services to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 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.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

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2.4.1.1 Electronic Filing for Laboratory Providers

Referring provider information is always required on laboratory claims. Failure to submit this data will result in a claim rejection on the TMHP Electronic Data Interchange (EDI).

When the place of service is 6, and the billing NPI belongs to a laboratory, there is no need to submit the same NPI in the facility ID field. This notation causes the claim to suspend processing unnecessarily, and may cause a delay in the disposition of the claim. For questions about the electronic fields, contact the commercial software vendor or the TMHP EDI Help Desk at 1-888-863-3638.

2.4.2 Reimbursement

The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8085 and §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for clinical laboratory services cannot exceed the Medicare payment for that service.

As the result of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, independent laboratories are not directly reimbursed by Texas Medicaid when providing tests to clients who are registered as hospital inpatients. Hospital reimbursements (i.e., inpatient DRG reimbursement) include payment for all pathology and laboratory services, including those sent to referral laboratories. Hospital-based and referral laboratory providers must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. These services are not billable to Medicaid-covered clients.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

Texas Medicaid pays up to the amount allowed for the total component for the same procedure, same client, same date of service, any provider.

- Providers who perform the technical service and interpretation must bill for the total component.
- Providers who perform only the technical service must bill for the technical component.
- Providers who perform only the interpretation must bill for the interpretation component.

Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, are denied. Claims are paid based on the order in which they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure, same dates of service, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components. Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

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3 Genetic Testing

Genetic testing is the study of heredity covering an array of techniques, including analysis of human deoxyribonucleic acid (DNA), ribonucleic acid (RNA), or protein. Genetic testing may be a benefit of Texas Medicaid program when all of the following conditions of medical necessity are met:

- The client displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic).
- The result of the test will directly impact the treatment or management being delivered to the client.
- After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.
- Disease-specific criteria met.

Definition of medical necessity for genetic testing is also made in accordance with Chapter 1372 of Subtitle E, Title 8 of the Texas Insurance Code, which requires biomarker testing to include relevant genetic tests, supported by medical and scientific evidence as described by one or more of the criteria outlined below:

- A United States Food and Drug Administration (FDA) labeled indication for the test or an indicated test for a drug approved by the FDA.
- A national coverage determination made by the Centers for Medicare and Medicaid Services (CMS), or a local coverage determination made by a Medicare administrative contractor.
- Nationally recognized clinical practice guidelines.
- Consensus statement recommendations for specific clinical circumstances when biomarker testing may optimize clinical care outcomes.

Genetic testing includes:

- Single-analyte tests
- Multiplex panel tests
- Whole genome sequencing (WGS) or whole exome sequencing (WES)

Providers may refer to the Texas Medicaid fee schedule for procedure codes that may be reimbursed for specific genetic testing.

Refer to: Subsection 2.2.1, "Online Fee Lookup (OFL) and Static Fee Schedules" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*)

The following procedure codes may be reimbursed for Genetic Testing services:

Procedure Codes									
0037U	0239U	0364U	0493U	0540U	81105	81106	81107	81109	81110
81111	81112	81120	81121	81161	81162	81163	81164	81165	81166
81167	81170	81177	81178	81179	81180	81181	81184	81185	81186
81200	81201	81202	81203	81205	81206	81207	81208	81209	81210
81212	81215	81216	81217	81218	81219	81220	81221	81222	81223
81224	81225	81226	81227	81229	81233	81235	81237	81238	81240
81241	81242	81243	81244	81245	81246	81247	81248	81249	81250
81251	81252	81253	81254	81255	81256	81257	81258	81259	81260
81261	81262	81263	81264	81265	81266	81267	81268	81269	81270

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Procedure Codes									
81272	81273	81275	81276	81278	81279	81287	81288	81290	81291
81292	81293	81294	81295	81296	81297	81298	81299	81300	81301
81302	81303	81304	81305	81307	81310	81313	81314	81315	81316
81317	81318	81319	81320	81321	81322	81323	81324	81325	81326
81327	81329	81330	81331	81332	81334	81336	81337	81340	81341
81342	81345	81349	81350	81351	81352	81353	81355	81361	81362
81363	81364	81370	81371	81372	81373	81374	81375	81376	81377
81378	81379	81380	81381	81382	81383	81400	81401	81402	81403
81404	81405	81406	81407	81408	81410	81411	81415	81416	81417
81420	81425	81426	81427	81443	81449	81450	81451	81455	81456
81457	81458	81459	81462	81463	81464	81507	81513	81514	81517
81519	81520	81528	81595	S3800	S3840	S3841	S3842	S3846	

Genetic testing is allowed once per lifetime, with some exception.

3.1 ClonoSEQ (procedure code 0364U)

Reimbursement for ClonoSEQ (procedure codes 0364U), the next generation sequencing (NGS) of tumor DNA to detect or quantify minimal residual disease (MRD) in clients with acute lymphocytic leukemia (ALL), chronic lymphocytic leukemia (CLL), or multiple myeloma is limited to claims with one of the following diagnoses. All other diagnoses will be denied.

Diagnosis Codes							
C9000	C9001	C9002	C9100	C9101	C9102	C9110	C9111
C9112							

Procedure code 0364U is limited to six times per rolling year by any provider. Additional tests may be reimbursed for the same client on appeal with medical necessity.

3.2 * Enhanced Liver Fibrosis (ELF) (Procedure code 81517)

Reimbursement of ELF (procedure code 81517) for the detection and prognosis of liver fibrosis in clients with chronic liver diseases is limited to claims with one of the following diagnoses. All other diagnoses will be denied.

[Revised] Diagnosis Codes							
K700	K7010	K7011	K702	K7030	K7031	K7040	K7041
K709	K710	K7110	K7111	K712	K713	K714	K7150
K7151	K716	K717	K718	K719	K7200	K7201	K7210
K7211	K7290	K7291	K730	K731	K732	K738	K739
K7400	K7401	K7402	K740A	K741	K742	K743	K744
K745	K7460	K7469	K750	K751	K752	K753	K754
K7581	K7589	K759	K760	K761	K762	K763	K764
K765	K766	K767	K7681	K7682	K7683	K7689	K769
K77							

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Enhanced Liver Fibrosis (ELF) test more than twice per year is considered not medically necessary. Performance of this test within 6 months following a liver biopsy (or other test for liver fibrosis) is considered not medically necessary.

Documentation of medical necessity for a liver biopsy (procedure code 47000 or 47100) performed within 6 months following TE (procedure code 91200) or MRE (procedure code 76391) must be maintained in the client's records and is subject to retrospective review.

3.3 Documentation Requirements

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. Providers must maintain documentation of medical necessity in the client's medical record.

Documentation must support medical necessity for the procedure code and modifier billed. All services outlined in this handbook are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

3.4 Authorization Requirements

Prior authorization is not required for genetic testing unless otherwise described. Certain genetic tests do require prior authorization. Providers can refer to the provider handbooks for the guidelines and requirements listed for a specific service.

Refer to: Subsection 5.5, "Prior Authorization Submission Methods" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*)

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via 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 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 forms and supporting documentation using electronic or wet signatures.

For tests requiring prior authorization, a completed Special Medical Prior Authorization (SMPA) Request Form must be signed, dated, and submitted by the ordering provider rendering direct care. Requests from laboratories will not be processed.

Note: *The provider is expected to share the authorization number with the lab submitting the claim.*

Any provider's signature, including the prescribing provider's, on a submitted document indicates the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete.

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3.4.1 Authorization Requirements for Whole Genome Sequencing and Whole Exome Sequencing

WGS describes the sequencing of the entire human genome, including protein-coding regions (exons) and noncoding regions. WGS captures most genomic variation in a single test and is useful for clients who have rare disorders where hypothesis-driven approaches have failed to produce a diagnosis. WGS can identify or confirm the genetic etiology of a disorder in clients (procedure code 81425). When needed for additional diagnostic insight, comparator genomes can be used from a relative such as parents or siblings (procedure code 81426). Re-evaluation of the genome is also available when needed for additional diagnostic yield (procedure code 81427).

Procedure codes 81425 and 81427 may be a benefit once per lifetime with any provider. Procedure code 81426 may be a benefit up to a maximum of twice per lifetime.

WES is an alternative to WGS. It is a laboratory test used to determine the sequence of the protein coding regions of the genome. The exome is the part of the genome that encodes protein, where roughly 85% of variants are known to contribute to diseases in humans. WES can identify or confirm the genetic etiology of a disorder in clients (procedure code 81415). When needed for additional diagnostic insight, comparator genomes can be used from a relative, such as parents or siblings, (procedure code 81416). Re-evaluation of the genome is also available when needed for additional diagnostic yield (procedure code 81417).

Procedure codes 81415 or 81417 may be a benefit once per lifetime with any provider. Procedure code 81416 may be a benefit up to a maximum of twice per lifetime.

Prior authorization is required for WGS and WES, and they are considered medically necessary when all the following criteria are met for individuals under 21 years of age:

- Pre-test genetic counseling is required for any individual undergoing WGS or WES.
- The individual has been evaluated by a physician board-certified in one of the following fields:
  - Medical genetics
  - Maternal-fetal medicine
  - Neonatology
  - Neurology
  - Developmental Pediatrics
- The evaluation may be one of the following:
  - In person
  - Via synchronous audio-visual telemedicine in consultation with a consulting physician who has personally examined the individual
- A three-generation pedigree must be completed, as appropriate.
- The ordering physician must conduct a mandatory pre-test and commits to conducting post-test follow-up counseling.
- Test results are expected to directly impact clinical decision-making and/or clinical outcome for the client being tested.
- No other causative circumstances (e.g., environmental exposures, injury, prematurity, infection) can explain symptoms.
- A genetic etiology is considered the most likely explanation for the phenotype, based on either of the following:
  - Multiple congenital abnormalities affecting unrelated organ systems, or two of the following:

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    - Abnormality affecting at minimum a single organ system.
    - Profound global developmental delay, intellectual disability, symptoms of a complex neuro-developmental disorder, and/or severe neuropsychiatric condition.
    - Family history strongly suggestive of a genetic etiology, including consanguinity.
    - Period of unexplained developmental regression.
    - Biochemical findings suggestive of an inborn error of metabolism where targeted testing is not available.
- Clinical presentation does not fit a well-described syndrome for which single-gene or targeted panel testing (e.g., when comparative genomic hybridization [CGH]/chromosomal microarray analysis [CMA]) is available.
- The differential diagnosis list and/or phenotype warrant testing of multiple genes and one of the following:
    - WGS is more practical than the separate single gene tests or panels that would be recommended based on the differential diagnosis.
    - WGS results may preclude the need for multiple and/or invasive procedures, follow-up, or screening that would be recommended in the absence of testing.

Conditions that may be considered to qualify for WGS or WES include, but are not limited to, the following:

- Unexplained or global developmental delay
- Moderate, severe, or profound intellectual disability diagnosed before 21 years of age.
- Epileptic encephalopathy with onset before 3 years of age.
- Clinical history strongly suggests a genetic cause and two or more of the following features are present:
    - Congenital anomaly
    - Significant hearing or visual impairment diagnosed before 21 years of age
    - Laboratory abnormalities suggestive of an inborn error of metabolism (IEM)
    - Autism spectrum disorder neuropsychiatric condition (e.g., bipolar disorder, schizophrenia, obsessive-compulsive disorder)
    - Hypotonia or hypertonia in infancy
    - Dystonia, ataxia, hemiplegia, neuromuscular disorder, movement disorder, or other neurologic abnormality
    - Unexplained developmental regression, unrelated to autism or epilepsy
    - Growth abnormality (e.g., failure to thrive, short stature, microcephaly, macrocephaly, or overgrowth)
    - Persistent and severe immunologic or hematologic disorder
    - Dysmorphic features
    - Consanguinity
    - Other first- or second-degree family member(s) with similar clinical features

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Re-evaluation for WGS (procedure code 81427) and WES (procedure code 81417) of a previously obtained sequence (procedure code 81425 for WGS and procedure code 81415 for WES) is considered medically necessary when the above criteria for WGS or WES and any of the following conditions are met:

- Onset of additional symptoms that broadens the phenotype assessed during the original exome/genome evaluation.
- Birth or diagnosis of a similarly affected first-degree relative that has expanded the clinical picture.
- New scientific knowledge suggests a previously unknown link between the individual's findings and specific genes/pathogenic or likely pathogenic variants, and at least 18 months have passed since the last analysis.

WES is an alternative to WGS. Only one of the two tests is allowed per lifetime for those who meet the medical criteria for WGS and WES. It is the responsibility of the ordering providers to choose which test to perform for those who met the medical criteria for WGS and WES.

3.4.2 Authorization Requirements for Expanded Carrier Screening (ECS)

ECS is genetic testing performed to identify individuals who are at risk of having children with an inherited recessive (both parents must have the variant to pass the disorder to children or X-linked disorder [variant only occurs in the X chromosome]). Carriers are typically asymptomatic but can pass the disorder-causing genetic variant(s) to their children. Carrier screening may be performed in the preconception or prenatal periods. Risk-based carrier screening is performed in individuals with an increased risk to be a carrier of a specific disorder based on population carrier frequency, family history and/or ethnicity and typically tests for a single gene, or a small number of genes, known to have the disorder-causing variant(s).

ECS uses a panel test that screens for many genes simultaneously (5 genes up to 100s of genes) for disorders that are present in the general population and may have increased frequency in specific populations. The genes tested in an ECS panel vary by laboratory and may not all test for the same genes.

A targeted screening approach may be appropriate instead of ECS. Instances when targeted screening would be appropriate include but are not limited to:

- The individual or their reproductive partner is a known carrier for one or more conditions being screened.
- The individual or their reproductive partner has a first- or second-degree relative who is affected with a condition being screened.
- The individual or their reproductive partner has a first-degree relative with offspring affected with the condition being screened.
- The individual or their reproductive partner are members of a population known to have a carrier frequency rate that exceeds the threshold for American College of Medical Genetics and Genomics Tier 1 risk-based screening.

ECS (procedure code 81443) is limited to once per lifetime with any provider.

Prior authorization may be granted for ECS (procedure code 81443) when the following criteria are met:

- ECS is considered medically necessary when all the following criteria are met for females ages 10-55 years who are pregnant or considering pregnancy.
- Pre-test genetic counseling from one of the following is required for any individual undergoing ECS:
  - Board-certified physician in:
    - Medical genetics
    - Maternal-fetal medicine

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    - Obstetrics/Gynecology
    - Family Medicine
  - Board-certified genetic counselor
  - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, or Certified Nurse Midwife with training and expertise in genetics and genetic counseling
- Knowledge of the pathogenic variant(s) may be used for the management of:
  - Pregnancy or antenatal interventions
  - Delivery or other care planning for the potentially affected fetus of a pregnant individual
  - Pre-conception family planning
- The ECS panel should screen for conditions:
  - With childhood onset.
  - Which can be diagnosed prenatally.
  - With a well-defined phenotype.
  - Known to cause cognitive or physical impairment.
  - With a known pathogenic or likely pathogenic gene variant.
- The ECS panel does not include genes associated with known adult-onset conditions, including but not limited to, hereditary cancers, dementia, or blood clotting disorders (e.g., hereditary breast and ovarian cancer, Lynch Syndrome, Alzheimer's Disease, Huntington's Disease, or Factor V Leiden).
- The ECS panel must include sequencing of at least 15 genes including:
  - Conditions in American College of Medical Genetics and Genomics (ACMG) Tier 2, with a carrier frequency of 1 in 100 or greater
  - Conditions in ACMG Tier 1
  - X-linked conditions

Note: *A first-degree relative is defined as a blood relative with whom an individual shares approximately 50% of his/her genes, including the individual's parents, full siblings, and children. A second-degree relative is defined as a blood relative with whom an individual shares approximately 25% of his/her genes, including the individual's grandparents, grandchild, uncle, aunt, niece, nephew, or half-sibling.*

3.4.3 Prior Authorization Requirements for FoundationOne

FoundationOne tests are next-generation sequencing (NGS) to analyze hundreds of cancer-related genes and identify the four main classes of genomic alterations (base substitutions, insertions/deletions, copy number alterations, and gene rearrangements/fusions for clients with advanced solid tumor).

FoundationOne CDx test (procedure code 0037U) identifies alterations in 324 genes as well as genomic signatures, including microsatellite instability, tumor mutational burden, and positive homologous recombination deficiency status on DNA isolated from solid tumor tissue samples.

FoundationOne liquid CDx test (procedure code 0239U) using plasma, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations.

FoundationOne, either CDx or liquid CDx, may be a benefit of Texas Medicaid program when all of the following criteria are met:

- The test is ordered by an oncologist.

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- Used for advanced tumors.
- The test is intended to assist physicians in identifying treatment options and providing information about potential targeted therapies to better inform treatment decisions.
- The test for the intended use as a broad molecular profiling tool to identify biomarkers present in the tumor are not considered as medical necessary. It must be conducted for FDA-approved therapies as companion test.

FoundationOne testing, either CDx or liquid CDx, is allowed once per lifetime for one type of cancer to guide targeted therapy.

Only one of the two tests (procedure code 0037U or procedure code 0239U) is allowed for those who meet the medical necessity criteria for FoundationOne. It is the responsibility of the ordering provider to choose which test to perform for those who meet the medical criteria for FoundationOne.

3.4.4 Prior Authorization Requirements for Transplant Rejection Testing

Transplant Rejection testing involves an immune response to a transplanted organ. The client's immune system recognizes the donated organ as "foreign," thereby initiating an immune response as if the transplanted organ was a foreign antigen. This response may cause the transplanted organ to fail. Gene expression profiling tests and serum cell-free DNA evaluation are possible ways to monitor organ transplant rejection.

Transplant Rejection testing is considered medically necessary when all of the following are met:

- The transplant rejection test must provide information about at least one of the two following clinical status determinations:
  - Active Rejection (AR) status, or
  - Cellular or Antibody-mediated rejection (ACR or AMR) status
- The intended use of the transplant rejection test must be:
  - To assist in the evaluation of adequacy of immunosuppression, wherein a non-invasive or minimally invasive test can be used in lieu of a tissue biopsy in a client for whom information from a tissue biopsy would be used to make a management decision regarding immunosuppression, or
  - As a rule-out test for AR in validated populations of clients with clinical suspicion of rejection with a non-invasive or minimally invasive test to make a clinical decision regarding obtaining a biopsy, or
  - For further evaluation of allograft status for the probability of allograft rejection after a physician assessed pretest, or
  - To assess rejection status in clients that have received a biopsy, but the biopsy results are inconclusive or limited by insufficient material.
- For a given client encounter, only one molecular transplant rejection test for assessing allograft status may be performed unless a second transplant rejection test, meeting all the criteria established herein, is reasonable and necessary as an adjunct to the first test.

For heart transplant recipients who are 15 years of age or older and who are 55 or more days post-transplant, the use of procedure code 81595 is considered medically necessary at the following frequency:

- Every month for clients who are 2–12 months post-transplant.
- Every three months for clients who are greater than 12 months post-transplant.
- Every six months for clients who are greater than 36 months post-transplant.

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For heart transplant clients who are 15 years of age or older and who are 28 or more days post-transplant, the use of donor-derived, cell-free DNA tests procedure codes 0493U and 0540U is considered medically necessary at the following frequency:

- Every month for clients who are 1–12 months post-transplant.
- Every three months for clients who are greater than 12 months post-transplant.
- Every six months for clients who are greater than 36 months post-transplant.

For any other organ transplant not listed above (e.g., lungs, liver), the use of donor-derived cell-free DNA tests is considered not medically necessary.

For any other organ transplant not listed above (e.g., kidneys, lungs, liver), the use of peripheral blood gene expression profiling tests is considered not medically necessary.

To assess for rejection and injury in transplanted organs, mRNA expression profiling of biopsied tissue from a transplanted organ is considered not medically necessary.

To assist in the detection of moderate grade 2R/grade 3 heart transplant rejection, the measurement of volatile organic compounds is considered not medically necessary.

3.5 Breast Cancer Gene 1 and 2 (BRCA) Testing

Breast Cancer Gene 1 and 2 (BRCA) testing services are benefits of Texas Medicaid when billed with the following procedure codes:

Procedure Codes									
81162	81163	81164	81165	81166	81167	81212	81215	81216	81217

Breast cancer gene 1, early onset (BRCA1) and breast cancer gene 2, susceptibility protein (BRCA2) are tumor repressor genes responsible for keeping breast cells from growing too rapidly or in an uncontrolled way. Mutations within the gene interrupt this regulatory function and increase the risk of breast and ovarian cancer, have been linked to other types of cancer such as pancreatic and prostate, and can be inherited from a person's mother or father.

> ***Note:*** *Coverage of BRCA mutation analysis testing, including large rearrangement gene mutation analysis testing, are based on the National Comprehensive Cancer Network (NCCN) guidelines.*

Interpretation of gene mutation analysis results is not separately reimbursable. Interpretation is part of the physician E/M service.

BRCA gene mutation analysis testing must be ordered based on familial medical history and the availability of previous familial gene mutation analysis testing results and only if the test results will affect treatment decisions or provide prognostic information.

Unaffected male or females with a family history of breast cancer, including diagnosis of ductal carcinoma in situ (DCIS), should only be considered for testing when the appropriate affected family member is unavailable. Clinical judgment should be used to determine if the client has a reasonable likelihood of a mutation, considering the client's current age and the age of the unaffected female relatives who link the client with the affected relatives.

It is mandatory that a client who is at risk for BRCA1, BRCA2, or BRCA large rearrangement genetic mutation receive genetic counseling before and after BRCA gene mutation testing.

BRCA gene mutation analysis testing (procedure codes 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217) is limited to once per lifetime.

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The ordering provider is responsible for ordering the appropriate BRCA test (e.g., BRCA1 versus BRCA2) based on medical necessity of the testing criteria and genetic counseling results. If a client's BRCA test has a positive result, any further BRCA testing services requested with documentation of medical necessity will be considered on a case-by-case basis by Medical Director review for prior authorization.

Procedure codes 81162 and 81163 are for comprehensive BRCA gene mutation analysis testing. Procedure 81162 may only be used for clients who meet the criteria for both BRCA comprehensive and BRCA large rearrangement gene mutation analysis testing.

3.5.1 Genetic Counseling

Genetic counseling must be provided by a trained genetic counselor, nurse specialist in genetics, or other medical provider possessing expertise in genetic counseling for clients before and after BRCA gene mutation testing.

Both pre- and post-test counseling must provide the depth of content and time for the client to make an informed testing decision. The genetic counseling must be nondirective, and information about the purpose and nature of the tests must be provided to the client.

Pre-test genetic counseling must include:

- The risks and benefits of the specific genetic testing.
- The limitations of the specific genetic testing to be performed and the limitations of interpreting test results for an unaffected individual.

3.5.2 Documentation

Providers must maintain the following gene mutation analysis testing documentation in the client's medical record:

- The appropriateness of the genetic testing
- The client's specific high-risk criteria
- The benefit of the specific genetic testing to be performed
- Pre-testing genetic counseling, including all of the following:
  - Pre-test counseling date with the name and qualifications of the counseling professional
  - The risks, benefits, and limitations discussed with the client
  - The client's ability to understand the risks, benefits, and limitations and the client's informed choice to proceed with the specific gene mutation analysis testing as evidenced by the client's signature on a consent form specific to the genetic mutation testing to be performed.
- The client's previous BRCA comprehensive gene mutation analysis testing results to support medical necessity for ordering BRCA gene mutation analysis testing
- Post-testing genetic counseling, including all the following:
  - Post-test counseling date with the name and qualifications of the counseling professional
  - The client's ability to understand the results of the gene mutation analysis testing and the appropriate medical treatment resulting from the test results.
- The client's treatment plan and any treatment plan changes based on interpretation of the test results

The medical record is subject to retrospective review.

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3.5.3 Prior Authorization for BRCA Testing

Prior authorization is required for initial BRCA testing (procedure codes 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217).

For clients with a known familial BRCA variant, targeted testing for BRCA1 (procedure code 81215) and BRCA2 (procedure 81217) for the specific variant must be performed before utilizing more comprehensive tests.

If the client is of Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent, testing for the three known founder variants (procedure code 81212) should be performed first.

The prior authorization request must include documentation that indicates that the client meets one or more of the criteria below:

- An individual (male or female) from a family with a known deleterious BRCA1/BRCA2 mutation
- A female with a personal history of breast cancer, including invasive or ductal carcinoma in situ (DCIS), diagnosed at age 45 years or younger
- A female with a personal history of breast cancer, including DCIS, diagnosed at any age and of an ethnicity associated with higher mutation frequency, such as: Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent
- A female with a personal history of epithelial ovarian cancer, including fallopian tube and primary peritoneal cancers, diagnosed at any age
- A male with a personal history of breast cancer, including DCIS, diagnosed at any age
- A female with a personal history of breast cancer, including DCIS, diagnosed at age 50 years or younger, and has one of the following:
  - An additional primary (2 primary sites, including bilateral or clearly separate ipsilateral) tumors occurring either synchronously or asynchronously
  - At least one close blood relative with breast cancer at any age
  - An unknown or limited family history
- A female with a personal history of breast cancer, including DCIS, diagnosed at age 60 years or younger with triple negative breast cancer
- A female with a personal history of breast cancer, including DCIS, diagnosed at any age, and has one of the following:
  - At least one close blood relative with breast cancer diagnosed at age 50 years or younger
  - At least two close blood relatives with breast cancer at any age
  - At least one close blood relative with epithelial ovarian cancer, including fallopian tube and primary peritoneal cancers
  - At least two close blood relatives with pancreatic cancer or prostate cancer (Gleason score 7 or greater) at any age
  - A close male blood relative with breast cancer at any age
- A male or female with a personal history of pancreatic cancer or prostate cancer (Gleason score 7 or greater) at any age regardless of ancestry with at least two close blood relatives with one of the following:
  - Breast cancer
  - Ovarian cancer, including fallopian tube and primary peritoneal cancers
  - Prostate cancer (Gleason score 7 or greater)

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    - Pancreatic cancer
- A male or female with a personal history of pancreatic cancer at any age and of an ethnicity associated with higher mutation frequency, such as Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent and one or more close blood relatives with pancreatic cancer
- A male or female with a family history of breast or ovarian cancer, including DCIS with one of the following:
    - At least one first or second degree blood relative meeting any of the criteria above; or
    - At least one third degree blood relative who has breast cancer, including DCIS, or ovarian cancer, including fallopian tube and primary peritoneal cancers, and at least two close blood relatives with one of the following:
        - Breast cancer, including DCIS, of which at least one with breast cancer was diagnosed at 50 years of age or younger
        - Ovarian cancer, including fallopian tube and primary peritoneal cancers

Note: *The term "close blood relative" includes first-degree male or female relatives (e.g., parents, siblings), second-degree relatives (e.g., aunts, uncles, grandparents), and third-degree relatives (e.g., first cousins, great grandparents), from the same side of the family as the client.*

Prior authorization for additional BRCA testing may be considered on a case-by-case basis by Medical Director review when testing criteria for these studies are met for clients who:

- Have previously been tested for BRCA sequencing gene mutation analysis testing and received negative results. Documentation of negative results for all previous BRCA1 sequencing gene mutation analysis testing is required.
- Every reasonable effort and documentation of the specific efforts made to obtain the previous BRCA sequencing gene mutation analysis test results from the client's genetic testing physician or the testing laboratory.

A completed Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Request Form that has been signed and dated by the ordering provider must be submitted.

A provider's signature on a submitted document indicates that the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete.

For comprehensive sequencing (procedure codes 81162 or 81163), the ordering physician must indicate one of the following on the prior authorization request form:

- The client's familial genetic history that supports medical necessity for the requested BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing.
- Every reasonable effort was made to obtain the client's familial genetic history and have been unable to obtain BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing results for the affected family member(s). Documentation of the specific efforts made to obtain the client's familial genetic history must be submitted with the request.

To facilitate a determination of medical necessity and avoid unnecessary denials, the ordering physician must provide correct and complete information, including accurate medical necessity of the services requested. Medical documentation that is submitted by the ordering physician must verify the client's diagnosis or family history. Requisition forms from the laboratory are not sufficient for the establishment of a client's personal and family history.

To complete the prior authorization process, the ordering provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity.

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A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

3.6 Genetic Testing for Colorectal Cancer

Genetic testing is provided to clients who have a first- or second-degree relative who has or has had colorectal cancer in order to determine if the client may have increased risk for developing colorectal cancer.

Note: *A first-degree relative is defined as: sibling, parent, or offspring. A second-degree relative is defined as: uncle, aunt, grandparent, nephew, niece, or half-sibling.*

Interpretation of gene mutation analysis results are part of the evaluation and management service and will not be reimbursed separately.

Genetic test results, when informative, may influence clinical management decisions. The documentation that is maintained in the client's medical record must reflect that the client or family member has been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions prior to the genetic testing. The testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client's medical record and made available upon request.

3.6.1 Documentation Requirements

Providers must maintain the following documentation in the client's medical record for genetic testing for colorectal cancer:

- Documentation of formal pre-test counseling, including assessment of the client's ability to understand the risks and limitations of the test.
- The client's informed choice to proceed with the genetic testing for colorectal cancer.

The ordering provider must select the test based on the familial medical history and the availability of previous family testing results. The medical record is subject to retrospective review.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for genetic testing procedure codes that may be reimbursed.

3.6.2 Authorization Requirements

Prior authorization is required for gene mutation analysis. A completed Special Medical Authorization (SMPA) Request Form, signed and dated by the provider rendering direct care, must be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prior authorized services may be reimbursed once per lifetime when billed by any provider. Additional services will not be prior authorized.

Prior authorization requests may be considered for Familial Adenomatous Polyposis (FAP) testing for clients of any age with well defined hereditary cancer syndromes and for which either a positive or negative result will change medical care. The client for whom the request is made must have more than 20 polyps or a first-degree relative with FAP and a documented mutation.

Note: *Clients who are seven years of age or younger must have clear rationale for testing and documentation of medical necessity from the client's medical record must be submitted with the prior authorization request.*

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Prior authorization requests may be considered for Hereditary Nonpolyposis Colorectal Cancer (HNPCC) testing for clients of any age. Testing for HNPCC is used to determine whether an individual has an increased risk for colorectal cancer or other HNPCC-associated cancers. Results of the test may influence clinical management decisions. The request must include one or more of the following criteria for testing:

- The client has three or more family members (at least one must be a first-degree relative) who have colorectal cancer, and FAP has been ruled out. Two successive generations were affected, and one or more of the relatives was diagnosed with colorectal cancer at 50 years of age or younger.
- The client has had two HNPCC cancers.
- The client has colorectal cancer and a first-degree relative who also has colorectal cancer or HNPCC extracolonic cancer at 50 years of age or younger or colorectal adenoma at 40 years of age or younger.
- The client has had colorectal cancer or endometrial cancer at 50 years of age or younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern on histology at 50 years of age or younger.
- The client has had signet-cell type colorectal cancer at 50 years of age or younger.
- The client has had colorectal adenoma at 40 years of age or younger.
- The client is an asymptomatic individual with a first- or second-degree relative with a documented HNPCC mutation.

Note: *Clients who are 20 years of age or younger must have clear rationale for testing and documentation of medical necessity from the client's medical record must be submitted with the prior authorization request.*

The ordering provider's signature on a submitted document indicates that the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete.

Requisition forms from the laboratory are not sufficient for verification of the personal and family history.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the services requested. Medical documentation that is submitted by the physician must verify the client's diagnosis or family history.

Guidelines for MLH1 and MLH2 mutation testing are based on guidelines established by the American College of Medical Genetics and the American Gastroenterological Association.

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

3.7 Pharmacogenetics

Refer to: Subsection 9.2.43, "Pharmacogenetics" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*)

3.8 Exclusions

The following services are not benefits of the Texas Medicaid Program:

- Genetic testing that is not supported by medical and scientific evidence as outlined in S.B. 989 Biomarker, or that does not show evidence of clinical utility. Clinical utility is defined under S.B.989 Biomarker Sec. 1372.003(a)(1-5), as a test result that provides information that is used in the formu-

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lation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

- Genetic testing that does not predominately address the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision.

4 Radiological and physiological laboratory services

4.1 Enrollment

To enroll in Texas Medicaid, physiological laboratory, portable X-ray supplier, independent diagnostic testing facility (IDTF), and radiological laboratory providers must be actively enrolled in Medicare.

4.1.1 Enrollment Criteria for Mammography Providers

All mammography providers, including those providing stereotactic biopsies, must be certified by the Bureau of Radiation Control (BRC).

Additionally, the Department of State Health Services (DSHS) issues mammography certification to providers who render mammography services. Providers can submit this certification to the TMHP Provider Enrollment Department in lieu of certification issued by the Food and Drug Administration (FDA), because a mammography certification issued by DSHS is recognized by the FDA. TMHP will also accept mammography certification issued by the FDA. The certificate will contain the BRC certification number, dates of issue and expiration, type of service, and Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program provider identifiers.

Providers must check the expiration date of their mammography certification and submit an updated mammography certification prior to the expiration date. The certifications can be uploaded to the Provider Enrollment and Management System (PEMS).

4.2 * Services, Benefits, Limitations, and Prior Authorization

The following high-technology radiology services may be reimbursed by Texas Medicaid with prior authorization:

- Cardiac nuclear imaging
- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Functional MRI (fMRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance elastography (MRE)
- Magnetic resonance imaging (MRI)
- Positron emission tomography (PET) scan imaging

Note: *Providers and facilities are required to use the lowest possible radiation dose that is consistent with acceptable image quality for cardiac nuclear imaging, CT, and PET examinations of all clients. It is recommended that providers and facilities use national standards such as those established by the American College of Radiology (ACR) in their ACR Practice Guidelines and Technical Standards manual.*

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Radiology interpretations in any place of service will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.

Note: *The 3-dimensional (3-D) obstetric ultrasound is not a benefit of Texas Medicaid.*

Refer to: ***[Revised]*** The appropriate radiology service authorization section for exceptions to prior authorization requirements.

4.2.1 Cardiac Nuclear Imaging

Cardiac nuclear imaging is a benefit of Texas Medicaid and may be reimbursed using the following procedure codes:

Procedure Codes									
78414	78428	78451	78452	78453	78454	78466	78468	78472	78473
78481	78483	78494	78496						

The cardiac nuclear imaging study may be reimbursed separately from the diagnostic radiopharmaceutical.

Refer to: The online fee lookup (OFL) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

4.2.1.1 Authorization Requirements

Authorization is required for cardiac nuclear imaging.

Refer to: Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in this handbook.

4.2.2 Computed Tomography, Magnetic Resonance Imaging, and Related Services

CT, CTA, fMRI, MRA, MRE, MRI, and ultrasound transient elastography (TE) services are benefits of Texas Medicaid.

The following procedure codes may be reimbursed with prior authorization for CT, CTA, fMRI, MRA, MRE, and MRI radiology services:

Procedure Codes									
70336	70450	70460	70470	70471	70472	70473	70480	70481	70482
70486	70487	70488	70490	70491	70492	70496	70498	70540	70542
70543	70544	70545	70546	70547	70548	70549	70551	70552	70553
70554	70555	71250	71260	71270	71271	71275	71550	71551	71552
71555	72125	72126	72127	72128	72129	72130	72131	72132	72133
72141	72142	72146	72147	72148	72149	72156	72157	72158	72159
72191	72192	72193	72194	72195	72196	72197	72198	73200	73201
73202	73206	73218	73219	73220	73221	73222	73223	73225	73700
73701	73702	73706	73718	73719	73720	73721	73722	73723	73725
74150	74160	74170	74174	74175	74176	74177	74178	74181	74182
74183	74185	75557	75559	75561	75563	75565	75571	75572	75573
75574	75577	75580	75635	76376	76377	76380	76390	76391	76497
76498	77011	77046	77047	77048	77049	77084			

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The professional component may be reimbursed when the service is rendered in the office, inpatient hospital, or outpatient hospital setting by physician providers.

The technical component will be a benefit when rendered in the office setting by physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers.

Procedure codes 76497 and 76498 will be a benefit when rendered in the outpatient hospital setting by radiation treatment center providers.

The following revenue codes must be billed with the most appropriate corresponding procedure code for CT, CTA, fMRI, MRA, MRE, and MRI radiology services rendered by outpatient hospital providers:

Revenue Codes									
350	351	352	359	610	611	612	619		

The addition of post 3-D reconstruction (procedure codes 76376 and 76377) CT, CTA, MRA, and MRI studies must be prior authorized. No additional payment will be made in absence of prior authorization.

4.2.2.1 Functional MRI (fMRI)

Texas Medicaid considers fMRI medically necessary when it is being used as part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, which might potentially be put at risk during the proposed surgery.

Neurofunctional testing procedure code 96020 must be reported in conjunction with brain fMRI procedure code 70555. Procedure code 96020 is informational and will not be reimbursed separately.

4.2.2.2 Intraoperative MRI (iMRI)

Indications for intracranial neurosurgical procedures using intraoperative MRI (iMRI) include, but are not limited to, the following:

- Oncologic neurosurgical procedures
- Epilepsy
- Chiari surgery
- Deep brain stimulators

Only one iMRI procedure code may be billed per operative session. Procedure codes 70557, 70558, and 70559 must not be billed in conjunction with procedure code 61751, 77021, or 77022.

Intraoperative MRI procedure codes 70557, 70558, and 70559 that are billed with modifier 26 may be reimbursed to physician providers for interpretation.

Procedure codes 75559 and 75563 must be billed in conjunction with stress testing procedure codes 93015, 93016, 93017, and 93018.

4.2.2.2.1 Laser Interstitial Thermal Therapy (LITT)

Laser interstitial thermal therapy (LITT) is an iMRI procedure used when a patient has one of the following diagnoses and is not a surgical candidate:

- Relapsed brain metastasis
- Acute cerebrovascular insufficiency
- Radiation Necrosis
- Secondary malignant neoplasm of brain

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LITT therapy is billed under procedure codes 61736 or 61737, and requires prior authorization.

4.2.2.3 Magnetic Resonance Elastography (MRE)

MRE is a diagnostic tool for assessing hepatic fibrosis by relying on visualization of the passage of acoustic waves through liver tissue while the patient is undergoing magnetic resonance imaging (MRI). MRE combines MRI imaging with low-frequency vibrations to create a visual map (elastogram) that identifies stiffness of the liver.

MRE (procedure code 76391) may be reimbursed for diagnosis or monitoring of liver fibrosis or cirrhosis in clients suspected of having, or who have been diagnosed with chronic liver disease.

Performance of MRE may be reimbursed two times per rolling year. Performance of MRE may not be reimbursed within 6 months following a liver biopsy or TE, as it is not medically necessary.

4.2.2.4 * Ultrasound Transient Elastography (TE)

TE is a noninvasive device that uses a patented ultrasound-controlled attenuation parameter (CAP) technology, and aspartate-aminotransferase (AST) values to detect or monitor liver fibrosis. TE involves the analysis of ultrasonographic wave propagation and tissue deformation in patients suspected of having or diagnosed with chronic liver disease. TE is used to measure the presence and extent of liver fibrosis.

TE (procedure code 91200) may be reimbursed for the diagnosis or monitoring of liver fibrosis or cirrhosis in clients suspected of having, or who have been diagnosed with chronic liver disease.

Reimbursement for procedure code 91200 is limited to the following diagnosis codes:

[Revised] Diagnosis Codes									
K710	K7110	K7111	K712	K713	K714	K7150	K7151	K716	K717
K718	K719	K7400	K7401	K7402	K740A	K742	K7581	K760	

Performance of TE may be reimbursed up to two times per rolling year. Performance of TE may not be reimbursed within 6 months following a liver biopsy or MRE, as it is not medically necessary.

TE may be inappropriate and ineffective in clients with obesity, ascites, or narrow intercostal spaces.

4.2.2.5 Authorization Requirements and Flexibility

Authorization is required for CT, CTA, fMRI, MRA, MRE, and MRI procedures.

Note: *Intraoperative MRI (iMRI) does not require prior authorization, except for LITT (procedure codes 61736 and 61737), which does require prior authorization. TE does not require prior authorization (procedure code 91200).*

Refer to: Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in this handbook.

If the ordering physician or radiologist determines that a CT, CTA, fMRI, MRA, MRE, or MRI procedure that is different from the authorized procedure is required or that additional procedures are required, the following will apply:

- The procedure performed is less complex than the procedure authorized but of the same modality (e.g., an MRI with contrast is prior authorized and the actual procedure performed is an MRI without contrast). Full reimbursement is allowed for the billed procedure.
- The authorized procedure is performed and an additional higher-level procedure of the same modality is deemed medically necessary within the same authorization period. A separate authorization is required. The additional procedure must be prior authorized separately and submitted on a separate claim.

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- The procedure billed is more complex than the procedure authorized but of the same modality. No authorization update will result in reimbursement according to the rate of the lesser authorized code. For full reimbursement of the more complex procedure, the authorization requires an update.

The following table includes the recognized relationships for authorization flexibility:

Level 1 (High)	Level 2 (Moderate)	Level 3 (Low)
70470	70460	70450
70471	70482	70481
70472	70480	70488
70473	70487	70486
70492	70491	70490
70543	70542	70540
70546	70545	70544
70549	70548	70547
70553	70552	70551
71270	71260	71250
71552	71551	71271
72127	72126	71550
72130	72129	72125
72133	72132	72128
72156	72142	72131
72157	72147	72141
72158	72149	72146
72194	72193	72148
72197	72196	72192
73202	73201	72195
73220	73219	73200
73223	73222	73218
73702	73701	73221
73720	73719	73700
73723	73722	73718
74170	74160	73721
74178	74177	74150
74183	74182	74176
75559	75557	74181
75563	75561	

4.2.3 Positron Emission Tomography (PET) Scan Imaging

PET scan imaging services are benefits of Texas Medicaid and may be reimbursed using the following procedure codes:

Procedure Codes						
78608	78811	78812	78813	78814	78815	78816

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Procedure codes 78459, 78491, and 78492 are not reimbursed by Texas Medicaid.

The PET scan procedure may be reimbursed separately from the diagnostic radiopharmaceutical.

Refer to: The online fee lookup (OFL) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

4.2.3.1 Authorization Requirements

Prior authorization is required for PET imaging services.

Refer to: Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.4 Radiology/Diagnostic Imaging

Radiography and radiology/diagnostic imaging may be reimbursed by Texas Medicaid using the following procedure codes:

Procedure Codes									
33880	33881	33882	33883	33886	74775				

Procedure code 74775 may be reimbursed for services rendered to clients who are 20 years of age and younger.

4.2.4.1 Authorization Requirements

Prior authorization is not required for the radiology/diagnostic imaging procedure codes in this section.

4.2.5 Physician-Performed Radiology Services

Refer to: Subsection 9.2.65, "Radiology Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.6 Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET

Prior authorization is not required for emergency department services, outpatient observation services, or inpatient hospital radiology services.

Prior authorization is required for outpatient nonemergent services (i.e., those that are planned or scheduled). Prior authorization must be obtained before the service is rendered.

The following table summarizes the authorization requirements for cardiac nuclear imaging services, CT, CTA, fMRI, MRA, MRE, MRI, and PET:

Condition	Authorization Requirements
Emergency department visit	Authorization is not required for emergency department radiology services that are rendered during an emergency department visit. • For professional claims, the appropriate radiology procedure code must be billed with modifier U6. • The facility may be reimbursed using the appropriate, corresponding emergency services revenue code.

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Condition	Authorization Requirements
Outpatient observation	Authorization is not required for radiology services rendered during outpatient observation. • For professional claims, the appropriate radiology procedure code must be billed with modifier U6. • The facility may be reimbursed using the appropriate, corresponding outpatient observation revenue code.
Nonemergent condition: planned or scheduled radiology service	Texas Medicaid defines a nonemergent condition as a symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical, or diagnostic studies prior to diagnosis and treatment. Prior authorization is required for outpatient nonemergent (i.e., those studies that are planned or scheduled) cardiac nuclear imaging services, CT, CTA, fMRI, MRA, MRE, MRI, and PET scan. ***Important:*** *The authorization number must be on the claim when it is submitted to TMHP for reimbursement. Only one authorization is allowed per claim. For the most accurate and efficient claims processing, TMHP recommends that the procedure code that is submitted on the claim match the procedure code that is authorized. Providers are encouraged to contact TMHP and update the prior authorization if the ordering physician or radiologist changes the actual procedure that is performed. Providers have 14 calendar days after the day on which the study was completed to update the prior authorization.* Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization. ***Refer to:*** Subsection 4.2.6.1, "Retroactive Authorization" in this handbook.
Outpatient urgent condition	Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures. Texas Medicaid defines an urgent condition as a symptom or condition that is not an emergency, but requires further diagnostic work-up or treatment within 24 hours to avoid a subsequent emergent situation. ***Refer to:*** Subsection 4.2.6.1, "Retroactive Authorization" in this handbook. ***Note:*** *Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization.*

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Condition	Authorization Requirements
Outpatient emergent condition	Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures. Texas Medicaid defines an emergent condition as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance use) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in at least one of the following: • Placing the recipient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction to any bodily organ or part The physician must determine that a medical emergency, which imminently threatens life or limb exists and that the medical emergency requires advanced diagnostic imaging. ***Refer to:*** Subsection 4.2.6.1, "Retroactive Authorization" in this handbook.
Inpatient hospital	Authorization is not required for inpatient hospital radiology services.

Prior authorization of nonemergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the service and must be maintained in the client's medical record, both by the ordering physician (i.e., the physician who orders the study) and the performing facility.

Nationally-accepted guidelines and radiology protocols based on medical literature are used in the authorization processes for urgent, emergent, and nonemergent services. These include, but are not limited to:

- American College of Radiology (specifically, their Appropriateness Criteria)
- American Academy of Neurology
- American Academy of Orthopedic Surgeons
- American College of Cardiology
- American Heart Association
- National Comprehensive Cancer Care Network

Refer to: Subsection 4.2.2.5, "Authorization Requirements and Flexibility" in this handbook for information about authorization flexibility for CT, CTA, fMRI, MRA, and MRI procedures.

4.2.6.1 Retroactive Authorization

A request for retroactive authorization for an emergent or urgent cardiac nuclear imaging service, CT, MR, or PET must be submitted no later than 14 calendar days after the day on which the study was completed.

Retroactive authorization of urgent or emergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the study and must be maintained in the client's medical record, both by the ordering physician (i.e., the physician ordering the study) and the performing facility.

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Retroactive authorization for outpatient urgent services is considered when all of the following criteria are met:

- The physician who renders the imaging service determines, during the provision of prior-authorized services, that additional or alternate procedures are medically indicated.
- The urgent condition requires additional or alternate advanced diagnostic imaging.

Retroactive authorization for outpatient emergent services is considered when all of the following criteria are met:

- The physician determines that a medical emergency that imminently threatens life or limb exists.
- The medical emergency requires advanced diagnostic imaging.

Retroactive authorization is not required when a prior-authorized CT or MR procedure is changed by the ordering physician or radiologist to a lesser procedure of the same modality (e.g., MRI with contrast is authorized and the actual procedure performed is MRI without contrast).

Documentation of medical necessity for a liver biopsy (procedure code 47000 or 47100) performed within 6 months following TE (procedure code 91200) or MRE (procedure code 76391) must be maintained in the client's records and is subject to retrospective review.

4.2.6.2 Request Form and Documentation

Regardless of method of submission, the ordering physician must complete and retain the Radiology Prior Authorization Request Form with an original signature in the client's medical record.

Providers must submit the form with the request information related to the medical necessity for the service, including all of the following:

- Diagnosis
- Treatment history
- Treatment plan
- Medications that the client is currently taking
- Previous imaging results

Providers may also be asked to provide additional documentation as necessary during the authorization process.

Section A of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the ordering physician before requesting prior authorization, regardless of the method of request for authorization.

Section B of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the physician who performs the service prior to requesting retroactive authorization for urgent or emergent studies.

Residents, physician assistants (PAs), and nurse practitioners (NPs) may order radiological procedures; however, the ordering or referring clinician must sign the authorization form and provide the group or supervising provider's NPI.

Refer to: Section 3, "Inpatient Hospital (Medical/Surgical Acute Care Inpatient Facility)" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 9, "Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information on MRI and contrast material.

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4.2.6.3 Methods of Submission

Authorization requests for cardiac nuclear imaging studies, CT, CTA, fMRI, MRA, MRE, MRI, and PET for Texas Medicaid clients must be submitted to TMHP. Providers can submit authorizations to TMHP:

- By fax to 833-912-1129
- By mail to:

Texas Medicaid & Healthcare Partnership
Radiology Prior Authorization
12365A Riata Trace Parkway
Austin, TX 78727

Requests for retroactive authorization may be submitted by fax or mail.

4.2.7 Additional Radiology and Physiological Laboratory Services

4.2.7.1 Ambulatory Electroencephalogram

Refer to: Subsection 9.2.26.2, "Ambulatory and Long-Term Electroencephalogram (Ambulatory EEG)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.2 Brachytherapy

Refer to: Subsection 9.2.64.1, "Brachytherapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.3 Diagnostic Doppler Sonography

Refer to: Subsection 9.2.27, "Diagnostic Doppler Sonography" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.4 Electrocardiograms

Refer to: Subsection 9.2.26.6, "Electrocardiogram (ECG)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.5 Electromyography (EMG) and Nerve Conduction Studies (NCS)

Refer to: Subsection 9.2.26.7, "Esophageal pH Probe Monitoring" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Subsection 4.2.10, "Electrodiagnostic (EDX) Testing" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.6 Esophageal pH Probe Monitoring

Refer to: Subsection 9.2.26.7, "Esophageal pH Probe Monitoring" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.7 Mammography Services

The following procedure codes will be denied if the provider does not have a BRC mammography certification on file:

Procedure Codes		
77032	77053	77054

Refer to: Subsection 9.2.15.4, "Prognostic Breast and Gynecological Cancer Studies" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about mammography services.

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4.2.7.8 Nonsurgical Vision Services

Refer to: Subsection 4.3.6.2, "Ophthalmic Ultrasound" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.9 Obstetric Services

Refer to: Section 4, "Obstetric Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.10 Radiation Therapy Services

Refer to: Subsection 9.2.64, "Radiation Therapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about radiation therapy, including brachytherapy and stereotactic radiosurgery.

4.2.7.11 Screening and Diagnostic Studies of the Breast

Refer to: Subsection 9.2.15.3, "Mammography (Screening and Diagnostic Studies of the Breast)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.12 Sleep Studies

Refer to: Subsection 9.2.72, "Sleep Studies" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including radiological and physiological laboratory services. Radiological and physiological laboratory services are subject to retrospective review and recoupment if documentation does not support the service billed.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

Claims for radiological and physiological laboratory services and portable X-ray supplier services must include the referring or ordering provider. Radiological and physiological laboratory services and portable X-ray supplier services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 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.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

4.4.1.1 Diagnosis Requirements

A diagnosis is not required with a provider's request for payment except when providing the following services:

- Ambulatory Electroencephalogram (A/EEG)

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- Arteriogram
- Cardiac nuclear imaging
- Chest X-ray
- Computed tomography imaging (CT)
- Echography
- Electrocardiogram (ECG)
- Functional MRI (fMRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance imaging (MRI)
- Mammographies, noninvasive diagnostic studies
- Positron emission tomography (PET) scan
- Polysomnographies
- Venographies

Claims for all services provided to clients who are eligible for "Emergency Care Only" must have a diagnosis to be considered for reimbursement. As with all procedures billed to Texas Medicaid, most baseline screening or comparison studies are not a benefit.

Refer to: Section 9, "Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information on these services.

4.4.1.2 Modifier Requirements for Type of Service Assignment

For the radiology, physiological lab, and X-ray procedures in this chapter, providers must bill modifier 26 for the interpretation component or modifier TC for the technical component. No modifier is necessary for the total component.

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.3.2, "Type of Service (TOS)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

4.4.2 Reimbursement

Radiological and physiological laboratory and portable X-ray supplier providers are reimbursed in accordance with 1 TAC §355.8085. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Texas Medicaid pays only up to the amount allowed for the total component for the same procedure submitted for reimbursement by the same provider for the same client with the same date of service. Providers who perform the technical service and the interpretation must bill the total component. Providers who perform only the technical service must bill the technical component, and those who perform only the interpretation must bill the interpretation component. The total component and the technical or interpretation component for the same procedure are not reimbursed separately when billed by any provider with the same date of service; the first claim may be reimbursed and the additional claim(s) will be denied. Claims are considered for reimbursement based on the order in which they are received.

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For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure with the same date of service for the same client, regardless of provider, the claim for the total component is denied. The same is true if a total component has already been paid and claims are received for the individual components.

Radiology and physiological laboratory and portable X-ray services are not payable when the client is in an inpatient setting. The reimbursement for these services are included in the diagnosis-related group (DRG) payment.

Imaging services submitted by outpatient hospital providers may be reimbursed a flat fee.

Imaging services procedure codes can be found on the TMHP fee schedule website titled, "Hospital Outpatient Imaging Services."

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

4.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

5 Claims Resources

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

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7 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing
Radiology Prior Authorization Request Form

8 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Independent Laboratory
Office Visit with Lab and Radiology
Radiological/Physiological Laboratory and Portable X-Ray Supplier

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SCHOOL HEALTH AND RELATED SERVICES (SHARS) HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NOVEMBER 2026

TEXAS
Health and Human Services

SCHOOL HEALTH AND RELATED SERVICES (SHARS) HANDBOOK

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1 General Information

The information in this handbook is intended for school districts and healthcare providers who provide school-based health services for children aged 20 years and younger. This handbook contains information about Texas Medicaid benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.7, "Provider Responsibilities" in "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information).

2 School Health and Related Services (SHARS)

2.1 Overview

SHARS are direct medical services and transportation services available to children who are 20 years of age or younger, enrolled in Medicaid and are eligible to receive services under the Individuals with Disabilities Education Act (IDEA). The services must be included in the child's individualized education program (IEP) established under IDEA.

SHARS also includes audiology evaluation and management services provided to eligible students under Section 504 of the Rehabilitation Act of 1973. The services must be included in the child's written Section 504 Plan.

Local Education Agencies (LEAs), which include Texas independent school districts (ISDs) and public charter schools, must enroll in Texas Medicaid as a SHARS provider to be reimbursed for providing direct medical and transportation services to Medicaid enrolled students in a school setting.

The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and the Texas Health and Human Services Commission (HHSC).

According to Title 34 Code of Federal Regulations (CFR) §300.303, re-evaluations for SHARS services must occur at least once every 3 years, unless the parent and the public agency agree that a re-evaluation is unnecessary.

SHARS allows LEAs to be reimbursed for direct medical and transportation services that are determined to be medically necessary and are documented in the IEP.

The Centers for Medicare & Medicaid Services (CMS) require LEAs to be enrolled as SHARS Medicaid providers, participate in the Random Moment Time Study (RMTS), submit claims that are reimbursed on an interim basis, and submit an annual SHARS Cost Report.

To receive SHARS services, Medicaid-enrolled students must:

- Be enrolled in a public school's special education program; and

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- Be 20 years of age or younger; and
- Have a disability or chronic medical condition; and
- Have an IEP documenting disability and medical necessity; or
  - An IEP is a written plan mandated by IDEA that is developed by the school, in conjunction with the parents or guardians, teachers and other health professionals. This plan authorizes the services that can be provided and defines the individualized objectives of a child who has been found to have a disability.
  - The IEP is created by an ARD (Admission, Review, and Dismissal) Committee.
  - Title 34 CFR §300.320 outlines what must be included in an IEP.
  - The SHARS program cannot reimburse for services beyond what is detailed in the IEP.
- Have a written Section 504 plan, documenting disability and medical necessity for audiology evaluation and management services.
  - A Section 504 plan is a plan mandated by 29 United States Code (U.S.C.) Section 794, regulated by 34 CFR §104, and developed by the school, in conjunction with the parents or guardians, teachers, and school administration. The plan must include evaluation data along with placement information regarding the type of services the student needs.
  - Evaluation under a Section 504 plan may be conducted using the same process to evaluate the needs of students under IDEA. In accordance with 34 CFR §104.35, LEAs may choose to adopt a separate process for evaluating students under a Section 504 plan.
  - The SHARS program cannot reimburse for services under a Section 504 plan beyond audiology evaluation and management services.

SHARS covers the following services:

- Audiology, delivered by licensed audiologist
- Counseling, individual and group, delivered by licensed master's level therapist
- Nursing services, including medication administration and nursing services delegated by a registered nurse (RN) (in compliance with RN delegated nursing tasks criteria as determined by the Texas Board of Nursing) to an employee or health aide
- Occupational therapy (OT), individual and group, delivered by licensed therapist or licensed assistant
- Personal care services (PCS)
- Physician services
- Physical therapy (PT), individual and group, delivered by licensed therapist or licensed assistant
- Psychological services, individual and group, delivered by a licensed psychiatrist/psychologist or a licensed specialist in school psychology (LSSP)
- Special transportation services
- Speech therapy (ST), individual and group, delivered by licensed therapist or licensed assistant

Note: *These services must be provided by qualified personnel who are employed by the LEA or under contract with the LEA.*

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Subject to the specifications, conditions, limitations, and requirements established by HHSC, SHARS are the services outlined above and determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and who are 20 years of age or younger receive the benefits accorded to them by federal and state law guaranteeing a free and appropriate public education.

Care coordination between SHARS OT, PT, and ST providers and non-SHARS OT, PT, and ST providers is strongly encouraged to reduce or avoid duplication of services. Care coordination requires parental consent and must be carried out in a manner that complies with privacy and confidentiality requirements in accordance with state and federal law and regulations including Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA).

Multi-disciplinary team evaluations performed collaboratively with any combination of OT, PT, ST, and Psychology are billable by each provider when performed during overlapping time periods.

Reimbursement is available for OT, PT, or ST prescribed on the student's IEP when delivered as co-treatment. Providers should document in the session notes the reason for co-treatment.

Co-treatment is defined as two different therapy disciplines performing therapy on the same client at the same time by a licensed therapist as defined in this handbook for each therapy discipline and rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners (ECPTOTE) and Texas Department of Licensing and Regulation (TDLR).

Providers of SHARS services must meet Texas Medicaid provider qualifications for each service according to the Texas Medicaid state plan and the Texas Medicaid Provider Procedures Manual (TMPPM).

All SHARS policies must be consistent with the Texas state plan and the following Texas Administrative Code rules:

- 1 TAC §354.1341 & §354.1342 SHARS
- 1 TAC §354.1003(a)(5)(J) Time Limits for Submitted Claims
- 1 TAC §355.8441(a)(12)(A) Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
- 1 TAC §355.8443 Reimbursement Methodology for SHARS
- 1 TAC §355.101 - §355.114 Cost Determination Process

In accordance with 34 CFR §300.154, 1 TAC §354.1342, and FERPA, LEAs are required to obtain parental consent prior to disclosing personally identifiable student information maintained in a student's education record, and are also required to obtain parental consent for Medicaid-enrolled students prior to billing Medicaid for SHARS services prescribed in the Medicaid-enrolled student's IEP or Section 504 plan.

Providers must adhere to the documentation requirements for each SHARS service outlined in this handbook.

SHARS services may be provided in the following places of service: office, home, or other location (e.g., school).

A prescription is defined as a written order for services from the ordering physician or other eligible prescribing provider. Prescriptions are required for SHARS OT and PT services.

Other eligible prescribing provider is defined as an advanced practice registered nurse (APRN) under the delegation of a physician, or a physician assistant (PA) under the delegation of a physician.

Referrals are required for SHARS audiology and speech therapy (ST) services.

Note: *A prescription may serve as a referral.*

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A referral is defined as a written document requesting evaluation for services from the referring physician or other eligible referring provider, defined as follows:

- For SHARS audiology - an audiologist referring for audiology services, an APRN under the delegation of a physician, or a PA under the delegation of a physician
- For SHARS ST services - a speech-language pathologist (SLP) with an unrestricted license to provide services independently referring for speech and language services, an APRN under the delegation of a physician, or a PA under the delegation of a physician

2.1.1 Eligibility Verification

The following are means to verify Medicaid eligibility of students:

- Verify electronically through third party software or TexMedConnect.
- School districts may inquire about the eligibility of a student by submitting the student's Medicaid number or two of the following: name, date of birth, or Social Security number (SSN). A search can be narrowed further by entering the county code or sex of the student. Verifications may be submitted in batches without limitations on the number of students.
- Contact AIS at 1-800-925-9126.

2.2 Enrollment

2.2.1 School Health and Related Services Enrollment

To enroll in Texas Medicaid as a SHARS provider, the provider must:

- Be an LEA school that employs or contracts with individuals or entities that meet health care practitioner certification and licensing requirements in accordance with the Texas Medicaid state plan for SHARS.
- Since LEAs are government entities, they should select "public entity" on the enrollment application.
- Comply with all applicable federal and state laws and regulations governing the services provided.
- Be enrolled and approved for Texas Medicaid participation.
- Sign a written provider agreement.
- Comply with the terms of the provider agreement and all requirements of Texas Medicaid, including the rules, policies and procedures, manuals, bulletins, banners, standards, and guidelines published by Texas Health and Human Services Commission (HHSC) or its designee.
- Bill for services covered by Texas Medicaid in the manner and format prescribed by HHSC or its designee.

SHARS providers are required to notify parents or guardians of their rights to a "freedom of choice of providers" (42 CFR §431.51) under Texas Medicaid. SHARS providers may provide this notification during the initial Admission, Review, and Dismissal (ARD) process. If a parent requests that someone other than the employees or currently contracted staff of the SHARS provider LEA provide a required SHARS service listed in the student's IEP, the SHARS provider must make a good faith effort to comply with the parent's request. The SHARS provider can negotiate with the requested provider to provide the services under contract. The requested provider must meet, comply with, and provide all of the employment criteria and documentation that the SHARS provider normally requires of its employees and currently contracted staff. The SHARS provider can negotiate the contracted fee with the requested provider and is not required to pay the same fee that the requested provider might receive from Medicaid for similar services.

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If the requested provider is a currently enrolled Medicaid provider, the requested provider can bill Medicaid for the services they provide. The services provided to the student can only be billed once; either by the requested provider or the SHARS provider. If the requested provider signs a contract with the SHARS provider, then only the SHARS provider can bill for the services provided by the requested provider.

2.2.2 Private School Enrollment

A private school may not participate in the SHARS program as a SHARS provider.

2.3 Services, Benefits, Limitations, and Prior Authorization

All of the SHARS procedures listed in the following sections require a valid diagnosis code. SHARS includes audiology services, counseling services, nursing services, occupational therapy services, personal care services, physical therapy services, physician services, psychological services (including testing), special transportation services, and speech therapy services.

Reminder: *SHARS are the services determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and who are 20 years of age and younger receive the benefits accorded to them by federal and state law in order to participate in the educational program.*

2.3.1 Audiology Services

Audiology services include, but are not limited to, the following:

- Identification of children with hearing loss
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing
- Provision of amelioration activities, such as language amelioration, auditory training, speech reading (lip reading), hearing evaluation and speech conversion
- Determination of the child's need for group and individual amplification
- Hearing services

Audiology services must be provided by a professional who holds a valid state license as an audiologist. An audiology assistant who is licensed by the state may provide services within the guidelines of state licensure when the assistant or intern is acting under the supervision of a qualified audiologist.

A referral is required for audiology services. The referral must be updated a minimum of one time every three calendar years.

The LEA must maintain the referral in the student's medical record.

Audiology services must be referred by a physician or other eligible referring provider. A referral for audiology services must be signed and dated within three calendar years before the initiation of services.

In order for audiology services to be reimbursed through SHARS, the name and national provider identifier (NPI) of the referring licensed physician, or other eligible referring provider, must be listed on the claim and kept in the student's medical record.

Within SHARS, Medicaid-enrolled audiologists may refer for their own services or those of another SHARS audiologist. They may not refer for any services outside of SHARS or for SHARS services of other disciplines.

SHARS audiologists whose evaluations serve as the referral must be enrolled in Texas Medicaid as either individual practitioners or ordering, referring, or prescribing (ORP) providers. When submitting claims for SHARS audiology services, LEAs must include the referring provider's NPI in the referring provider NPI field of the claim form.

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IDEA requires that a student receiving services must have a re-evaluation every three years, which requires current information; unless the parent and the LEA agree that a re-evaluation is unnecessary (IDEA §1414 (a)(2)(B)).

A separate referral is not required for a re-evaluation. The need for a re-evaluation should be determined by the student's ARD committee.

Only the time spent with the student present is billable; time spent without the student present is not billable. Direct audiology evaluation time with the student present is billable. Indirect time for interpretation and report writing is not billable.

Hearing aids and fittings are not covered by the SHARS program, but may be reimbursed through Texas Medicaid outside of the SHARS program. Audiologists and hearing aid fitters and dispensers employed by or contracted with school districts must enroll in Texas Medicaid as individual practitioners and choose "Hearing Aid" on the enrollment application to be reimbursed for hearing aid devices and accessories, and fitting and dispensing visits and revisits.

Functional listening evaluations are not billable.

Audiometry is the testing of a person's ability to hear various sound frequencies and is performed with the use of calibrated electronic equipment. The results of the audiometry test may be recorded on a grid or graph called an audiogram. Audiometry is used to identify and diagnose hearing loss.

Audiology Services Procedure Codes

Procedure Code	Individual or Group	Provider	Student Population	Unit of Service
92552 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92552 with modifier U4	Individual	Licensed audiologist	504	Untimed
92553 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92553 with modifier U4	Individual	Licensed audiologist	504	Untimed
92555 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92555 with modifier U4	Individual	Licensed audiologist	504	Untimed
92556 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92556 with modifier U4	Individual	Licensed audiologist	504	Untimed
92557 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92557 with modifier U4	Individual	Licensed audiologist	504	Untimed
92567 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92567 with modifier U4	Individual	Licensed audiologist	504	Untimed
92568 with modifier TM	Individual	Licensed audiologist	IEP	Untimed

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Procedure Code	Individual or Group	Provider	Student Population	Unit of Service
92568 with modifier U4	Individual	Licensed audiologist	504	Untimed
92582 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92582 with modifier U4	Individual	Licensed audiologist	504	Untimed
92620 with modifier TM	Individual	Licensed audiologist	IEP	60 minutes
92620 with modifier U4	Individual	Licensed audiologist	504	60 minutes
92621 with modifier TM	Individual	Licensed audiologist	IEP	15 minutes
92621 with modifier U4	Individual	Licensed audiologist	504	15 minutes
92630 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92630 with modifier U4	Individual	Licensed audiologist	504	Untimed
92633 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92633 with modifier U4	Individual	Licensed audiologist	504	Untimed
92636 with modifier TM	Individual	Licensed audiologist	IEP	30 minutes
92636 with modifier U4	Individual	Licensed audiologist	504	30 minutes
92637 with modifier TM	Individual	Licensed audiologist	IEP	15 minutes
92637 with modifier U4	Individual	Licensed audiologist	504	15 minutes

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Audiology Services Modifiers

Modifier	Description
52	Reduced Services
TM	Audiology services provided to students with individualized education program (IEP)
U4	Audiology services provided to students with Section 504 plan

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

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Pure tone audiometry (procedure codes 92552 and 92553) is limited to one per day, any provider. If both procedure codes are billed for the same date of service, same provider, and same student, procedure code 92553 will be reimbursed and procedure code 92552 will be denied.

Speech audiometry threshold (procedure codes 92555 and 92556) is limited to one of either procedure code per day, any provider. If both procedure codes are billed for the same date of service, same provider, and same student, procedure code 92556 will be reimbursed and procedure code 92555 will be denied.

Comprehensive audiometry (procedure code 92557) is limited to one per day, same provider. This service includes testing of both ears. If procedure codes 92552, 92553, 92555, or 92556 are billed for the same date of service, same provider, and same student as procedure code 92557, only procedure code 92557 will be reimbursed.

Procedure codes 92553 and 92556 are not reimbursed on the same day by the same provider for the same student. Instead of billing both procedure codes for the same date of service, same provider, and same student, providers should bill with the more appropriate, comprehensive audiometry procedure code 92557.

Tympanometry (procedure code 92567) is limited to one per day, any provider. Acoustic reflex testing, threshold (procedure code 92568) is limited to one per day, any provider.

Conditioning play audiometry (procedure code 92582) is limited to one per day, any provider.

The use of procedure codes 92552, 92553, 92555, 92556, 92557, 92567, 92568, and 92582 implies that testing is performed in both ears. Audiologists must use modifier 52, reduced services, if a test is applied to one ear instead of both.

Auditory processing evaluation (procedure codes 92620 and 92621) is billable on an individual basis only. The maximum billable time for the first hour of an auditory processing evaluation (procedure code 92620) is 60 minutes (1 unit). The maximum billable time for each additional 15 minutes of an auditory processing evaluation (procedure code 92621) is 60 minutes (4 units).

Auditory processing evaluation (procedure code 92620) is limited to one per day, any provider.

Auditory rehabilitative treatment (procedure codes 92630 and 92633) is limited to one per day, any provider. Session notes for therapy services (procedure codes 92630 and 92633) are required.

2.3.2 Nursing Services

Nursing services are defined as the promotion of health, prevention of illness, and the care of ill, disabled and dying people through the provision of services essential to the maintenance and restoration of health. SHARS nursing services are skilled nursing tasks, as defined by the Texas Board of Nursing (BON) that are included in the student's IEP.

Examples of reimbursable nursing services include, but are not limited to, the following:

- Inhalation therapy
- Ventilator monitoring
- Nonroutine medication administration
- Tracheostomy care
- Gastrostomy care
- Ileostomy care
- Catheterization
- Suctioning
- Client training

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- Assessment of a student's nursing service's needs

Nursing services must be provided by a registered nurse (RN), advanced practice registered nurse (APRN) (including nurse practitioners [NPs] and clinical nurse specialists [CNSs]), licensed vocational nurse/licensed practical nurse (LVN/LPN), or a school health aide or other trained, unlicensed assistive person delegated and supervised by an RN or APRN.

As defined by 22 TAC §225.4, nurse-delegated tasks are those in which a registered nurse authorizes an unlicensed person to perform tasks of nursing care in selected situations and indicates that authorization in writing. Nurse-delegated tasks includes tasks listed in 22 TAC §225.10 and must meet the professional standards of the Texas Board of Nursing.

Personal Care Services (PCS) cannot be billed as a nursing service. If a SHARS provider is not sure whether to bill a service as PCS or a nursing service, the SHARS provider must discuss the services provided to the student with the RN or APRN who can make that determination.

A prescription is not needed to provide nursing services through SHARS.

Only the time spent with the student present is billable. Time spent without the student present is not billable.

Private duty nursing (PDN) is not a SHARS covered service.

Providers of nursing services must follow the Texas BON guidelines for documenting the administration of medication.

Nursing Services Procedure Codes

Procedure Code	Individual or Group	Unit of Service
T1002 with modifier TD	Individual	15 minutes
T1002 with modifier TD and UD	Group	15 minutes
T1002 with modifier U7	Delegation, Individual	15 minutes
T1002 with modifier U7 and UD	Delegation, Group	15 minutes
T1003 with modifier TE	Individual	15 minutes
T1003 with modifier TE and UD	Group	15 minutes
T1502 with modifier TE	Unspecified	Medication, administration per visit
T1502 with modifier TD	Unspecified	Medication administration, per visit
T1502 with modifier U7	Unspecified	Delegation, medication administration, per visit

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

The following 15-minute procedure codes for direct nursing services are limited to 16 combined units (four hours) per day:

Procedure Codes					
T1002 with modifier TD	T1002 with modifier TD and UD	T1002 with modifier U7	T1002 with modifier U7 and UD	T1003 with modifier TE	T1003 with modifier TE and UD

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The following procedure codes are limited to a total of four combined medication administration visits per day:

Procedure Codes		
T1502 with modifier TD	T1502 with modifier U7	T1502 with modifier TE

All of the nursing services minutes that are delivered to a student during a calendar day must be added together before they are converted to units of service.

Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day.

Direct nursing care services are billed in 15-minute increments and medication administration is reimbursed on a per-visit increment. The RN or APRN determines whether these services must be billed as direct nursing care or medication administration.

Nursing Services Modifiers

Modifier	Description
TD	Nursing services provided by an RN or APRN
TE	Nursing services delivered by an LVN/LPN
U7	Nursing services delivered through delegation
UD	Nursing services delivered on a group basis

2.3.3 Occupational Therapy (OT) Services

OT evaluation services include determining what services, assistive technology, and environmental modifications a student requires for participation in the special education program.

Occupational therapy services include the following:

- Improving, developing, maintaining, or restoring functions impaired or lost through illness, injury, or deprivation.
- Improving the ability to perform tasks for independent functioning when functions are impaired or lost.
- Preventing, through early intervention, initial or further impairment or loss of function.

Occupational therapy uses purposeful activities to obtain or regain skills needed for activities of daily living (ADL) and/or functional skills needed for daily life lost through an acute medical condition, acute exacerbation of a medical condition, or chronic medical condition related to injury, disease, or other medical causes.

ADLs are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming, and mobility.

A prescription is required for OT services. The prescription must be updated a minimum of one time every three calendar years.

Occupational therapy services must be prescribed by a physician or other eligible prescribing provider. A prescription for OT services must be signed and dated within three calendar years before the initiation of services.

OT services may be reimbursed up to (but not to exceed) the amount designated in the prescription.

In order for OT services to be reimbursed through SHARS, the name and national provider identifier (NPI) of the prescribing licensed physician, or other eligible prescribing provider, must be listed on the claim and kept in the student's medical record.

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IDEA requires that a student receiving SHARS services must have a re-evaluation every three years, which requires current information; unless the parent and the LEA agree that a re-evaluation is unnecessary (IDEA §1414 (a)(2)(B)).

A separate prescription is not required for a re-evaluation.

The need for a re-evaluation should be determined by the student's ARD committee.

The LEA must maintain the prescription in the student's medical record.

Occupational therapy must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners to provide OT within his or her licensed scope of practice. An occupational therapist assistant (OTA) must act under the supervision of a qualified occupational therapist.

Services provided by an unlicensed person acting under the supervision of a licensed occupational therapist are not a benefit of Texas Medicaid.

OT treatment may be provided in an individual or group setting.

OT evaluation is billable on an individual basis only.

If an evaluation is performed over several days, the provider must submit the same evaluation procedure code for each evaluation session. The procedure code submitted must reflect the complexity level of the entire evaluation.

The therapist who performs the evaluation should use professional clinical judgment to decide which evaluation code to use. The selection of low (procedure code 97165), moderate (procedure code 97166), or high complexity (procedure code 97167) evaluation codes must be based on professional clinical judgment and may not be made by staff other than the rendering therapist.

The occupational therapist or OTA can only bill for time spent with the student present, including time spent assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time), report writing, and time spent manipulating or modifying the adaptive equipment is not billable.

Occupational Therapy Services Procedure Codes

Procedure Code	Individual or Group	Provider	Unit of Service
97150 with modifier GO	Group	Licensed occupational therapist	15 minutes
97150 with modifier GO and U1	Group	Licensed occupational therapy assistant	15 minutes
97165 (low), 97166 (moderate), and 97167 (high)	Individual	Licensed occupational therapist	15 minutes
97530 with modifier GO	Individual	Licensed occupational therapist	15 minutes
97530 with modifier GO and U1	Individual	Licensed occupational therapy assistant	15 minutes

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Session notes for procedure codes 97530 and 97150 (therapy services) are required.

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

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Providers must use a 15-minute unit of service for billing.

The following direct therapy procedure codes must be billed in 15-minute increments and are limited to a combined total of 4 units (one hour) per day:

Procedure Codes	
97150 with modifier GO	97530 with modifier GO
97150 with modifier GO and U1	97530 with modifier GO and U1

The maximum billable time for the following OT evaluation procedure codes is 12 units (three hours), which may be billed over several days within a 30-day period:

Procedure Codes		
97165	97166	97167

Occupational Therapy Modifiers

Modifier	Description
GO	OT therapy, individual/group, by licensed therapist
GO and U1	OT therapy, individual/group, by licensed/certified assistant

Note: *OT services delivered via telehealth are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth services.

2.3.4 Personal Care Services

Personal care services (PCS) are medical support services provided to students who require assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) because of a physical, functional, cognitive, or behavioral limitation related to a student's disability or chronic health condition.

PCS are medically necessary only when the student's physical, functional, cognitive, or behavioral limitation related to the student's disability or chronic health condition inhibits the student's ability to accomplish ADLs or IADLs.

PCS are not educational in nature and may not be reimbursed for activities that teach the student academic or functional skills.

2.3.4.1 PCS Provider Requirements

All PCS providers must:

- Be employed by or contracted with the local education agency (LEA).
- Meet the requirements of 42 CFR § 440.167.
- Have demonstrated the understanding and competence necessary to perform the eligible PCS tasks required by a student's IEP, including written documentation procedures.

PCS providers must understand and be competent to perform PCS in the following two competence areas:

- Appropriate techniques for assisting with ADLs and IADLs, including basic body mechanics, mobility, and techniques for transferring students.

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- The needs of students with disabilities, including appropriate techniques for managing adverse behaviors of the student and communicating with students with communication or sensory impairments.

The LEA may use the following methods to determine whether an individual is qualified to perform PCS in the two competence areas:

- A review of the individual's education, related certification, or related training
- An evaluation from one or more qualified employees of the LEA verifying competence, which may additionally consider work experience, evaluations from other qualified employees of the LEA, and on-site demonstration.

The LEA may provide training to develop understanding and competence if the individual lacks understanding and competence in an area of PCS.

LEAs must document the PCS provider's ability to perform assistance generally with ADLs and IADLs for students enrolled in special education. In a centralized location, the LEA must keep a statement that is signed and dated by a qualified employee of the LEA, that the individual is able to perform PCS tasks under the direction of a qualified employee of the LEA.

For the purposes of verifying PCS provider qualifications, a qualified employee of the LEA is defined as:

- An individual with current special education teacher certification under 19 TAC §233.8 whose work responsibilities include working with PCS providers; or
- An individual whose primary work responsibilities include supervising, training, and confirming the qualifications of PCS providers; or
- A licensed health care practitioner eligible to provide reimbursable services under a SHARS benefit other than PCS.

A prescription is not needed to provide PCS through SHARS.

2.3.4.2 Activities Eligible for PCS

PCS facilitate the completion of ADLs and IADLs through direct intervention or indirect intervention, which includes but is not limited to the following:

- Hands-on assistance
- Performing the tasks for the student
- Cueing or redirecting the student to perform a task

PCS are not intended to teach the student how to independently perform the task.

For the purposes of reimbursement, activities eligible for personal care services are limited to the ADLs and IADLs listed in this section. ADLs are activities that are essential to daily self-care. IADLs are activities related to living independently in the community.

> ***Note:*** *Health Maintenance Activities (HMAs) and nurse-delegated tasks, as defined by 22 TAC §225.4, should be considered Nursing Services and may only be billed under PCS if the task is listed as an ADL or IADL.*

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For the purposes of reimbursement, the activities that are eligible for PCS are limited to the following ADLs and IADLs. ADLs are activities that are essential to daily self-care. IADLs are activities related to living independently in the community.

ADLs	Description
Bathing	Assisting the student with any or all parts of bathing, including selecting appropriate water temperature and flow speed; turning water on and off; laying out and putting away supplies; transferring in and out of the bathtub or shower; washing and drying hair and body; and clean-up after task is completed
Dressing	Assisting the student with any or all parts of getting dressed, including putting on, fastening, and taking off all items of clothing; donning and removing shoes or prostheses; and choosing and laying out weather-appropriate clothing
Eating	Assisting the student with some or all parts of eating and drinking, including feeding the student; assistance with utensils or special or adaptive eating devices; and clean-up after task is completed.
Locomotion or mobility	Assisting the student with moving between locations, including assisting the student with walking or using a wheelchair, walker, or other mobility equipment
Personal hygiene	Assisting the student with some or all parts of personal hygiene, including routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, and perineum; basic nail care; applying deodorant; routine skin care; and clean-up after task is completed
Positioning	Assisting the student with positioning their body while in a chair, bed, or other piece of furniture or equipment, including changing and adjusting positions; moving to or from a sitting position; turning side-to-side; and assisting the student to sit upright
Toileting	Assisting the student with some or all parts of toileting, including using a commode, bedpan, urinal, or toilet chair; transferring on and off; cleansing; changing diapers, pads, and incontinence supplies; adjusting clothing; and clean-up after task is completed
Transferring	Assisting the student with moving from one surface to another with or without a sliding board, including moving from a bed, chair, wheelchair, or vehicle to a new surface; moving to or from a standing or sitting position; and moving the student with lift devices

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IADLs	Description
Escort	Assisting the student in making transportation arrangements for medical and other appointments; accompanying the student to a SHARS-eligible service or health care appointment on or off campus to assist with needed ADLs or with carrying equipment (feeding pump, oxygen tank, etc.) or other necessary supplies; accompanying the student between locations to facilitate assistance with needed ADLs or assistance with carrying equipment or other necessary supplies. Escort includes monitoring a student's behaviors that create an unsafe situation for the student, such as removing a seatbelt, attempting to open the vehicle door while the vehicle is in motion, or elopement. Escort duration includes the entire time that the PCS provider accompanies the student during a SHARS-eligible service or health care service on or off campus.
Meal preparation	Assisting the student in preparing meals and snacks, including cooking; assembling ingredients; cutting, chopping, grinding, or pureeing food; setting out food and utensils; serving food; preparing and pouring a predetermined amount of liquid nutrition; cleaning the feeding tube; cleaning the area after a meal; and washing dishes
Medication assistance	Assisting the student with oral medications that are normally self-administered
Money management	Assisting the student with managing their day-to-day finances, including paying bills and adhering to a budget
Telephone use or other communication	Assisting the student in making or receiving telephone calls, managing, and setting up communication devices, and sending and receiving communication for the student

Note: *For students receiving services in a school-based residential program managed by the LEA, the LEA may be reimbursed for the additional ADLs and IADLs listed in subsection 2.12.2, "Services, Benefits, and Limitations," in the Children's Services Handbook (Vol. 2, Provider Handbooks), as appropriate.*

PCS does not include the following:

- ADLs or IADLs that a typically developing child of the same chronological age could not safely and independently perform without adult supervision
- Services that provide direct intervention when the student has the physical, behavioral, and cognitive abilities to perform the ADL or IADL without adult supervision
- Services used for or intended to provide respite care, childcare, or restraint of a student
- Stand-by supervision related to safety
- Teaching a life skills or vocational curriculum
- Services delivered solely for the purpose of education, such as reading, English, language arts, writing, mathematics, science, social studies, physical education, functional curriculum, or electives
- Orientation and mobility or sign language interpretive services

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- Any form of assistance that does not facilitate the above-listed ADLs and IADLs. Supervision, monitoring, cueing, and redirection are not independently considered ADLs or IADLs, but may be used to facilitate the completion of ADLs and IADLs.

PCS may be billed simultaneously with another SHARS-eligible service if the student is receiving assistance with ADLs and IADLs from a PCS provider while receiving the SHARS-eligible service from another provider.

PCS may not be billed for activities that are encompassed in the other SHARS-eligible service being provided by the same provider.

Only the time spent on authorized PCS tasks for each student is eligible for reimbursement.

For PCS services to be reimbursed they must be listed in the student's IEP.

If PCS are provided on the bus, documentation of the type of personal care service that was performed must be included on service logs. Personal care services provided on a bus shall not be provided by a bus monitor, bus aide, or transportation aide.

PCS may be provided in a group setting. A provider may perform PCS for more than one student over the span of the day as long as each student's care is based on their IEP and needs. The time the provider is assisting one student must not overlap with the time the provider is working with another student. PCS must be provided to one student at a time but may be provided to multiple students sequentially.

Personal Care Services Procedure Codes

Procedure Code	Setting	Unit of Service
T1019 with modifier U5	Individual, School	15 minutes
T1019 with modifier U6	Individual, Bus	Per one-way trip

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Procedure code T1019 with modifier U6 may not be billed more than a total of four one-way trips per day.

Personal Care Services Modifiers

Modifier	Description
U5	Personal care services in school, individual
U6	Personal care services on the bus, individual per one-way trip

2.3.5 Physical Therapy (PT) Services

Physical therapy services include, but are not limited to, the following:

- Rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, or birth defect
- Evaluation of the purpose of determining the nature, extent, and degree of the need for physical therapy services
- Physical therapy services provided for the purpose of preventing or alleviating movement dysfunction and related functional problems
- A PT evaluation includes evaluating the student's ability to move throughout the school and participate in classroom activities and the identification of movement dysfunction and related functional problems.

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A prescription is required for PT services. The prescription must be updated a minimum of one time every three calendar years.

Physical therapy services must be prescribed by a physician or other eligible prescribing provider. A prescription for PT services must be signed and dated within three calendar years before the initiation of services.

PT services may be reimbursed up to (but not to exceed) the amount designated in the prescription.

In order for PT services to be reimbursed through SHARS, the name and national provider identifier (NPI) of the licensed physician, or other eligible prescribing provider, must be listed on the claim and kept in the student's medical record.

IDEA requires that a student receiving SHARS services must have a re-evaluation every three years, which requires current information; unless the parent and the LEA agree that a re-evaluation is unnecessary (IDEA §1414 (a)(2)(B)).

A separate prescription is not required for a re-evaluation.

The need for a re-evaluation should be determined by the student's ARD committee.

The LEA must maintain the prescription in the student's medical record.

Physical therapy must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners to provide PT within his or her licensed scope of practice. A licensed physical therapist assistant (PTA) must act under the supervision of a licensed physical therapist.

Services provided by an unlicensed person acting under the supervision of a licensed physical therapist is not a benefit under Texas Medicaid.

If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed therapist, the services cannot be regarded as skilled therapy.

PT evaluation is billable on an individual basis only. Procedure codes 97161, 97162, and 97163 may be submitted for initial evaluations and re-evaluations.

If an evaluation is performed over several days, the provider must submit the same evaluation procedure code for each evaluation session. The procedure code submitted must reflect the complexity level of the entire evaluation.

The physical therapist who performs the evaluation should use professional clinical judgment to decide which evaluation code to use. The selection of low (procedure code 97161), moderate (procedure code 97162), or high complexity (procedure code 97163) evaluation codes must be based on professional clinical judgment and may not be made by staff other than the rendering therapist.

The physical therapist can only bill time spent with the student present, including time spent helping the student to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time) and report writing, is not billable.

Physical Therapy Services Procedure Codes

Procedure Code	Individual or Group	Provider	Unit of Service
97110 with modifier GP	Individual	Licensed physical therapist	15 minutes
97110 with modifier GP and U1	Individual	Licensed physical therapy assistant	15 minutes
97150 with modifier GP	Group	Licensed physical therapist	15 minutes

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Procedure Code	Individual or Group	Provider	Unit of Service
97150 with modifier GP and U1	Group	Licensed physical therapy assistant	15 minutes
97161 (low), 97162 (moderate), and 97163 (high)	Individual	Licensed physical therapist	15 minutes

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Session notes for procedure codes 97110 and 97150 (therapy services) are required.

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

The following direct therapy procedure codes must be billed in 15-minute increments and are limited to a combined total of 4 units (one hour) per day

Procedure Codes	
97110 with modifier GP	97150 with modifier GP
97110 with modifier GP and U1	97150 with modifier GP and U1

The maximum billable time for the following PT evaluation procedure codes is 12 units (three hours), which may be billed over several days within a 30-day period:

Procedure Codes		
97161	97162	97163

Physical Therapy Modifiers

Modifier	Description
GP	PT therapy, individual/group, by licensed therapist
GP and U1	PT therapy, individual/group, by licensed/certified assistant

Note: *PT services delivered via telehealth are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth services.

2.3.6 Physician Services

Physician services include diagnostic and evaluation services to determine a child's medically related disabling condition that results in the child's need for services in the school setting.

Physicians are responsible for writing prescriptions for students that require PT or OT services.

In the school setting, speech therapy, and audiology services may be referred by either a physician or other eligible referring provider within the scope of his or her practice under state law in accordance with 42 CFR §440.110(c).

Physician services must be provided by a licensed physician Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.).

Physician services may also be provided by an APRN under the delegation of a physician, or a PA under the delegation of a physician.

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The following are billable physician services and must be provided on an individual basis:

- The diagnosis or evaluation time spent with the student present.
- The time spent without the student present reviewing the student's records for writing a prescription or referral for specific SHARS services.
- The diagnosis or evaluation time spent with the student present, or the time spent without the student present reviewing the student's records for the evaluation of the sufficiency of an ongoing SHARS service to see whether any changes are needed in the current prescription or referral for that service.
- When reviewing the student's records, the provider must use professional judgment to determine whether or not the student needs to be seen in person.

Procedure code T1023 is limited to 1 unit of service per day.

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

SHARS physician services are billable only when they are provided on an individual basis.

Note: *Physician services delivered via telemedicine are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telemedicine services.

2.3.7 Psychological Services and Counseling

2.3.7.1 Psychological Testing

Psychological Testing Services include the following activities:

- Administering psychological tests and other assessment procedures and interpreting testing and assessment results
- Obtaining, integrating, and interpreting information about a student's behavior and conditions related to learning and functional needs, planning, and managing a program of psychological services
- Evaluating a student for the purpose of determining the student's eligibility for specific psychological, health or related services, the needs for specific SHARS services, and the development or revision of IEP goals and objectives
- Assessing the effectiveness of the delivered services on achieving the goals and objectives of the student's IEP

Billable time includes the following:

- Psychological, educational, or intellectual testing time spent with the student present
- Necessary observation of the student associated with testing
- A parent or teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities
- Test interpretation and report writing

Psychological testing is billable if it leads to the creation of an IEP for a student with disabilities who is eligible for Medicaid and who is 20 years of age or younger, whether or not the IEP includes SHARS.

An assessment write-up during an ARD meeting is billable, however, participation in the ARD meeting itself is not billable under SHARS.

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Psychological testing (procedure codes 96130 and 96131) must be provided by a professional who is a licensed specialist in school psychology (LSSP), a licensed psychologist, or a licensed psychiatrist in accordance with 19 TAC 89.1040(b)(1) and 42 CFR 440.60(a).

A prescription is not needed to provide psychological testing through SHARS.

When billing, minutes of psychological testing are not accumulated over multiple days. Psychological testing can only be billed based on accumulated time per calendar day.

The following one-hour procedure codes are limited to eight hours (8 units) over a 30-day period:

Procedure Code	Unit of Service
96130	Initial (1 hour)
96131	Each additional hour

Important: *One unit (1.0) is equivalent to one hour or 60 minutes. Providers may bill in partial hours, expressed as 1/10th of an hour (six-minute segments). For example, express 30 minutes as a billed quantity of 0.5.*

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Time spent for the interpretation of testing results without the student present is billable time.

2.3.7.2 Counseling Services

Counseling services include, but are not limited to, the following:

- Assisting the child or parents in understanding the nature of the child's disability
- Assisting the child or parents in understanding the special needs of the child
- Assisting the child or parents in understanding the child's development
- Assisting to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to the prevention, treatment, or management of physical health problems
- Assessing the need for specific counseling services
- To help a child with a disability benefit from special education

Counseling services must be provided by one of the following:

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Counseling services may also be delivered by a psychologist, psychiatrist, or a licensed psychological associate.

Note: *Medicaid does not allow services delivered by LPC, LCSW, or LMFT interns to be billed under SHARS.*

A prescription is not needed to provide counseling services through SHARS.

LEAs may receive reimbursement for emergency counseling services if the student's IEP includes a behavior improvement plan (BIP) that documents the need for emergency services.

Health and Behavior Assessment and Intervention (HBAI) services are designed to identify the psychological, behavioral, emotional, cognitive, and social factors important to prevention, treatment, or management of physical health symptoms.

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The following HBAI procedure codes (96158, 96159, 96164, and 96165) are limited to three units (one hour) per day, cumulative between procedure codes (initial procedure code plus two additional 15 minutes), same procedure, same provider:

- The initial 30 minutes (procedure codes 96158 and 96164) are limited to one unit per day.
- Each additional 15 minutes (procedure codes 96159 and 96165) are limited to two units per day.

Procedure Code	Individual or Group	Unit of Service	Provider Type
96158 with modifier UB	Individual	30 minutes	LPC, LCSW, LMFT
96159 with modifier UB (add-on procedure code)	Individual	15 minutes	LPC, LCSW, LMFT
96164 with modifier UB	Group	30 minutes	LPC, LCSW, LMFT
96165 with modifier UB (add-on procedure code)	Group	15 minutes	LPC, LCSW, LMFT

Individual psychotherapy is defined as therapy that focuses on a single person.

The following individual psychotherapy procedure codes (90832, 90834, and 90837) are limited to two services per day, same procedure, same provider, and will be denied as follows:

- Procedure codes 90834 and 90837 will be denied if submitted on the same day as procedure code 90832.
- Procedure codes 90832 and 90837 will be denied if submitted on the same day as procedure code 90834.
- Procedure codes 90832 and 90834 will be denied if submitted on the same day as procedure code 90837.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90832 with modifier UB	Individual	30 minutes	LPC, LCSW, LMFT
90834 with modifier UB	Individual	45 minutes	LPC, LCSW, LMFT
90837 with modifier UB	Individual	60 minutes	LPC, LCSW, LMFT

Group psychotherapy is a type of psychotherapy that involves one or more therapists working with several clients at the same time.

Group psychotherapy (procedure code 90853) is limited to one service per day, same procedure, same provider.

Procedure codes 90832, 90834, and 90837 will be denied if submitted on the same day as 90853.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90853 with modifier UB	Group	Untimed, one per date of service	LPC, LCSW, LMFT

Session notes are required for all counseling services.

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

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Counseling Services Delivered by Licensed/Certified Therapist Modifier

Modifier	Description
UB	Counseling services, individual/group, by LPC, LCSW, LMFT

Note: *Counseling services delivered via telehealth are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth services.

2.3.7.3 Psychological Services

Psychological services are counseling services provided to help a child with a disability benefit from special education and must be listed in the IEP.

Psychological services must be provided by a licensed psychiatrist, a licensed psychologist, or an LSSP.

LEAs may contract for specific types of psychological services, such as clinical psychology, counseling psychology, neuropsychology, and family therapy, that are not readily available from the LSSP who is employed by the LEA. 22 TAC §465.38 (Psychological Services for Schools) does not prohibit public schools from contracting with licensed psychologists, licensed psychological associates, and provisionally licensed psychologists who are not LSSPs to provide psychological services, other than school psychology, in their areas of competency. Such contracting must be on a short-term or part-time basis and cannot involve the broad range of school psychological services listed in 22 TAC §465.38(b)(1).

LEAs may receive reimbursement for emergency psychological services if the student's IEP includes a behavior improvement plan that documents the need for the emergency services. These services may exceed the one-hour daily limit.

HBAI services are designed to identify the psychological, behavioral, emotional, cognitive, and social factors important to prevention, treatment, or management of physical health symptoms.

The following HBAI procedure codes (96158, 96159, 96164, and 96165) are limited to three units (one hour) per day, cumulative between procedure codes (initial procedure code plus two additional 15 minutes) same procedure, same provider, for non-emergency situations:

- The initial 30 minutes (procedure codes 96158 and 96164) are limited to one unit per day.
- Each additional 15 minutes (procedure codes 96159 and 96165) are limited to two units per day.

Procedure Code	Individual or Group	Unit of Service	Provider Type
96158 with modifier AH	Individual	30 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
96159 with modifier AH (add-on procedure code)	Individual	15 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
96164 with modifier AH	Group	30 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
96165 with modifier AH (add-on procedure code)	Group	15 minutes	Licensed psychiatrist, Licensed psychologist, LSSP

Individual psychotherapy is defined as therapy that focuses on a single person.

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The following individual psychotherapy procedure codes (90832, 90834, and 90837) are limited to two services per day, same procedure, same provider, and will be denied as follows:

- Procedure codes 90834 and 90837 will be denied if submitted on the same day as 90832.
- Procedure codes 90832 and 90837 will be denied if submitted on the same day as 90834.
- Procedure codes 90832 and 90834 will be denied if submitted on the same day as 90837.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90832 with modifier AH	Individual	30 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
90834 with modifier AH	Individual	45 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
90837 with modifier AH	Individual	60 minutes	Licensed psychiatrist, Licensed psychologist, LSSP

Group psychotherapy is a type of psychotherapy that involves one or more therapists working with several clients at the same time.

Group psychotherapy (procedure code 90853) is limited to one service per day, same procedure, same provider.

Procedure codes 90832, 90834, and 90837 will be denied if submitted on the same day as procedure code 90853.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90853 with modifier AH	Group	Untimed, one per date of service	Licensed psychiatrist, Licensed psychologist, LSSP

Session notes are required for all psychological services.

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

Note: *Psychological services delivered via telehealth or telemedicine are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth and telemedicine services.

2.3.8 Special Transportation Services

Transportation services in a school setting may be reimbursed when they are provided on a specially adapted vehicle and if the following criteria are met:

- Provided to or from a Medicaid-covered service on the day for which the claim is made
- A child requires transportation in a specially adapted vehicle to serve the needs of the disabled
- A child resides in an area that does not have school bus transportation, such as those in close proximity to a school
- The Medicaid services covered by SHARS are included in the student's IEP

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- The special transportation service is included in the student's IEP

Transportation services are provided on a specially adapted school bus to or from the location where the school-based service is provided.

A specially adapted vehicle is one that has been physically modified (e.g., addition of a wheelchair lift, addition of harnesses, or addition of child protective seating).

If an LEA already provides a modification for all students, then the modification is not considered a special adaptation.

Bus monitor or other personnel accompanying children on the bus is not considered an allowable special adaptive enhancement for Medicaid reimbursement under SHARS specialized transportation.

The student's IEP must document the need for transportation to be provided on a specially adapted vehicle.

Specialized transportation services reimbursable under SHARS requires the Medicaid enrolled special education student has the following documented in his or her IEP:

- The student requires a specific physical adaptation or adaptations of a vehicle in order to be transported
- The reason the student needs the specialized transportation

If a SHARS student rides the regular school bus to and from school with other nondisabled students, then that student is not required to have specialized transportation services listed in their IEP.

The cost of the regular school bus ride cannot be billed to SHARS.

The fact that a child may receive a service through SHARS does not necessarily mean that transportation services may be reimbursable.

Reimbursement for covered transportation services is on a per-student one-way trip basis. If the student receives a billable SHARS service (including personal care services on the bus) and is transported on the school's specially adapted vehicle, the following one-way trips may be billed:

- From the student's residence to school
- From the school to the student's residence
- From the student's residence to a provider's office that is contracted with the LEA
- From a provider's office that is contracted with the LEA to the student's residence
- From the school to a provider's office that is contracted with the LEA
- From a provider's office that is contracted with the LEA to the student's school
- From the school to another campus to receive a billable SHARS service
- From the campus where the student received a billable SHARS service back to the student's school

Covered transportation services from a child's residence to school and return are not reimbursable if, on the day the child is transported, the child does not receive Medicaid services covered by SHARS (other than transportation). This service must not be billed by default simply because the student is transported on a specially adapted bus.

Transportation services procedure code T2003 is limited to a total of four one-way trips per day.

2.3.8.1 Documentation for Special Transportation Services

Documentation of each one-way trip provided must be maintained by the LEA (e.g., trip log).

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Trip logs must be maintained daily to record one-way specialized transportation trips. This documentation must also include the number of one-way trips per day and the time for each trip (can be indicated using AM/PM).

At a minimum, trip logs must also include the following:

- Name of the LEA
- Route name or number
- Bus driver's name
- Dates of service and indicate day of the week
- If a service is not provided on a school day, Monday–Friday, mark the student as absent
- Copy of the school district's calendar (to be submitted once during the annual desk review)
- Student's full name and Medicaid number

  Note: *If the Medicaid number is not in the log, a separate ledger detailing student name, date of birth, and Medicaid status and number must be provided.*

- Dated signature of the bus driver

  Note: *Dated signatures should be captured after all trips have been documented.*

LEAs must adhere to all HIPAA and FERPA guidelines when documenting and submitting special transportation logs.

2.3.9 Speech and Language Services

Speech and language services include, but are not limited to, the following:

- Identification of students with speech or language disorders
- Diagnosis and appraisal of specific speech or language disorders
- Referral for medical or other professional attention necessary for the habilitation of speech or language disorders
- Provision of speech or language services for the habilitation or prevention of communicative disorders.

Speech and language services must be delivered by a qualified speech-language pathologist (SLP) holding an unrestricted Texas state license to provide services independently.

Speech and language services may also be delivered by a licensed SLP intern acting under the supervision and direction of a licensed SLP, or a licensed assistant in speech-language pathology acting under the supervision and direction of a licensed SLP.

A referral is required for ST services. The referral must be updated a minimum of one time every three calendar years.

The LEA must maintain the referral in the student's medical record.

Speech and language services must be referred by a physician or other eligible referring provider. A referral for speech therapy services must be signed and dated within three calendar years before the initiation of services.

In order for ST services to be reimbursed through SHARS, the name and national provider identifier (NPI) of the referring licensed physician, or other eligible referring provider, must be listed on the claim and kept in the medical record.

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Within SHARS, Medicaid-enrolled SLPs who may practice independently may refer for their own services or those of another SHARS provider of the same discipline. They may not refer for any services outside of SHARS or for other SHARS services of other disciplines.

A speech evaluation that documents the medical necessity for speech therapy may serve as the referral.

SHARS SLPs whose evaluations serve as the referral must be enrolled in Texas Medicaid as either individual practitioners or ordering, referring, or prescribing (ORP) providers. When submitting claims for SHARS audiology services, LEAs must include the referring provider's NPI in the referring provider NPI field of the claim form.

IDEA requires that a student receiving SHARS services must have a re-evaluation every three years, which requires current information; unless the parent and the LEA agree that a re-evaluation is unnecessary (IDEA §1414 (a)(2)(B)).

A separate referral is not required for a re-evaluation. The need for a re-evaluation should be determined by the student's ARD committee.

2.3.9.1 Supervision Requirements for SLPs

A supervisor of an intern or assistant shall:

- Ensure that all services provided are in compliance with 16 TAC §111.154 and current state licensure

A supervisor of an assistant shall:

- Be responsible for evaluations, interpretation, and case management
- Not designate anyone other than a licensed speech-language pathologist or intern in speech-language pathology to represent speech-language pathology to an Admission, Review, and Dismissal (ARD) meetings, except as provided by 16 TAC §111.51 and §111.52.

A licensed intern or assistant shall abide by the decisions made by his or her supervisor relating to the intern's or assistant's practice and duties. If the supervisor requests that the intern or assistant violate this policy, the Act, or any other law, the intern or assistant shall refuse to do so and immediately notify the Texas Department of Licensing and Regulation (TDLR) and any other appropriate authority.

The SLP who provides the direction must ensure that the personnel who carry out the directives meet the minimum qualifications set forth in the rules of the TDLR that relate to licensed interns or assistants in speech-language pathology.

Speech Therapy Services Procedure Codes

Procedure Code	Individual or Group	Provider	Unit of Service
92507 with modifier GN and U8	Individual	Licensed speech-language therapist	Untimed
92507 with modifier GN and U1	Individual	Licensed speech-language assistant	Untimed
92508 with modifier GN and U8	Group	Licensed speech-language therapist	Untimed
92508 with modifier GN and U1	Group	Licensed speech-language assistant	Untimed
92521, 92522, 92523, or 92524 with modifier GN	Individual	Licensed speech-language therapist	15 minutes

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Session notes are required for procedure codes 92507 and 92508.

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Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

ST evaluation (procedure codes 92521, 92522, 92523, and 92524) is billable on an individual basis only. ST is billable on an individual (procedure code 92507) or group (procedure code 92508) basis.

The maximum billable time for ST evaluation procedure codes 92521, 92522, 92523, and 92524 with modifier GN is 12 units (three hours), which may be billed over several days, within a 30-day period.

Speech evaluation (procedure codes 92521, 92522, and 92523, and 92524) will be denied if submitted on the same date of service as speech therapy (procedure codes 92507 and 92508).

Procedure code 92522 will be denied if submitted on the same date of service as procedure code 92523.

Procedure code 92523 will be denied if submitted on the same date of service as procedure code 92522.

Providers can only bill time spent with the student present, including assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as report writing and training teachers or aides to work with the student (unless the student is present during training), is not billable.

The following direct therapy procedure codes are limited to a total of one unit per day:

Procedure Codes	
92507 with modifier GN and U8	92508 with modifier GN and U8
92507 with modifier GN and U1	92508 with modifier GN and U1

Speech Therapy Modifiers

Modifier	Description
GN	SLP evaluation by licensed speech-language therapist
GN and U1	SLP therapy, individual/group, by licensed/certified speech-language therapy assistant
GN and U8	SLP therapy, individual/group, by licensed speech-language therapist

Note: *ST services delivered via telehealth are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth services.

2.3.10 Telehealth and Telemedicine Services

LEAs that participate in the SHARS program may be reimbursed for telehealth and telemedicine services delivered to children in school-based settings, or while receiving remote instruction.

A school-based setting is defined in Texas Government Code §548.0203 as a school district or an open enrollment charter school.

Remote instruction is defined according to requirements set forth by TEA and includes technology-based learning in home or community-based settings.

Providers may be reimbursed for telehealth and telemedicine services delivered to children in school-based settings, or while learning remotely with the following criteria:

- Reimbursement for providers is only available when the patient site is a school, home, or community-based setting.

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  - A patient site is the physical location of the student while the service is being rendered.
- Reimbursement for providers is only available when the distant site is a school or office-based setting.
  - A distant site is the physical location of the Texas Medicaid provider rendering the service.
- A telehealth or telemedicine visit may not be conducted if the provider and student are both physically located at the same school at the time the services are rendered.
- All medical necessity criteria for in-person services apply when services are delivered to children in school-based settings.

Providers must be able to defer to the needs of the student receiving services, allowing the mode of service delivery (synchronous audiovisual, synchronous telephone (audio-only), or in-person) to be accessible.

Providers should obtain informed consent for treatment from the student's parent or legal guardian and the student prior to rendering a telehealth or telemedicine service. Verbal consent is permissible and should be documented in the student's medical record.

Services delivered by synchronous audiovisual or synchronous telephone (audio-only) technology may require participation of a parent or caregiver to assist with the treatment.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law.

A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about telehealth or telemedicine and informed consent. All telehealth or telemedicine services must adhere to documentation, privacy, and security requirements as outlined in this handbook and those in the *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*).

2.3.10.1 Telehealth Services

Telehealth services are a benefit of Texas Medicaid and SHARS. Telehealth services has the meaning assigned by Texas Occupations Code (TOC) §111.001. Telehealth services are defined as healthcare services, other than telemedicine medical services or a teledentistry service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telehealth services must be provided in compliance with standards established by the respective licensing or certifying board of the professional providing the services.

LEAs that participate in the SHARS program may be reimbursed for telehealth occupational therapy (OT), physical therapy (PT), speech therapy (ST), counseling, and psychological services.

All other reimbursement and billing guidelines that are applicable to in-person services will also apply when OT, PT, ST, counseling, and psychological services are delivered as telehealth services.

OT, PT, ST, counseling, and psychological telehealth services provided by LEAs during school hours through SHARS may be delivered via synchronous audiovisual technologies.

Synchronous audiovisual technology is defined as an interactive, two-way audio and video telecommunications platform that meets the privacy requirements of HIPAA.

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Counseling and psychological telehealth services provided by LEAs during school hours through SHARS may also be delivered via synchronous telephone (audio-only) technologies.

Synchronous telephone (audio-only) technology is defined as an interactive, two-way audio telecommunications platform, including telephone technology, that uses only sound and meets the privacy requirements of HIPAA.

Synchronous Audiovisual Technology

The following procedure codes may be provided to children eligible through SHARS as telehealth services via synchronous audiovisual technology if clinically appropriate (as determined by the treating provider), safe and agreed to by the student receiving services.

The patient site must be a school, home, or community-based setting in order for the distant site provider to be eligible for reimbursement of these services.

All telehealth services provided by synchronous audiovisual technology must be billed using modifier 95.

The following procedure codes must be billed for telehealth services delivered via synchronous audiovisual technology:

Procedure Code	Individual or Group	Unit of Service	Provider
90832 with modifier UB and 95	Individual	30 minutes	LPC, LCSW, LMFT
90832 with modifier AH and 95	Individual	30 minutes	Licensed psychologist, LSSP
90834 with modifier AH and 95	Individual	45 minutes	Licensed psychologist, LSSP
90834 with modifier UB and 95	Individual	45 minutes	LPC, LCSW, LMFT
90837 with modifier AH and 95	Individual	60 minutes	Licensed psychologist, LSSP
90837 with modifier UB and 95	Individual	60 minutes	LPC, LCSW, LMFT
90853 with modifier AH and 95	Group	Untimed, one per date of service	Licensed psychologist, LSSP
90853 with modifier UB and 95	Group	Untimed, one per date of service	LPC, LCSW, LMFT
92507 with modifier GN, U8, and 95	Individual	Untimed, one per date of service	Licensed speech therapist
92507 with modifier GN, U1, and 95	Individual	Untimed, one per date of service	Licensed speech assistant
92508 with modifier GN, U8, and 95	Group	Untimed, one per date of service	Licensed speech therapist
92508 with modifier GN, U1, and 95	Group	Untimed, one per date of service	Licensed speech assistant
92521, 92522, 92523, or 92524 with modifier GN and 95	Individual	15 minutes	Licensed speech therapist
96158 with modifier AH and 95	Individual	30 minutes	Licensed psychologist, LSSP
96158 with modifier UB and 95	Individual	30 minutes	LPC, LCSW, LMFT

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Procedure Code	Individual or Group	Unit of Service	Provider
96159 with modifier AH and 95 (add-on procedure code)	Individual	15 minutes	Licensed psychologist, LSSP
96159 with modifier UB and 95 (add-on procedure code)	Individual	15 minutes	LPC, LCSW, LMFT
96164 with modifier AH and 95	Group	30 minutes	Licensed psychologist, LSSP
96164 with modifier UB and 95	Group	30 minutes	LPC, LCSW, LMFT
96165 with modifier AH and 95 (add-on procedure code)	Group	15 minutes	Licensed psychologist, LSSP
96165 with modifier UB and 95 (add-on procedure code)	Group	15 minutes	LPC, LCSW, LMFT
97110 with modifier GP and 95	Individual	15 minutes	Licensed physical therapist
97110 with modifier GP, U1, and 95	Individual	15 minutes	Licensed physical therapy assistant
97150 with modifier GP and 95	Group	15 minutes	Licensed physical therapist
97150 with modifier GP, U1, and 95	Group	15 minutes	Licensed physical therapy assistant
97150 with modifier GO and 95	Group	15 minutes	Licensed occupational therapist
97150 with modifier GO, U1, and 95	Group	15 minutes	Licensed occupational therapy assistant
97161 (low), 97162 (moderate), and 97163 (high) with modifier 95	Individual	15 minutes	Licensed physical therapist
97165 (low), 97166 (moderate), and 97167 (high) with modifier 95	Individual	15 minutes	Licensed occupational therapist
97530 with modifier GO and 95	Individual	15 minutes	Licensed occupational therapist
97530 with modifier GO, U1, and 95	Individual	15 minutes	Licensed occupational therapist assistant

Synchronous Telephone (Audio-Only) Technology

The following procedure codes may be provided to children eligible through SHARS as telehealth services via synchronous telephone (audio-only) technology to students with whom the treating provider has an 'established relationship' and if clinically appropriate (as determined by the treating provider), safe, and agreed to by the student receiving services.

HHSC encourages the use of synchronous audiovisual technology over telephone (audio-only) delivery of telehealth services whenever possible. Therefore, if delivered by synchronous telephone (audio-only) technology, providers must document in the student's medical record the reason(s) for why a synchronous audiovisual platform was not used.

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The patient site must be a school, home, or community-based setting in order for the distant site provider to be eligible for reimbursement of these services.

All telehealth services provided by synchronous telephone (audio-only) technology must be billed using modifier 93.

Procedure Code	Individual or Group	Unit of Service	Provider
90832 with modifier AH and 93	Individual	30 minutes	Licensed psychologist, LSSP
90832 with modifier UB and 93	Individual	30 minutes	LPC, LCSW, LMFT
90834 with modifier AH and 93	Individual	45 minutes	Licensed psychologist, LSSP
90834 with modifier UB and 93	Individual	45 minutes	LPC, LCSW, LMFT
90837 with modifier AH and 93	Individual	60 minutes	Licensed psychologist, LSSP
90837 with modifier UB and 93	Individual	60 minutes	LPC, LCSW, LMFT
90853 with modifier AH and 93	Group	Untimed, one per date of service	Licensed psychologist, LSSP
90853 with modifier UB and 93	Group	Untimed, one per date of service	LPC, LCSW, LMFT
96158 with modifier AH and 93	Individual	30 minutes	Licensed psychologist, LSSP
96158 with modifier UB and 93	Individual	30 minutes	LPC, LCSW, LMFT
96159 with modifier AH and 93 (add-on procedure code)	Individual	15 minutes	Licensed psychologist, LSSP
96159 with modifier UB and 93 (add-on procedure code)	Individual	15 minutes	LPC, LCSW, LMFT
96164 with modifier AH and 93	Group	30 minutes	Licensed psychologist, LSSP
96164 with modifier UB and 93	Group	30 minutes	LPC, LCSW, LMFT
96165 with modifier AH and 93 (add-on procedure code)	Group	15 minutes	Licensed psychologist, LSSP
96165 with modifier UB and 93 (add-on procedure code)	Group	15 minutes	LPC, LCSW, LMFT

2.3.10.2 Telemedicine Services

Telemedicine medical services, also known as telemedicine services, are a benefit of Texas Medicaid and SHARS. Telemedicine medical services has the meaning assigned by TOC §111.001. Telemedicine services are defined as health care services delivered by a physician licensed in the state of Texas, or a health professional acting under the delegation and supervision of a physician licensed in Texas and

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acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Telemedicine medical services must be provided in compliance with standards established by the respective licensing or certifying board of the professional providing the services.

LEAs that participate in the SHARS program may be reimbursed for telemedicine psychological and physician services.

All other reimbursement and billing guidelines that are applicable to in-person services will also apply when psychological and physician services are delivered as telemedicine services.

Psychological and physician telemedicine services provided by LEAs during school hours through SHARS may be delivered via synchronous audiovisual technologies.

Synchronous audiovisual technology is defined as an interactive, two-way audio and video telecommunications platform that meets the privacy requirements of HIPAA.

Psychological telemedicine services provided by LEAs during school hours through SHARS may also be delivered via synchronous telephone (audio-only) technologies.

Synchronous telephone (audio-only) technology is defined as an interactive, two-way audio telecommunications platform, including telephone technology, that uses only sound and meets the privacy requirements of HIPAA.

Synchronous Audiovisual Technology

The following procedure codes may be provided to children eligible through SHARS as telemedicine services via synchronous audiovisual technology if clinically appropriate (as determined by the treating provider), safe and agreed to by the student receiving services.

The patient site must be a school, home, or community-based setting in order for the distant site provider to be eligible for reimbursement of these services.

All telemedicine services provided by synchronous audiovisual technology must be billed using modifier 95.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90832 with modifier AH and 95	Individual	30 minutes	Licensed psychiatrist
90834 with modifier AH and 95	Individual	45 minutes	Licensed psychiatrist
90837 with modifier AH and 95	Individual	60 minutes	Licensed psychiatrist
90853 with modifier AH and 95	Group	Untimed, one per date of service	Licensed psychiatrist
96158 with modifier AH and 95	Individual	30 minutes	Licensed psychiatrist
96159 with modifier AH and 95 (add-on procedure code)	Individual	15 minutes	Licensed psychiatrist
96164 with modifier AH and 95	Group	30 minutes	Licensed psychiatrist
96165 with modifier AH and 95 (add-on procedure code)	Group	15 minutes	Licensed psychiatrist

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Procedure Code	Individual or Group	Unit of Service	Provider Type
T1023 with modifier 95	Individual	Untimed	MD, DO

Synchronous Telephone (Audio-Only) Technology

The following procedure codes may be provided to children eligible through SHARS as telemedicine services via synchronous telephone (audio-only) technology to students with whom the treating provider has an 'established relationship' and if clinically appropriate (as determined by the treating provider), safe, and agreed to by the student receiving services.

HHSC encourages the use of synchronous audiovisual technology over telephone (audio-only) delivery of telemedicine services whenever possible. Therefore, if delivered by synchronous telephone (audio-only) technology, providers must document in the student's medical record the reason(s) for why a synchronous audiovisual platform was not used.

The patient site must be a school, home, or community-based setting in order for the distant site provider to be eligible for reimbursement of these services.

All telemedicine services provided by synchronous telephone (audio-only) technology must be billed using modifier 93.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90832 with modifier AH and 93	Individual	30 minutes	Licensed psychiatrist
90834 with modifier AH and 93	Individual	45 minutes	Licensed psychiatrist
90837 with modifier AH and 93	Individual	60 minutes	Licensed psychiatrist
90853 with modifier AH and 93	Group	Untimed, one per date of service	Licensed psychiatrist
96158 with modifier AH and 93	Individual	30 minutes	Licensed psychiatrist
96159 with modifier AH and 93 (add-on procedure code)	Individual	15 minutes	Licensed psychiatrist
96164 with modifier AH and 93	Group	30 minutes	Licensed psychiatrist
96165 with modifier AH and 93 (add-on procedure code)	Group	15 minutes	Licensed psychiatrist

Refer to: *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on restrictions for services delivered by synchronous telephone (audio-only) technologies.

2.3.11 Prior Authorization

Prior authorization is not required for Medicaid services provided by a SHARS provider.

2.4 Documentation Requirements

Documentation of services should be generated at the time of service or shortly thereafter, in order to maintain an accurate medical record. Documentation of services must occur within 1 week (7 days) of the time the service is rendered.

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The following service log documentation is required for all SHARS services prescribed in the student's IEP or Section 504 plan:

- Student's name
- Student's date of birth
- Student's Medicaid identification number on every page of the chart/record/note
- Date of service; and for each date of service:
  - Billable start and stop time
  - Total billable minutes
  - Student observation
  - Procedure code(s)
  - Note activity performed. Documentation of service provided must support the services billed.
- The SHARS provider's printed name, title, and original handwritten or electronic signature
  - Any electronic signature technologies that are used must comply with all federal and state statutes and administrative rules.

Service logs for PCS must include all elements of a SHARS service log with the following:

- The specific PCS task
- The total billable minutes for each ADL and IADL recorded

The total billable minutes for PCS are determined by the combined total billable minutes for each ADL and IADL recorded.

The total billable minutes for PCS performed by a PCS provider cannot exceed the PCS provider's total number of hours at the place of service.

Session notes for evaluations are not required; however, documentation must include the billable start time, billable stop time, and total billable minutes with a notation of the activity performed (e.g., audiology evaluation, speech therapy evaluation). Service providers are expected to perform and document evaluations in accordance with discipline-specific standards of practice and retain records in the student's file.

Session notes are required for therapy. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

Session notes will include all elements of a service log plus:

- Student's progress towards goals (if applicable)
- Note whether the service was provided individually or in a group
- The related IEP objective

If a SHARS provider is supervising an assistant or intern, then the supervising provider must adhere to current state licensure signature requirements.

All SHARS services require documentation to support the medical necessity of the service rendered. SHARS services are subject to retrospective review and recoupment if documentation does not support the service billed.

The following are mandatory general requirements for all providers:

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- All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.
- Each page of the medical record documents the client's name and Texas Medicaid number.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information on additional mandatory general documentation requirements for all providers.

All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

2.4.1 Record Retention

Student-specific records that are required for SHARS become part of the student's educational records and must be maintained for seven years. All records that are pertinent to SHARS must be maintained by the LEA until all audit questions, appeal hearings, investigations, or court cases are resolved. Records must be stored in a secure and readily accessible location and format and must be available for state or federal audits.

The following is a checklist of the minimum documents to collect and maintain:

- Signed consent to bill Medicaid by parent or guardian
- IEP
- Current provider qualifications (licenses)

  Note: *Qualified PCS provider documentation must include a signed and dated statement from a qualified employee of the LEA, as described by the PCS Provider Requirements, verifying the individual is able to perform PCS tasks in accordance with the required PCS competence areas. Supporting documents or information must also be included as applicable.*
- Attendance records
- Prescriptions and referrals
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability)
- Session notes or service logs, including provider signatures, for each service/event
- Supervision logs
- Special transportation logs
- Claims submittal and payment histories
- Assessments/evaluations
- Written agreements (contracts) for contracted service providers
- Copies of signed Certification of Funds (COF) letters and supporting documentation, including quarterly COF reports
- E-signature authorization forms(s) if applicable

2.5 Managed Care Clients

SHARS services are available to clients regardless of Medicaid service delivery mechanism (traditional Medicaid or Medicaid Managed Care). SHARS services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's Managed Care Organization (MCO).

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2.6 Third Party Liability

SHARS claims are subject to Third Party Liability via the pay and recover later method.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for more information.

2.7 Claims Filing and Reimbursement

2.7.1 Claims Information

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

Claims must be submitted within 365 days from the date of service, or no later than 95 days after the end of the federal fiscal year (FFY) (i.e., January 3), whichever comes first.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims and additional general information about claims filing.

2.7.1.1 Appealing Denied SHARS Claims

SHARS providers that appeal claims denied for exceeding benefit limitations must submit documentation of medical necessity with the appeal. Documentation submitted with an appeal must include the pages from the IEP and ARD documents that show the authorization of the services, including the specified frequency and duration and the details of the need for additional time or the reasons for exceeding the benefit limitations.

Each page of the documentation must have the student's name and Medicaid number.

2.7.2 Reimbursement Guidelines: Cost Reporting and Interim Claims

During the cost report period, LEAs participating in SHARS are reimbursed on an interim claiming basis using SHARS interim rates. In order to accommodate participating SHARS districts that require interim cash flow to offset the financial burden of providing for students, an interim fee-for-service claiming system still exists for SHARS. It is important that SHARS providers understand that SHARS interim payments are provisional in nature. Providers are reimbursed for direct medical services and transportation services provided under the SHARS Program on a cost basis using federally mandated allocation methodologies in accordance with 1 TAC §355.8443.

There is no lifetime benefit cap for SHARS services provided so long as the services are medically necessary and documented in the student's IEP. The services provided to the student at the school do not affect the type or amount of Medicaid services the student receives outside the school setting.

2.7.2.1 Interim Claiming

LEAs must submit the following:

- At least one interim claim for each direct medical service that an eligible student receives within the cost report period.
- Interim claims for all personal care services that an eligible student receives within the cost report period
- Interim claims for all eligible specialized transportation trips provided within the cost report period.

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Untimed Units

For untimed procedure codes, claims that are submitted for reimbursement must include one unit of service for each unit billed. Untimed codes are reimbursed on a per unit basis and are subject to frequency limitations for each SHARS service category.

Timed Units

For timed procedure codes, providers must only report billable time when the midpoint of the total duration for the procedure code has been passed. All claims for reimbursement of timed procedure codes are based on the actual amount of billable time associated with the SHARS service.

For those services for which the unit of service is 15 minutes based on code description for SHARS services (i.e., 1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour for 15-minute units.

Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Examples of Billing Units Based on 15 Minutes

Minutes	Units
0 min - 7 mins	0 units
8 mins - 22 mins	1 unit
23 mins - 37 mins	2 units
38 mins - 52 mins	3 units
53 mins - 67 mins	4 units
68 mins - 82 mins	5 units

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service.

For 30-minute codes at least 16 minutes must pass in order to report a code with 1 unit = 30 minutes.

For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units must be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student and divide by 60 to convert to billable units of service. If the total billable minutes are not divisible by 60, the minutes are converted to partial units of service as follows:

Examples of Billing Units Based on an Hour

Minutes	Units
0 mins - 3 mins	0 units

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Minutes	Units
4 mins - 9 mins	0.1 unit
10 mins - 15 mins	0.2 unit
16 mins - 21 mins	0.3 unit
22 mins - 27 mins	0.4 unit
28 mins - 33 mins	0.5 unit
34 mins - 39 mins	0.6 unit
40 mins - 45 mins	0.7 unit
46 mins - 51 mins	0.8 unit
52 mins - 57 mins	0.9 unit
58 mins - 63 mins	1 unit
64 mins - 69 mins	1.1 units
70 mins - 75 mins	1.2 units
76 mins - 81 mins	1.3 units
82 mins - 87 mins	1.4 units
88 mins - 93 mins	1.5 units

2.7.2.2 Cost Reporting

The total allowable costs for providing services for SHARS must be documented by submitting the required annual cost report.

The provider's final reimbursement amount is arrived at by a cost report, cost reconciliation, and cost settlement process. The provider's total costs for both direct medical and transportation services as reported in the cost report are adjusted using the federally mandated allocation methodologies.

The provider's interim payments will be reimbursed in compliance with 1 TAC §355.8443.

Submittal of a SHARS cost report is mandatory for each provider that requests and receives interim payments. Failure to file a SHARS cost report will result in sanctions, which includes recoupment of all interim payments for the cost report period in which the default occurs.

CMS requires annual cost reporting, cost reconciliation, and cost settlement processes for all Medicaid SHARS services delivered by LEAs. CMS requires that LEAs, as public entities, not be paid in excess of their Medicaid-allowable costs and that any overpayments be recouped through the cost reconciliation and cost settlement processes. In an effort to minimize any potential recoupments, HHSC has assigned SHARS interim rates that are as close as possible to each district's Medicaid allowable costs for providing each SHARS service.

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous FFY (October 1 through September 30). The cost report is due on or before April 1 of the year following the reporting period.

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The following certification forms must be submitted and received by HHSC for the cost report. The annual cost report includes two certification forms which must be completed to certify the provider's incurred actual costs:

- Cost report certification
- Claimed expenditures

The certification forms received by HHSC for the cost report must be:

- The original certification pages.
- Signed by the business officer or other financial representative who is responsible for legally binding the district.
- Notarized.

The primary purpose of the cost report is to document the provider's costs for delivering SHARS, including direct costs and indirect costs, and to reconcile the provider's interim payments for SHARS with its actual total Medicaid-allowable costs.

All annual SHARS cost reports that are filed are subject to desk review by HHSC or its designee.

2.7.2.3 Cost Reconciliation and Cost Settlement

The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report. The total Medicaid-allowable costs are compared to the provider's interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation.

If a provider has not complied with all cost report requirements or a provider's interim payments exceed the actual certified Medicaid-allowable costs of the provider for SHARS to Medicaid clients, HHSC will recoup the federal share of the overpayment by one of the following methods:

- Offset all future claims payments to the provider until the amount of the federal share of the overpayment is recovered
- Recoup an agreed-upon percentage from future claims payments to the provider to ensure recovery of the overpayments within one year
- Recoup an agreed-upon dollar amount from future claims payments to ensure recovery of the overpayment within one year

If the actual certified Medicaid-allowable costs of a provider for SHARS exceed the provider's interim payments, HHSC will pay the federal share of the difference to the provider in accordance with the final, actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

HHSC issues a notice of settlement that denotes the amount due to or from the provider.

2.7.2.4 * Informal Review of Cost Reports Settlement

An LEA or the Superintendent, Chief Financial Officer, Business Officer, or other LEA Official with legal authority who disagrees with the adjustments made during the cost reconciliation process has the right to request an informal review of the adjustments. Requests for informal reviews must be sent by certified mail and received by HHSC within the time frame designated on the settlement notice. Furthermore, the request for informal review must include a concise statement of the specific actions or determinations the LEA disputes, the LEA's recommended resolution, and any supporting documentation deemed relevant to the dispute. Failure to follow these instructions will result in the denial of the request for an informal review.

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[Revised] For more information on the Cost Report and SHARS interim rates please reference the Cost Report Instructions and the HHSC Rate Analysis SHARS webpage at pfd.hhs.texas.gov/acute-care/school-health-and-related-services-shars. Further information can be found in 1 TAC §355.8443.

SHARS providers can also contact a SHARS Rate Analyst by email at ProviderFinance-SHARS@hhs.texas.gov or by telephone at 512-730-7400.

Refer to: "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information on reimbursement and the Federal Medical Assistance Percentage (FMAP).

2.7.2.5 Quarterly Certification of Funds

SHARS providers are required to certify on a quarterly basis the amount reimbursed during the previous federal fiscal quarter. TMHP Provider Enrollment mails the quarterly Certification of Funds statement to SHARS providers after the end of each quarter of the FFY (October 1 through September 30). The purpose of the statement is to verify that the LEA incurred costs on the dates of service that were funded from state or local funds in an amount equal to, or greater than, the combined total of its interim rates times the paid units of service. While the payments were received the previous FFY, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the dates of the FFY quarter and not the dates of service paid within the quarter.

In order to balance amounts in the Certification of Funds, providers will receive, or have access to, the Certification of Funds Claims Information Report. For help balancing the amounts in the statement, providers can contact the TMHP Contact Center at 800-925-9126.

Refer to: "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

The Certification of Funds statement must be:

- Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit.
- Notarized.
- Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider's payments until the signed Certification of Funds statement is received by TMHP. Providers must contact the TMHP Contact Center at 800-925-9126 if they do not receive their Certification of Funds statement.

On an annual basis, SHARS providers are required to certify through their cost reports their total, actual, incurred costs, including the federal share and the nonfederal share.

Refer to: Subsection 2.7.2, "Reimbursement Guidelines: Cost Reporting and Interim Claims" in this handbook for additional information about cost reporting.

2.8 * Random Moment Time Study (RMTS)

CMS requires SHARS providers to participate in the RMTS to be eligible to submit claims and receive reimbursement for SHARS services. SHARS providers must comply with the Texas Time Study Guide, which includes, but is not limited to, Mandatory Annual RMTS Contact training certification of RMTS participants for all four annual RMTS quarters, and compliance with participation requirements for selected sampled moments. The four annual RMTS quarters are October through December, January through March, April through June, and July through September.

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An existing LEA can only become a SHARS provider effective October 1, each year and they must participate in all four RMTS quarters for that annual period. SHARS providers that do not participate in all four required RMTS quarters, or are RMTS non-compliant, cannot be a SHARS provider for that entire annual period (October 1 through September 30) and will be required to return any Medicaid payments received for SHARS services delivered during that annual cost report period. The LEA can return to participating in the SHARS program the following FFY beginning on October 1.

A new LEA (i.e., a newly formed district that began operations after October 1) can become a SHARS provider effective with the first day of the federal quarter in which it participates in the RMTS. New SHARS providers may not submit claims or be reimbursed for SHARS services provided prior to the RMTS quarter in which they begin to participate, and they must participate in all remaining RMTS quarters for that annual period.

[Revised] LEAs can access the Texas Time Study Guide, on the HHSC website at pfd.hhs.texas.gov/acute-care/time-study.

SHARS providers can contact the HHSC Time Study Unit by email at TimeStudy@hhsc.texas.gov or by telephone at 512-491-1715.

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Telecommunication Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

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TEXAS
Health and Human Services

TELECOMMUNICATION SERVICES HANDBOOK

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1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

The information in this handbook is intended for home health agencies, hospitals, nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), licensed professional counselors (LPC), licensed marriage and family therapists (LMFT), licensed clinical social workers (LCSW), physicians, physician assistants (PA), psychologists, licensed psychological associates, provisionally licensed psychologists, and licensed dieticians.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2 Enrollment

Providers may provide telecommunication services for Texas Medicaid clients under the provider's National Provider Identifier (NPI). No additional enrollment is required to provide telemedicine medical service or telehealth services.

Home health agency and hospital providers who wish to provide telemonitoring services must notify the Texas Medicaid & Healthcare Partnership (TMHP) as follows:

- Current providers must use the Provider Enrollment and Management System (PEMS) to indicate that they provide telemonitoring services.
- Newly enrolling or re-enrolling home health agency or outpatient hospital providers must indicate whether they provide telemonitoring services during the enrollment process.

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Refer to: Subsection 3.1, "Provider Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about CNM provider enrollment.

Subsection 8.1, "Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about NP and CNS provider enrollment.

Subsection 9.1, "Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about physician provider enrollment.

Subsection 10.1, "Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about PA provider enrollment.

Subsection 4.1, "Provider Enrollment" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for information about mental health services provider enrollment.

Subsection 4.1, "Provider Enrollment" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for information about psychologist and licensed psychological associate provider enrollment.

Subsection 2.11.1, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about licensed dietitian enrollment.

3 Services, Benefits, Limitations, and Prior Authorization

Health professionals who deliver telemedicine and telehealth services must follow applicable Texas statutes, including the Texas Occupations Code, Title 3, and any rules and standards established by their respective licensing or certifying board. This includes all requirements for obtaining and documenting informed consent for treatment, data collection, and data sharing, while ensuring the privacy and security of patient data, in compliance with all record retention requirements.

The use of telemedicine and telehealth services within intermediate care facilities for individuals with intellectual disabilities (ICF-IID) and State Supported Living Centers is subject to the policies established by the Health and Human Services Commission (HHSC).

More than one medically necessary telemedicine service or telehealth service may be reimbursed for the same date and same place of service if the services are billed by providers of different specialties.

All confidentiality and Health Insurance Portability and Accountability Act (HIPAA) standards apply to telemedicine medical service and telehealth transmissions.

Refer to: Subsection 1.7.7, "Release of Confidential Information" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about confidentiality standards.

3.1 Patient Health Information Security

The software system used by the distant site provider must allow secure authentication of the distant site provider and the client.

The physical environments of the client and the distant site provider must ensure that the client's protected health information remains confidential. A parent or legal guardian may be physically located in the patient site or distant site environment during a telehealth or telemedicine service with a child.

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A parent or legal guardian must provide written or verbal consent to the distant site provider to allow any other individual to be physically present in the distant or patient site environment during a telehealth or telemedicine service with a child.

An adult client must also provide written or verbal consent to the distant site provider to allow any other individual to be physically present in the distant or patient site environment during a telehealth or telemedicine service.

Providers of telehealth or telemedicine must maintain the confidentiality of protected health information (PHI) as required by Federal Register 42, Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, Chapters 111 and 159 of the Texas Occupations Code, and other applicable federal and state law.

Providers of telehealth or telemedicine must also comply with the requirements for authorized disclosure of PHI relating to clients in state mental health facilities and residents in state supported living centers, which are included in, but not limited to, 42 CFR Part 2, 45 CFR Parts 160 and 164, Texas Health and Safety Code §611.004, and other applicable federal and state law.

All client health information generated or utilized during a telehealth or telemedicine service must be stored by the distant site provider in a client health record. If the distant site provider stores the patient health information in an electronic health record, the provider should use software that complies with Health Insurance Portability and Accountability Act (HIPAA) confidentiality and data encryption requirements, as well as with the United States Department of Health and Human Services (HHS) rules implementing HIPAA.

3.2 General Guidelines for Texas Medicaid MCOs

Texas Medicaid managed care organiziations (MCOs) are prohibited from denying reimbursement for covered services solely because they are delivered remotely. MCOs must consider reimbursement for all medically necessary Medicaid-covered services that are provided using telemedicine or telehealth.

Texas Medicaid MCOs must determine whether to reimburse for a telemedicine or telehealth service based on clinical and cost effectiveness, among other factors.

Texas Medicaid MCOs cannot deny, limit, or reduce reimbursement for a covered health-care service or procedure based on the provider's choice of telecommunications platform to provide the service or procedure using telemedicine or telehealth.

Providers should refer to individual MCO policies for additional coverage information.

Clinical and cost effectiveness determinations that result in prohibiting a service from being delivered using a synchronous audio-only technology, or store and forward technology in conjunction with synchronous audio-only technology are not considered denying, limiting, or reducing reimbursement for a covered health care service.

3.3 Services Provided through Telecommunications

3.3.1 Definitions of Terminology for Telemedicine and Telehealth Services

The following are definitions of terms used in telemedicine and telehealth services:

Telecommunications - The exchange of information by electronic and electrical means.

Platform - The technology, system, software, application, modality, or other method or means of delivery through which a health professional remotely interfaces with a client when providing a health care service or procedure as a telemedicine service or telehealth service.

Audiovisual - Synchronous audiovisual technology or store and forward technology in conjunction with synchronous audio-only technology.

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Synchronous audiovisual technology - An interactive, two-way audio and video telecommunications platform that meets the privacy requirements of the Health Insurance Portability and Accountability Act.

Synchronous audio-only, also called synchronous telephone (audio-only), technology - An interactive, two-way audio telecommunications platform, including telephone technology, that uses only sound and meets the privacy requirements of the Health Insurance Portability and Accountability Act.

Store and forward technology - A telecommunications platform that stores and transmits or grants access to a person's clinical information for review by a health professional at a different physical location than the person that meets the privacy requirements of the Health Insurance Portability and Accountability Act.

In-person (or in person) - Within the physical presence of another person.

Not all Medicaid-covered services are authorized by HHSC for telemedicine or telehealth delivery in fee-for-service. Providers must always ensure the covered service is allowable by HHSC for telemedicine or telehealth services delivery.

Note: *For example, if a service is authorized for telemedicine or telehealth delivery only when using synchronous audiovisual technology, that service may not be delivered using store and forward technology, store and forward technology in conjunction with synchronous audio-only technology, synchronous audio-only technology, or asynchronous audio-only technology.*

Telemedicine or telehealth may be provided if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit.

3.3.2 Telemedicine and Telehealth Conditions for Reimbursement

Conditions for reimbursement applicable to telemedicine and telehealth provided using a synchronous audiovisual technology platform, or using store and forward technology in conjunction with synchronous audio-only are those that meet the following conditions:

- Must be designated for reimbursement by HHSC.
- Must be clinically effective and cost-effective, as determined and published in the benefit language by HHSC.
- May not be denied solely because an in-person medical service between a provider and client did not occur.
- May not be limited by requiring the provider to use a particular synchronous audiovisual technology platform to receive reimbursement for the service.

Other conditions for reimbursement applicable to services may vary by service type. Providers may refer to the appropriate TMPPM handbook for additional information on synchronous audiovisual technology platform coverage conditions.

Note: *Telemedicine and telehealth services that HHSC has determined are clinically effective and cost-effective when provided via a synchronous audiovisual technology platform or using store and forward technology in conjunction with synchronous audio-only technology can be found in the appropriate TMPPM handbooks.*

Conditions for reimbursement applicable to behavioral health services provided using a synchronous audio-only technology platform are those that meet the following conditions:

- Must be designated for reimbursement by HHSC.

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- Provider must obtain informed consent from the client, client's parent, or the client's legally authorized representative prior to rendering a behavioral health service through a synchronous audio-only technology platform; except when doing so is not feasible or could result in death or injury to the client. Verbal consent is permissible and must be documented in the client's medical record.
- Must be clinically effective and cost-effective, as determined and published in the benefit language by HHSC.
- May not be denied solely because an in-person medical service between a provider and client did not occur.
- May not be limited by requiring the provider to use a particular synchronous audio-only technology platform to receive reimbursement for the service.
- Other conditions for reimbursement applicable to behavioral health services may vary by service type. Providers may refer to the appropriate TMPPM handbook for additional information on audio-only coverage conditions.

Conditions for reimbursement applicable to non-behavioral health services provided using a synchronous audio-only technology platform:

- Must be designated for reimbursement by HHSC.
- Clinically effective and cost-effective, as determined and published by HHSC.
- May not be denied solely because an in-person medical service between a provider and client did not occur.
- May not be limited by requiring the provider to use a particular synchronous audio-only technology platform to receive reimbursement for the service.

Note: *Behavioral or non-behavioral health services that HHSC has determined are clinically effective and cost-effective when provided via a synchronous audio-only technology platform can be found in the appropriate TMPPM handbooks.*

Telemedicine and telehealth services are reimbursed in accordance with 1 TAC §355.

In the event of a Declaration of State of Disaster, HHSC will issue direction to providers regarding the use of telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law.

Declaration of State of Disaster is when to an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Texas Government Code §418.014.

3.4 Telemedicine Services

Telemedicine medical services, also known as telemedicine, are allowable for Texas Medicaid. Telemedicine has the meaning assigned by *Texas Occupations Code* §111.001. Telemedicine services are defined as health-care services delivered by a physician licensed in Texas or a health professional who acts under the delegation and supervision of a health professional licensed in Texas and within the scope of the health professional's license to a client at a different physical location using telecommunications or information technology. Telemedicine excludes teledentistry services.

3.4.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site telemedicine benefits include services that are performed by the following providers, who must be enrolled as a Texas Medicaid provider:

- Physician

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- CNS
- NP
- PA
- CNM
- Federally Qualified Health Center (FQHC)

A distant site provider is the physician, or PA, NP, CNM, FQHC, Rural Health Clinic (RHC), or CNS who is supervised by and has delegated authority from a licensed Texas physician, who uses telemedicine to provide health-care services to a client in Texas.

Distant site providers must be licensed in Texas.

Distant site providers that provide mental health services must be appropriately licensed or certified in Texas, or be a qualified mental health professional-community services (QMHP-CS), as defined in 26 TAC §301.303(48).

A valid practitioner-patient relationship must exist between the distant site provider and the patient. A valid practitioner-patient relationship exists between the distant site provider and the patient if:

- The distant site provider meets the same standard of care required for and in-person service.
- The relationship can be established through:
  - A prior in-person service.
  - A prior telemedicine service that meets the delivery method requirements specified in *Texas Occupations Code* §111.005(a)(3).
  - The current telemedicine service that meets the delivery method requirements specified in *Texas Occupations Code* §111.005(a)(3).

A call coverage agreement established in accordance with Texas Medical Board (TMB) administrative rules in 22 TAC §174.1.

The distant site provider must obtain informed consent to treatment from the patient, patient's parent, or the patient's guardian prior to rendering a telemedicine medical service.

Distant site providers that communicate with clients using electronic communication methods other than phone or facsimile must provide clients with written notification of the physician's privacy practices prior to evaluation and treatment. A good faith effort must be made to obtain the client's written acknowledgment of the notice, including by email response.

A distant site provider should provide patients who receive a telemedicine service with guidance on the appropriate follow-up care.

Procedure codes that are reimbursed to distant site providers when billed with the 95 modifier (synchronous audiovisual technology) are included in the individual TMPPM handbooks. Procedure codes that indicate remote (telemedicine) delivery in the description do not need to be billed with the 95 modifier.

Procedure codes that are reimbursed to distant site providers when billed with the 93 modifier (audio-only services) are included in the individual TMPPM handbooks. Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the 93 modifier.

Behavioral health procedure codes that are reimbursed to distant site providers when billed with the FQ modifier (audio-only services) are included in the individual TMPPM handbooks. Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the FQ modifier.

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Texas Medicaid MCOs must reimburse the following procedure codes when delivered via telemedicine services:

Procedure Codes									
G0406	G0407	G0408	G0425	G0426	G0427				

3.4.2 Telemedicine Service Delivery

The following delivery methods may be used to provide telemedicine within fee-for-service (FFS) Medicaid:

- Synchronous audiovisual technology between the distant site provider and the client in another location
- Synchronous audio-only technology between the distant site provider and the client in another location
- Store and forward technology in conjunction with synchronous audio-only technology between the distant site provider and the client in another location. The distant site provider must use one of the following:
  - Clinically relevant photographic or video images, including diagnostic images
  - The client's relevant medical records, such as medical history, laboratory and pathology results, and prescriptive histories

A Texas Medicaid managed care organization (MCO) is not required to provide reimbursement for telemedicine services that are provided through the following methods:

- A text-only email message
- A facsimile transmission

Texas Medicaid MCOs may optionally provide reimbursement for telemedicine services that are provided through asynchronous audio-only technology, such as voice mail technology. Distant site providers should contact each MCO to determine whether an MCO provides reimbursement for a specified modality.

3.4.2.1 Prescriptions Generated from a Telemedicine Medical Service

A distant site provider may issue a valid prescription as part of a telemedicine service. An electronic prescription (e-script) may be used as permitted by applicable federal and state statues and rules.

The same standards that apply for the issuance of a prescription during an in-person setting apply to prescriptions issued by a distant site provider.

The prescription must be issued for a legitimate medical purpose by the distant site provider as part of a valid practitioner-patient relationship.

The prescribing physician must be licensed in Texas. If the prescription is for a controlled substance, the prescribing physician must have a current valid U.S. Drug Enforcement Administration (DEA) registration number.

A licensed health professional acting under the delegation and supervision of a physician licensed in Texas may also issue a valid prescription. Prescribing must be in accordance with the required prescriptive authority agreement or other forms of delegation.

If the prescription is for a controlled substance, the health professional must have a current valid DEA registration number. If the prescription is for a schedule II controlled substance, the health professional must comply with DEA regulations regarding the use of electronic prescriptions. The health professional may also use the official prescription forms issued with their name, address, phone number, DEA registration number, delegating physician's name, and delegating physician's DEA registration number.

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As applicable, all drug prescriptions must meet the requirements of the Texas Controlled Substance Act (*Texas Health and Safety Code* §481), the Texas Dangerous Drug Act (*Texas Health and Safety Code* §483), and any other federal or state statutes or rules.

Telemedicine medical services used for the treatment of chronic pain with scheduled drugs via audio-only is prohibited, unless a patient:

- Is an established chronic pain patient of the physician or health professional issuing the prescription;
- Is receiving a prescription that is identical to a prescription issued at the previous visit; and
- Has been seen by the prescribing physician or health professional defined under Section 111.001(1) of Texas Occupations Code, in the last 90 days either in-person or via telemedicine using audio-visual communication.

Treatment of a client for acute pain with scheduled drugs using telemedicine is permitted. Acute pain is defined by 22 TAC §172.1(1).

All physicians must comply by 22 TAC §175.3 when issuing prescriptions through a telemedicine service.

3.4.3 Patient Site

A patient site is the place where the client is physically located. A client's home may be the patient site for telemedicine.

Patient-site providers that are enrolled in Texas Medicaid may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to NP, CNS, PA, physicians, and outpatient hospital providers. Charges for other services that are performed at the patient site may be submitted separately. Procedure code Q3014 is not a benefit if the patient site is the client's home.

3.4.3.1 School-Based Setting

Telemedicine provided in a school-based setting by a physician, even if the physician is not the client's primary care physician or provider, are benefits if all of the following criteria are met:

- The physician is an authorized health-care provider enrolled in Texas Medicaid.
- The client is a child who is receiving the service in a primary or secondary school-based setting.
- The parent or legal guardian of the client provides consent before the service is provided.

Telemedicine services provided in a school-based setting are also a benefit if the physician delegates provision of services to a nurse practitioner, clinical nurse specialist, or physician assistant, as long as the nurse practitioner, clinical nurse specialist, or physician assistant is working within the scope of their professional license and within the scope of their delegation agreement with the physician.

3.4.4 Telemedicine Services for FQHCs

3.4.4.1 Distant Site

FQHCs may be reimbursed the distant-site provider fee for telemedicine services at the Prospective Payment System (PPS) rate or Alternative Prospective Payment System (APPS) rate.

FQHC practitioners may be employees of the FQHC or contracted with the FQHC.

FQHCs may be reimbursed the facility fee (procedure code Q3014) as an add-on procedure code that should not be included in any cost reporting that is used to calculate a PPS or APPS per visit encounter rate.

To receive reimbursement for more than one facility fee for the same client on the same date of service, an FQHC must submit documentation of medical necessity that indicates that the client needed multiple distant-site provider consultations. An FQHC can use a signed letter from the client's treating health-

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care provider at the FQHC to document the client's medical need for receiving multiple distant-site provider consultations on the same date of service. The letter must state that the client suffered an illness or injury that required additional diagnosis or treatment by a distant-site provider.

If an FQHC is eligible for payment of both an encounter fee and a facility fee for the same client on the same date of service, the FQHC must submit a claim for the facility fee separate from the claim that was submitted for the encounter.

3.4.5 Telemedicine Services for RHCs

RHCs may be reimbursed the distant-site provider fee for telemedicine services at the PPS rate. RHC practitioners may be employees of the RHC or contracted with the RHC.

The facility fee (procedure code Q3014) may be reimbursed as an add-on procedure code that should not be included in any cost reporting that is used to calculate the RHC AIR (All Inclusive Rate) PPS per visit encounter rate.

To receive reimbursement for more than one facility fee for the same client on the same date of service, an RHC must submit documentation of medical necessity that the client needed multiple distant-site provider consultations. An RHC can use a signed letter from the client's treating health care provider at the RHC documenting that the client suffered an illness or injury requiring additional diagnosis or treatment by a distant site provider. This will suffice to document the client's medical need for purposes of receiving additional facility fee payments for the same client on the same date of service. The letter must state that the client suffered an illness or injury that required additional diagnosis or treatment by a distant-site provider.

If an RHC is eligible for payment of both an encounter fee and a facility fee for the same client on the same date of service, the RHC must submit a claim for the facility fee separate from the claim submitted for the encounter.

The facility fee should not be included in any cost reporting that is used to calculate the RHC All Inclusive Rate (AIR) prospective payment system (PPS) per-visit encounter rate.

> ***Note:*** *Telemedicine and telehealth services must be billed with modifier 95. Procedure codes that indicate remote delivery (telemedicine medical services or telehealth services) in the description do not need to be billed with modifier 95.*

3.4.6 Documentation Requirements for Telemedicine

In addition to documentation requirements outlined in the Prior Authorization section, if any, all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

Medical records must be maintained for all telemedicine services.

Documentation for a service provided via telemedicine must be the same as for a comparable in-person service.

If a patient has a primary care provider who is not the distant site provider and the patient or their parent or legal guardian provides consent to a release of information, a distant site provider must provide the patient's primary care provider with the following information:

- A medical record or report with an explanation of the treatment provided by the distant site provider
- The distant site provider's evaluation, analysis, or diagnosis of the patient

Unless the telemedicine services are rendered to a child in a school-based setting, distant site providers of mental health services are not required to provide the patient's primary care provider with a treatment summary.

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For telemedicine provided to a child in a school-based setting, a notification provided by the telemedicine physician to the child's primary care provider must include a summary of the service, exam findings, prescribed or administered medications, and patient instructions.

If the child does not have a primary care provider, the notification must be provided to the child's parent or legal guardian. In addition to providing treatment information, the notification must include a list of primary care providers from which the child's parent or legal guardian may select a primary care provider.

3.5 Telehealth Services

Telehealth services, also known as telehealth, are allowable for Texas Medicaid. Telehealth has the meaning assigned by *Texas Occupations Code* §111.001. Telehealth services are defined as health-care services, other than telemedicine medical services or a teledentistry service, delivered by a health professional licensed, certified or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification or entitlement to a patient at a different physical location other than the health professional using telecommunications or information technology.

Telehealth services are reimbursed in accordance with 1 TAC §355.

3.5.1 Distant Site

A distant site is the location of the provider rendering the service. A distant site provider is the health professional licensed, certified, or otherwise entitled to practice in Texas who uses telehealth services to provide health care services to a patient in Texas.

Licensed psychological associates (LPAs), provisionally licensed psychologists (PLPs), post-doctoral psychology fellows, and pre-doctoral psychology interns under psychologist supervision may also deliver telehealth services. All requirements outlined in the Outpatient Mental Health Services benefit language must be met.

Distant site providers that provide mental health services must be appropriately licensed or certified in Texas or be a QMHP-CS as defined in 26 *Texas Administrative Code* §301.303(48).

A distant-site provider that is located outside of state lines while rendering services is considered an out-of-state provider.

The distant site provider must obtain informed consent to treatment from the patient, patient's parent or the patient's legal guardian prior to rendering a telehealth service.

Distant site providers should meet all other telehealth service requirements specified in Texas Occupations Code §111.

Procedure codes that are benefits for distant site providers when billed with the 95 modifier (synchronous audiovisual technology) are included in the individual TMPPM handbooks. Procedure codes that indicate remote (telehealth service) delivery in the description do not need to be billed with the 95 modifier.

Procedure codes that are a benefit for distant site providers when billed with the 93 modifier (synchronous audio-only technology) are included in the individual TMPPM handbooks. Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the 93 modifier.

Behavioral health procedure codes that are a benefit for the distant site providers when billed with the FQ modifier (synchronous audio-only technology) are included in the individual TMPPM handbooks. Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the FQ modifier.

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3.5.2 Patient Site

A patient site is the place where the client is physically located while the service is rendered. Patient-site providers that are enrolled in Texas Medicaid may only be reimbursed for the facility fee using procedure code Q3014. Charges for other services that are performed at the patient site may be submitted separately.

A client's home may be the patient site for telehealth. Procedure code Q3014 is not a benefit if the patient site is the client's home.

3.5.3 Distant-Site Telehealth Services for FQHCs

FQHCs may be reimbursed the distant-site provider fee for telehealth services at the Prospective Payment System (PPS) rate or Alternative Prospective Payment System (APPS) rate.

FQHC practitioners may be employees of the FQHC or contracted with the FQHC.

The facility fee (procedure code Q3014) may be reimbursed as an add-on procedure code and should not be included in any cost reporting that is used to calculate a PPS or APPS per visit encounter rate.

To receive reimbursement for more than one facility fee for the same client on the same date of service, an FQHC must submit documentation of medical necessity indicating that the client needed multiple distant site provider consultations.

An FQHC can use a signed letter from the client's treating health care provider at the FQHC documenting that the client suffered an illness or injury requiring additional diagnosis or treatment by a distant site provider. This will suffice to document the client's medical need for purposes of receiving additional facility fee payments for the same client on the same date of service.

If an FQHC is eligible for payment of both an encounter and a facility fee for the same client on the same date of service, the FQHC must submit claims for the facility fee separate from claims submitted for the encounter.

3.5.4 Distant-Site Telehealth Services for RHCs

RHCs may be reimbursed the distant-site provider fee for telehealth services at the PPS rate.

RHC practitioners may be employees of the RHC or contracted with the RHC.

The facility fee (procedure code Q3014) may be reimbursed as an add-on procedure code that should not be included in any cost reporting that is used to calculate the RHC AIR (All Inclusive Rate) PPS per visit encounter rate.

To receive reimbursement for more than one facility fee for the same client on the same date of service, an RHC must submit documentation of medical necessity indicating that the client needed multiple distant site provider consultations.

A signed letter from the client's treating health care provider at the RHC documenting that the client suffered an illness or injury requiring additional diagnosis or treatment by a distant site provider will suffice to document the client's medical need for purposes of receiving additional facility fee payments for the same client on the same date of service.

If an RHC is eligible for payment of both an encounter and a facility fee for the same client on the same date of service, the RHC must submit claims for the facility fee separate from claims submitted for the encounter.

3.5.5 Telehealth Service Delivery

The following delivery methods may be used to provide telehealth services within FFS Medicaid:

- Synchronous audiovisual technology between the distant site provider and the client in another location

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- Synchronous audio-only technology between the distant site provider and the client in another location
- Store and forward technology, in conjunction with synchronous audio-only technology between the distant site provider and the client in another location. The distant site provider must use one of the following:
  - Clinically relevant photographic or video images, including diagnostic images
  - The client's relevant medical records, such as medical history, laboratory and pathology results, and prescriptive histories

A Texas Medicaid MCO is not required to provide reimbursement for telehealth services that are provided through the following methods:

- A text-only email message
- A facsimile transmission

Texas Medicaid MCOs may optionally provide reimbursement for telehealth services that are provided through asynchronous audio-only technology, including voice mail technology. Distant site providers should contact each MCO to determine whether an MCO provides reimbursement for a specified modality.

3.5.6 Telehealth Service Documentation Requirements

In addition to documentation requirements outlined in the Prior Authorization section, if any, all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

Medical records must be maintained for all telehealth services.

Documentation for a telehealth service must be the same as a comparable in-person service.

If a client has a primary care provider, and the client or their parent or legal guardian provides consent to release information, a distant site provider must provide the client's primary care provider with the following information:

- A medical record or report with an explanation of the treatment provided by the distant site provider
- The distant site provider's evaluation, analysis, or diagnosis of the client

Providers of mental health services are not required to provide a client's primary care provider with a treatment summary.

ECI providers are not required to provide the client's primary care physician with a treatment summary.

3.6 Home Telemonitoring Services

Home telemonitoring services, also known as remote patient monitoring, is a benefit of Texas Medicaid. Home telemonitoring is a health service that requires scheduled remote monitoring of data related to a client's health, and transmission of the data from the client's home to a licensed home health agency, hospital, FQHC, or RHC. Data and information collected remotely will be transmitted from the client's home to the home health agency, hospital, FQHC, or RHC. The data transmission must comply with standards set by HIPAA.

Home telemonitoring providers must establish a plan of care (POC) with outcome measures based on the physician or requesting provider's order for each client, and the POC and outcome measures must be reviewed by the client's physician.

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The RN, NP, CNS, or PA in a licensed home health agency, hospital, FQHC, or RHC is responsible for reporting data to the physician or requesting provider. Telemonitoring providers must be available 24 hours a day, 7 days a week. Although transmissions are generally at scheduled times, they can occur any time of the day or any day of the week, according to the client's plan of care.

Scheduled periodic reporting of the client data to the physician or requesting provider is required in the event of a measurement outside the parameters established in the physician's orders, or at least once per month when there have been no readings outside the established parameters.

Collection and interpretation of a client's data for home telemonitoring services (procedure code 99091) is a benefit in the office or hospital setting when services are provided by a physician or other qualified health care professional. Procedure code 99091 is limited to once in a 30-day period to the physician or provider ordering the services.

Home telemonitoring is a benefit for clients who have been diagnosed with either diabetes or hypertension or both.

Home telemonitoring services are also a benefit for clients who are 20 years of age and younger, with one or more of the following conditions:

- End-stage solid organ disease
- Organ transplant recipient
- Requiring mechanical ventilation

The physician or requesting provider who orders home telemonitoring services has a responsibility to ensure the following:

- The client has a choice of home telemonitoring providers.
- The client has the right to discontinue home telemonitoring services at any time.

Note: *A nurse practitioner (NP), clinical nurse specialist (CNS) or physician assistant (PA) are considered requesting providers and may request home telemonitoring and sign prior authorization forms.*

Although Texas Medicaid supports the use of home telemonitoring, clients are not required to use this service.

3.6.1 Facility Services

The provision and maintenance of home telemonitoring equipment is the responsibility of the home health agency, hospital, FQHC, or RHC. Procedure code S9110 with modifier U1 is reimbursed one time to a home health agency or hospital for the initial setup and installation in the client's home. A claim for a subsequent set up and installation will not be reimbursed unless there is a documented new episode of care. There will not be reimbursement for the addition of monitoring parameters during the current episode of care. Monthly home telemonitoring services (procedure code S9110 with the appropriate modifier) are a benefit when services are provided by a home health agency or hospital. Home health agency and hospital providers must submit revenue code 780 with procedure code S9110 and one of the appropriate modifiers listed in the table within this section.

Use one of the following modifiers with monthly home telemonitoring services procedure code S9110 to indicate the number of days per month data is transmitted from the client's home to the home telemonitoring provider:

Modifier	Number of Days Per Month
U2	1 through 5 days per month
U3	6 through 10 days per month
U4	11 through 15 days per month

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Modifier	Number of Days Per Month
U7	16 through 20 days per month
U8	21 through 25 days per month
U9	26 through 30 days per month

The unit of reimbursement for procedure code S9110 and the appropriate modifier is a rolling month.

Providers must bill the appropriate modifier to indicate the number of days that transmissions of data were received and reviewed for the client within a rolling month.

Providers are not required to submit modifiers U2, U3, U4, U7, U8, or U9 for telemonitoring on the prior authorization request, but are required to submit the appropriate modifier on the claim for reimbursement based on the number of days as outlined in the table.

Documentation supporting medical necessity for home telemonitoring services must be maintained in the client's medical record by the entity providing the service (home health agency, hospital, FQHC, or RHC) and is subject to retrospective review. All paid home telemonitoring services not supported by documentation of medical necessity are subject to recoupment.

3.7 Prior Authorization

Prior authorization is not required for telemedicine or telehealth services; however, it may be required for the individual procedure codes billed.

3.7.1 Prior Authorization of Telemonitoring Services

Procedure code 99091 does not require prior authorization.

Procedure code S9110 with or without modifier U1 requires prior authorization. Home telemonitoring services may be approved for up to 180 days per prior authorization request.

Procedure code S9110 with modifier U1 can only be prior authorized once per episode of care even if monitoring parameters are added after initial setup and installation, unless the provider submits documentation that extenuating circumstances require another installation of home telemonitoring equipment.

Procedure code S9110 for the transmission of client data will be prior authorized no more than once per month for the duration of the prior authorization period.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

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

The initial request for prior authorization must be received no more than three business days from the date the home telemonitoring services are initiated. Requests received after the three-business day period will be denied for dates of service that occurred before the date the request was received.

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Requests for additional home telemonitoring services received after the current prior authorization period ends will be denied for dates of service provided before the date the request was received.

Prior authorization requests for home telemonitoring must include all of the following:

- A completed Home Telemonitoring Services Prior Authorization Request Texas Medicaid form.
- The physician or requesting provider's signature dated within 30 days before the start of care.
- The frequency of the clinical data ordered by the physician or requesting provider.

An NP, CNS, or PA may sign the prior authorization request form. The NP, CNS, or PA's name, NPI, signature, and date must appear on the form.

The client's diagnoses or conditions and risk factors are necessary to qualify for home telemonitoring services.

For clients of any age who have diabetes or hypertension, at least one of the following risk factors will be required for approval of home telemonitoring services:

- Two or more hospitalizations in the previous 12-month period
- Frequent or recurrent emergency department visits
- A documented history of poor adherence to medication regimens
- Documented risk of falls
- A documented history of care access challenges

For clients who are 20 years of age or younger, one of the following conditions is required:

- End-stage solid organ disease
- Organ transplant recipient
- Mechanical ventilation

If the physician or requesting provider has not signed and dated the request form, the request must be accompanied by a written order or prescription that is signed and dated by the physician, or a complete verbal order from the physician. A complete written order or verbal order contains the following:

- Home telemonitoring transmission frequency
- The client's qualifying condition(s) and risk factors for home telemonitoring services.
- The ordered services including applicable procedure codes or descriptions.
- Dates of service matching or greater than those on the prior authorization request form.

If the initial setup and deployment is to be authorized, orders for initial requests must include the initial setup procedure code or description.

> ***Note:*** *A verbal order is considered current when the date received is on, or no more than, 30 days before the start of home telemonitoring services for the requested authorization period. A written order or prescription is considered current when it is signed and dated on, or no more than, 30 days before the start of home telemonitoring services.*

A request received without a physician's or a requesting provider's signature, documented verbal order, or written prescription will not be approved and may be denied.

3.8 Documentation Requirements

Documentation for a telecommunication service must be the same as for a comparable in-person service.

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3.8.1 Documentation Requirements for Telemonitoring Providers

Home telemonitoring providers, the home health agency, hospital, FQHC, or RHC must maintain all documentation in the client's medical record that shows:

- The home telemonitoring equipment is:
  - Capable of monitoring any data parameters included in the plan of care.
  - A Food and Drug Administration (FDA) Class II hospital-grade medical device.
  - Capable of measuring and transmitting the client's weight, oxygen levels in blood, glucose levels in blood, or blood pressure data.
- The monitoring equipment is being used, which must be demonstrated with data transmission information such as the:
  - Date of transmission.
  - Frequency of transmission.
  - Clinical data that was provided to the client's primary care physician or the requesting provider.
- The provider's staff is qualified to install the home telemonitoring equipment and to monitor the client's data, which will be transmitted according to the client's plan of care.
- No other provider is also monitoring the client's clinical data.
- Whether the client is able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data. (Not required if the equipment does not require active participation from the client.)
- There are written protocols, policies, and procedures about the provision of the home telemonitoring services that are available to HHSC or its designee upon request and that they address the:
  - Authentication and authorization of users.
  - Authentication of the origin of client data transmitted.
  - Prevention of unauthorized access to the system or information.
  - System security, including the integrity of information that is collected, program integrity, and system integrity.
  - Maintenance of documentation about system and information usage.
  - Information storage, maintenance, and transmission.
  - Synchronization and verification of patient profile data.

4 Claims Filing and Reimbursement

4.1 Claims Information

Claims for telecommunication services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills and itemized statements are not accepted as claim supplements.

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Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

4.1.1 Telemonitoring Services

Providers submitting claims for clients who have dual eligibility for Medicaid and Medicare must first submit their claims to Medicare for procedure code 99091. Claims for procedure code S9110 with any modifier should not be submitted to Medicare. Procedure code S9110 is not payable by Medicare.

4.2 Reimbursement

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

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

5 Claims Resources

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

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Resource	Location
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday–Friday from 7 a.m. to 7 p.m., Central Time.

7 Forms

The following linked form can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Form
Home Telemonitoring Services Prior Authorization Request Texas Medicaid

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Vision and Hearing Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

November 2026

TEXAS
Health and Human Services

VISION AND HEARING SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for optometrists (doctors of optometry), ophthalmologists, and opticians who render services related to the eye and vision and for hearing aid professionals (fitters and dispensers, physicians, and audiologists) who provide hearing evaluations or fitting and dispensing services. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with subsection 4.1, "Enrollment" in this handbook. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

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2 Nonimplantable Hearing Aid Devices and Related Services

2.1 Enrollment

To enroll in Texas Medicaid, hearing aid professionals (physicians, audiologists, and hearing aid fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service is performed. Hearing aid providers are eligible to enroll as individuals and facilities.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

2.1.1 School Districts, State Agencies, and Inpatient Facilities

To be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss (other than audiology evaluation and therapy services reimbursed to School Health and Related Services [SHARS] providers), audiologists employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or group practitioners by choosing "Audiologist" on the enrollment application.

To be reimbursed for hearing aid devices and accessories, and fitting and dispensing visits and post-fitting follow-up visits, audiologists and hearing aid fitters and dispensers employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or facilities by choosing "Hearing Aid" on the enrollment application.

2.2 Services, Benefits, Limitations, and Prior Authorization

The Texas Medicaid hearing services benefit includes those services that are medically necessary for clients of any age who have suspected or identified hearing loss that can be improved or ameliorated using a hearing aid device. Such services may be reimbursed to audiologists or hearing aid fitters and dispensers.

> ***Note:*** *Hearing-related services that are medically necessary because of a medical condition that cannot be improved or ameliorated using a nonimplantable hearing aid device are not considered part of the Texas Medicaid hearing services benefit. Providers may refer to the other Texas Medicaid Provider Procedures Manual Handbooks for benefit and limitation information about other hearing-related services.*

Texas Medicaid clients of any age are eligible to receive medically necessary hearing aid devices and services through the hearing services benefit outlined in the following sections. The Texas Medicaid hearing services benefit includes a broad range of hearing services for clients of all ages and reimburses providers who are appropriately enrolled with Texas Medicaid in accordance with their licensure and scope of practice. Prior authorization is not necessary for benefits within program limitations unless specifically addressed in the sections below.

The following hearing services are benefits of Texas Medicaid to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians according to their licensure, scope of practice, and enrollment as indicated:

- Audiologists and physicians may be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss.
- Hearing aid fitters and dispensers may be reimbursed for hearing aid devices and accessories and fitting and dispensing visits and post-fitting follow-up visits.
- Physicians may be reimbursed for physician otology and otorhinolaryngology (ENT) services.

Texas Medicaid clients whose jobs are contingent on their possessing a hearing aid or who appear to have vocational potential and who need a hearing aid may be referred to the Texas Workforce Commission (TWC) for hearing aids.

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2.2.1 Limitations and Required Forms

All services provided to Texas Medicaid clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations. In addition to services that always require prior authorization, providers may request prior authorization for medically necessary services that exceed benefit limitations.

Required forms, which are indicated in the specific sections below, are not required to be submitted with the claim, but the forms must be completed and maintained in the client's medical record and made available upon request by the Texas Health and Human Services Commission (HHSC) or the Texas Medicaid & Healthcare Partnership (TMHP) for retrospective review.

2.2.2 Hearing Screenings

Hearing screening provided due to client concern, or at the provider's discretion, is a benefit for clients of any age when the client is referred by a Medicaid-enrolled physician, and the screening is provided by a Medicaid-enrolled provider licensed to perform these services.

Note: *A nurse practitioner, clinical nurse specialist, or a physician assistant under physician supervision and delegation may also refer the client for hearing screening.*

Routine newborn hearing screenings and Texas Health Steps (THSteps) medical checkup hearing screenings are benefits for Texas Medicaid clients, and are included in the reimbursement for the routine service or visit.

2.2.2.1 Routine Hearing Screenings

Routine hearing screenings that are required as part of the newborn hospital stay and as part of a THSteps medical checkup are included in the Texas Medicaid hearing services benefit. These routine screenings are not reimbursed to audiologists, hearing aid fitters and dispensers, or physicians.

Newborn Hearing Screen

The newborn hearing screening is included in the reimbursement to the hospital for the newborn hospital stay and is not reimbursed separately. A newborn hearing screening must be offered to each newborn by the facility where the birth occurs, through a program mandated by the Texas State Legislature and certified by the Texas Department of State Health Services (DSHS). The screening is covered as part of the newborn delivery. An infant born outside a birthing facility and not admitted to a birthing facility shall be referred to a facility that provides newborn hearing screening. If a facility is not required by legislative mandate to perform newborn hearing screening, a referral must be made to a facility that offers the screening.

Refer to: Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the newborn hearing screening.

THSteps Medical Checkup Hearing Screen

Hearing screening is a required component of the THSteps medical checkup, and a standardized audiometric hearing screening is required at specific ages according to the periodicity schedule.

Refer to: The THSteps Medical Checkups Periodicity Schedule including the footnotes, which is available on the Texas HHS website, for coverage criteria when performed as part of a THSteps medical checkup.

Subsection 4.3.12.2.3, "Hearing Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on THSteps checkup hearing screening.

2.2.2.2 Additional Hearing Screenings

A hearing screening requested outside of a routine newborn or THSteps medical checkup may be reimbursed as medically necessary without prior authorization using procedure code 92551.

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Further diagnostic testing may also be reimbursed using the appropriate procedure code as indicated in subsection 2.2.3, "Audiology and Audiometry Evaluation and Diagnostic Services" in this handbook.

2.2.2.3 Abnormal Hearing Screening Results

If the screening returns abnormal results, the client must be referred to a Texas Medicaid-enrolled provider who is a licensed audiologist or physician who provides audiology services. Clients who are 20 years of age or younger and have abnormal screening results must be referred to a Texas Medicaid-enrolled provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

The referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record. A new Physician's Examination Report must be completed whenever there is a change in the client's hearing or a new hearing aid is needed. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

In addition to being referred to an appropriate provider for further testing, clients who are 35 months of age and younger and have suspected hearing loss must be referred to Early Childhood Intervention (ECI) as soon as possible but no longer than 7 days after identification, even if the client was referred to an appropriate provider for further testing.

The client's responsible adult may refuse to permit the referral or decline ECI services at any time. The provider must document the client's responsible adult's decision in the client's medical record.

Refer to: Subsection 2.9, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about ECI.

2.2.3 Audiology and Audiometry Evaluation and Diagnostic Services

Audiometry is a benefit of Texas Medicaid for clients of any age. Physicians must recommend hearing evaluations based on examination of the client. Only physicians or licensed audiologists will be reimbursed for hearing evaluations. Hearing aid fitters and dispensers are not reimbursed for hearing evaluations.

Important: *The date of service for audiology and audiometry evaluations and diagnostic services is the date the service is rendered to the client. The date of service that is billed on the claim must match the date of service that is documented in the client's medical record.*

The following audiometry procedure codes are benefits of Texas Medicaid for a basic comprehensive audiometry survey:

Procedure Codes									
92550	92551	92552	92553	92555	92556	92557			

The following additional procedure codes may be benefits for audiometric testing:

Procedure Codes									
92558	92563	92565	92567	92568	92570	92571	92572	92575	92576
92578	92579	92582	92583	92584	92587	92588	92650	92651	92652
92653									

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP web site at www.tmhp.com for procedure codes that may be reimbursed to individual types of providers.

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Automated auditory brainstem response (AABR) and otoacoustic emissions (OAE) are benefits for clients of any ages when performed to identify and diagnose hearing loss and for newborns when performed for the purpose of a newborn hearing screening.

Note: *AABR and OAE tests performed as part of the newborn hearing screen are reimbursed as part of the hospital visit and are not reimbursed separately.*

2.2.3.1 Otological Examinations

Otological examinations are a benefit when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

Procedure codes 92504 and 92505 are benefits for otological examinations.

An otological examination may also include physician evaluation and management (E/M) services provided to diagnose or treat medical conditions.

Refer to: Subsection 9.2.60.3, "Group Clinical Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about medically necessary physician E/M services.

2.2.3.2 Vestibular Evaluations

Vestibular evaluations are a benefit when medically necessary and provided by a Medicaid-enrolled physician or nonphysician provider licensed to perform this service.

The following procedure codes for vestibular evaluations are benefits:

Procedure Codes									
92531	92532	92533	92534	92537	92538	92540	92541	92542	92544
92545	92546	92547							

2.2.3.3 Evaluative and Therapeutic Services

The following procedure codes may be reimbursed for evaluative and therapeutic services:

Procedure Codes									
92620	92621	92625							

Audiology providers may be reimbursed for services rendered in the office setting for procedure code 92621.

2.2.3.4 Intraoperative Neurophysiology Monitoring (IONM)

Audiology providers may be reimbursed for performing intraoperative neurophysiology monitoring (IONM) with the following procedure codes:

Procedure Codes									
95940	95941								

Refer to: Section 9.2.28.3, "Evoked Potential Testing" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about intraoperative neurophysiology monitoring.

2.2.3.5 Forms and Documentation

Providers of hearing evaluations must have a report in the client's record. Providers must include in the report hearing evaluation test data. The Hearing Evaluation and Fitting and Dispensing Report (Form 3503) must be completed by the physician or audiologist who conducts the diagnostic testing. The provider who signs the report must maintain it in the client's file. The report includes audiometric

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assessment results of the hearing evaluation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

For physician diagnostic hearing services (procedure codes 92502, 92504, 92540, 95940, and 95941), providers must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

2.2.3.6 Prior Authorization

Hearing screening and testing services do not require prior authorization. Documentation of medical necessity must be maintained by the provider in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Providers should use the Special Medical Prior Authorization (SMPA) Request Form for all prior authorization requests.

2.2.3.7 Limitations

Newborn hearing screenings provided during the birth admission are considered part of the newborn delivery payment to the facility and are not reimbursed as separate procedures.

An otological examination is a benefit of Texas Medicaid when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

An otological examination may also include physician E/M services provided to diagnose or treat medical conditions.

Refer to: Subsection 9.2.60.3, "Group Clinical Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about medically necessary physician E/M services.

Audiometry survey procedure codes and evoked potential and otoacoustic emissions screening procedure codes may be reimbursed once per day.

Procedure codes 92551, 92552, and 92553 for pure tone audiometry are limited to one of any of these procedure codes per day, same provider, same client.

Procedure codes 92553 and 92556 are not reimbursed on the same day by the same provider for the same client. If both procedure codes are billed for the same date of service, same provider, and same client, they are denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Procedure codes 92558, 92587, 92588, 92650, 92651, 92652, and 92653 may be reimbursed once per day, same provider, same client, assuming testing is done in both ears and must be billed with modifier 52 if the testing is only performed on one ear.

Procedure codes 92620, 92621, and 92625 may be reimbursed to the same provider four times each per rolling year. Providers must submit a prior authorization request for additional reimbursement of either procedure code.

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2.2.3.7.1 Tympanometry

Tympanometry (procedure code 92567) must be limited to selected individual cases where its use demonstrably adds to the provider's ability to establish a diagnosis and provide appropriate treatment. Tympanometry is limited to three services per rolling year when billed by any provider and is based on medical necessity, which must be documented in the client's medical record.

2.2.3.7.2 Electrical Testing

Electrical testing may be reimbursed for services rendered to clients of any age.

Electrical testing (procedure code 92547) must be billed with the same date of service by the same provider as procedure codes 92540, 92541, 92542, 92544, 92545, or 92546.

2.2.3.7.3 Vestibular Evaluation

Vestibular evaluation is a benefit of Texas Medicaid when medically necessary and provided by a provider who is licensed to provide this service.

Hearing pathway tests such as audiometry, AABR, and electrocochleography (ECoG) can also be used for the same purpose and are frequently combined with vestibular tests.

2.2.3.7.4 AABR and OAE Hearing Screening Services

An electroencephalogram (EEG) may be reimbursed for the same date of service as evoked response testing by any provider.

Texas Medicaid may reimburse physicians for ear and throat examination procedure codes 92502 and 92504. Physicians and non-physician providers licensed to perform this service may be reimbursed for procedure code 92540.

Refer to: Subsection 9.2.60, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about these services.

Procedure codes 95940 and 95941 may be reimbursed in addition to each evoked potential test. Procedure codes 95940 and 95941 are limited to a maximum of 2 hours per day, per client, any provider, without documentation of medical necessity. Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

2.2.3.8 SHARS Audiology Services

Audiology services may be reimbursed to school districts and state agencies that are enrolled with Texas Medicaid as SHARS providers.

Refer to: Subsection 2.3.1, "Audiology Services" in the *School Health and Related Services (SHARS) Handbook* (*Vol. 2, Provider Handbooks*) for more information about SHARS services.

Other hearing evaluation, diagnostic, and hearing aid services may be reimbursed to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians as outlined in this section.

2.2.3.9 Noncovered Services

Texas Medicaid does not reimburse for a hearing screening completed in a day care, Head Start location, or a school, unless it is performed in a school-based health clinic as follow-up to an acute care medical visit. Separate procedure codes must not be billed for these services.

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2.2.4 Hearing Aid Devices and Accessories (Nonimplantable)

Texas Medicaid may reimburse hearing aid fitters and dispensers for the following devices and accessories:

Service	Limitation
Hearing aid devices	**Limitation:** • For clients who are 20 years of age and younger, 1 hearing aid device per ear may be reimbursed every 5 rolling years from the month it is dispensed. • For clients who are 21 years of age and older, if the client has at least a 35 dB hearing loss in both ears, 1 hearing aid device may be reimbursed every 5 years from the month it is dispensed. Either the left or the right may be reimbursed, but not both in the same 5 year period. ***Refer to:*** Subsection 2.2.4.1, "Forms and Documentation" in this handbook for additional medical necessity criteria. Replacement hearing aid devices that are required within the same 5-year period must be prior authorized. Repairs or modifications may be reimbursed without prior authorization once per rolling year after the 1-year warranty period has lapsed if the requested repair or modification is a better alternative than a new purchase. **Procedure codes:** See below for monaural and binaural procedure codes. Procedure code V5014 may be reimbursed for repairs and modifications. **Date of service:** The date of service for the initial hearing aid device is the date the client successfully completes the 30-day trial period and accepts the hearing aid device. ***Note:*** *During the warranty period, Texas Medicaid may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. Texas Medicaid will not reimburse hearing aid repairs or modifications that are rendered during the 12-month manufacturer's warranty period. Providers must follow the manufacturer's repair process as outlined in their warranty contract.*
Hearing aid accessories	**Limitation:** As often as is medically necessary for clients who are 20 years of age and younger with prior authorization. ***Note:*** *Hearing aid accessories include, but are not limited to, chin straps, clips, boots, and headbands.* **Procedure code:** V5267 **Date of service:** The date of service is the date the client successfully completes the 30-day trial period and accepts the hearing aid device or the date the client receives the replacement accessory item.
Ear impression	**Limitation:** 1 each per hearing aid device as follows: • For one impression, bill a quantity of 1. • For two impressions, bill a quantity of 2. **Procedure codes:** V5275 **Date of service:** The date of service for the ear impression is the date the ear impression is taken.

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Service	Limitation
Ear mold	**Limitation:** As medically necessary for clients who are 20 years of age and younger. For clients who are 21 years of age and older: • 3 ear molds per rolling year for custom ear molds • 4 ear molds per 30 days for disposable ear molds Ear molds must be billed using the appropriate LT or RT modifier. Replacement ear molds may be reimbursed as often as is medically necessary without prior authorization. Documentation of medical necessity must be maintained in the client's medical record. **Procedure codes:** V5264 and V5265 **Date of service:** The date of service for the ear mold is the date the ear mold is dispensed to the client.
Batteries (Replacement only)	**Limitation:** Replacement batteries may be reimbursed as often as is medically necessary when a hearing aid device has been previously reimbursed by Texas Medicaid. ***Note:*** *If a hearing aid has not been reimbursed by Texas Medicaid in the last 5 years, the replacement batteries may be reimbursed on appeal with a statement that documents medical necessity.* **Procedure code:** V5266 **Date of service:** The date of service is the date the client receives the replacement batteries.

The following monaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements that are rendered to clients of any age when they are billed with the appropriate modifier LT or RT to indicate for which ear the hearing aid device was purchased and fitted:

Procedure Codes									
V5030	V5040	V5244	V5245	V5246	V5247	V5254	V5255	V5256	V5257
V5298									

Procedure codes V5171, V5172, and V5181 may be reimbursed for monaural hearing aids that are rendered to clients who are 20 years of age and younger only.

The following binaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements that are rendered to clients who are 20 years of age and younger:

V5100	V5211	V5212	V5213	V5214	V5215	V5221	V5249	V5250	V5251
V5252	V5253	V5258	V5259	V5260	V5261				

Binaural hearing aid procedure codes must be submitted with a quantity of 1 per procedure code. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

Refer to: Subsection 2.4.2, "Reimbursement" in this handbook for more information about manual pricing.

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2.2.4.1 Forms and Documentation

Monaural hearing aids may be reimbursed for clients who have no medical contraindication for using a hearing aid and who have documentation of medical necessity. The following documentation of medical necessity must be maintained in the client's medical record:

- Hearing loss in the better ear of 35 dB or greater for the pure tone average of 500, 1000, 1500, and 2000 Hz, or a spondee threshold in the better ear of 35 dB or greater when pure tone thresholds cannot be established
- Documentation of communication need and a statement that the patient is alert and oriented and able to use the device appropriately by themselves or with assistance

Clients who are 21 years of age and older must meet the medical necessity criteria outlined above and have at least a 35 dB hearing loss in both ears to qualify for the purchase of a monaural hearing aid device.

Clients who are 20 years of age and younger must meet the medical necessity criteria outlined above and have at least a 35 dB hearing loss in both ears to qualify for the purchase of binaural hearing aid devices.

Claims for non-implantable hearing aid devices must be submitted with a manufacturer invoice showing the net acquisition cost of the non-implantable hearing aid device.

An invoice printed from an email or the Internet will not be accepted and should not be submitted with the claim as documentation to show the net acquisition cost of the hearing aid device unless the invoice reflects the actual price the provider paid for the hearing aid device.

Note: *The requirement to submit the net acquisition cost of the hearing aid device applies only to non-implantable monaural and binaural hearing aid devices including, but not limited to, procedure code V5298.*

Refer to: Subsection 6.3.1.1, "Place of Service (POS) Coding" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about coding place of service for other locations.

2.2.4.2 Prior Authorization

Prior authorization is not required for medically necessary hearing aid devices and supplies that are provided within the limitations outlined in the table above.

Prior authorization is required for the following:

- *Replacement hearing aid devices that are required within the same 5-year period.* A replacement hearing aid device may be considered for prior authorization when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the prior authorization request. Replacements will not be authorized when the equipment has been abused or neglected by the client, the client's family, or the caregiver.
- Hearing aid repair in excess of one per rolling year. The prior authorization request must include documentation supporting the need for the requested repair.
- *Hearing aid accessories for clients who are birth through 20 years of age.* Requests for prior authorization for children's hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands will be considered when the requests are submitted with documentation that shows that the client is birth through 20 years of age and that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.
- *Hearing aid devices that are not currently a benefit of Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age (using procedure code V5298).*

  The prior authorization request must include:

  - The medical necessity for the requested hearing aid device.

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  - The name of the manufacturer.
  - The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.
- Additional medically necessary repairs or modifications beyond 1 per year.
  For additional repairs or modifications, requests for prior authorization must include documentation that supports the need for the requested repair.

For services that require prior authorization, prior authorization must be obtained before the services are rendered. The prior authorization number must be included on the claim form when the claim is submitted to TMHP.

Prior authorization requests must be submitted to the TMHP Special Medical Prior Authorization (SMPA) Department with documentation that supports medical necessity for the requested device, service, or supply. Authorization may be submitted on the TMHP website at www.tmhp.com or by fax to 1-512-514-4213.

Important: *For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet benefit criteria, the TMHP SMPA Department will refer the request to the TMHP Comprehensive Care Program (CCP) Department for consideration under CCP. The provider is not required to complete additional forms or request referral to the TMHP CCP Department.*

Providers may use the form of their choice to submit the required information to the TMHP SMPA Department. No specific request form is required.

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about the authorizations and claims filing processes.

2.2.4.3 Limitations

The following services and supplies must be provided to Texas Medicaid clients if a nonimplantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting/implantation of the device
- The re-assessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

Hearing devices are a benefit for clients of any age. Some types of hearing devices are age restricted.

A hearing aid dispensed through Texas Medicaid must meet the following criteria:

- Be a new and current model
- Meet the performance specifications indicated by the manufacturer
- Include, at minimum, a standard 12-month warranty that begins on the dispensing date of the hearing aid.

Providers must dispense each hearing aid reimbursed through Texas Medicaid with all necessary hearing aid accessories and supplies, including a 1-month supply of batteries. The reimbursement for monaural and binaural procedure codes includes the required hearing aid package as follows, and no separate reimbursement will be made for these items:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts or rebates have been deducted)

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- Manufacturer's postage and handling charges, including shipping insurance
- All necessary hearing aid accessories or supplies
- Instructions for care and use
- A 1-month supply of batteries

Note: *TMHP does not supply the hearing aid devices, supplies, and accessories. Providers must purchase equipment directly from manufacturers and submit claims to TMHP for reimbursement using the appropriate procedure codes.*

Claims for procedure code 92628 will be denied when submitted by any provider on the same date of service if performed on the same ear as procedure code 92622, 92623, 92626, 92627, 92634, 92635, 92636, 92637, or V5010.

Procedure code 92629 is an add-on procedure and must be billed on the same claim as the primary procedure code 92628 for reimbursement.

Claims for procedure code 92631 will be denied when submitted by any provider on the same date of service if performed on the same ear as procedure codes 92622, 92623, 92626, 92627, 92636, and 92637.

Procedure code 92632 is an add-on procedure and must be billed on the same claim as the primary procedure code 92631 for reimbursement.

One hearing aid fitting service (either procedure code 92634 or V5011) per hearing aid is allowed within a rolling five-year period by any provider.

Claims for procedure code 92634 will be denied when submitted by any provider on the same date of service as procedure code 92636, 92637, or V5011.

Clients should have one follow-up fitting visit within five weeks following the hearing aid fitting visit and is included as part of the hearing aid fitting service (procedure code 92634).

Procedure code 92635 is an add-on procedure and must be billed on the same claim as the primary procedure code 92634 for reimbursement.

Claims for procedure code 92636 will be denied when submitted by any provider on the same date of service as procedure code 92628, 92629, 92631, 92632, 92634, or 92635.

Claims for procedure code 92636 are limited to a total of two visits per hearing aid, per calendar year, by any provider. Additional services for procedure code 92636 may be reimbursed with prior authorization.

Procedure code 92637 is an add-on procedure and must be billed on the same claim as the primary procedure code 92636 for reimbursement.

Procedure code 92638 is an add-on procedure and must be billed on the same claims that include the primary procedure code 92634 or 92636 for reimbursement.

Providers may perform hearing aid measurement services (procedure code 92639) and hearing device verification services (procedure code 92641) for clients who are:

- 20 years of age or younger for unilateral or bilateral services.
- 21 years of age or older for only unilateral services.

Providers must submit claims for procedure code 92639 and 92641 with modifier 52 if the service is performed on only one ear.

Procedure code 92639 is an add-on procedure and must be billed on the same claims that include primary procedure code 92634 or 92636 for reimbursement.

Procedure code V5298 may be reimbursed with prior authorization for hearing aid devices that are not currently a benefit of Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age.

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Services for residents in a skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility (ECF) must be ordered by the attending physician. The order must be on the client's chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

2.2.5 Hearing Aid Services

The following additional hearing aid related procedures are benefits for services that are rendered to clients of any age:

Procedure Codes									
92628	92629	92631	92632	92634	92635	92636	92637	92638	92639
92641	V5010	V5011	V5264	V5265	V5266	V5275			

Texas Medicaid may reimburse hearing aid fitters and dispensers for the following services:

Service	Limitation
Fitting and dispensing visits	**Limitation:** 1 fitting per hearing aid procedure code per 5 rolling year period, regardless of the number of times a device is returned as unacceptable during a 30-day trial period **Procedure code:** 92634 or V5011 **Limitation:** 1 dispensing fee each time a hearing aid is dispensed and a new 30-day trial period begins **Procedure codes:** V5090 and V5241 (for clients of any age) and V5110, V5160, V5200, and V5240 (for clients who are 20 years of age and younger) The dispensing fee may be reimbursed separately from the fitting of the hearing aid. A fitting follow-up visit should occur within five weeks of the fitting and dispensing visit and is included in the reimbursement for the fitting and dispensing procedure and is not reimbursed separately.
Post-fitting follow-up services	**Limitation:** 2 per calendar year when billed by any provider **Procedure codes:** 92636 (monaural and binaural) first 30 minutes; 92637 (monaural and binaural) each additional 15 minutes Post-fitting follow-up services are limited to a total of two per calendar year by any provider. Additional hearing aid checks may be reimbursed with prior authorization.

2.2.5.1 Forms and Documentation

The forms and documentation required for the fitting and dispensing visits are as follows:

- Physician's Examination Report—The referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record.

  Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) under physician supervision and delegation may also complete the Physician's Examination Report.*

- Hearing Evaluation and Fitting and Dispensing Report (Form 3503)—The Hearing Evaluation and Fitting and Dispensing Report (Form 3503) must be completed by the fitter/dispenser that conducts the fitting and dispensing visit. The provider who signs the report must maintain it in the client's file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation to support improved communication ability with amplification. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

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- Client Acknowledgement Statement (created by the provider)—At the time the hearing aid device and supplies are dispensed, the client must sign a client acknowledgement statement to verify the client was evaluated and offered an appropriate hearing aid that meets the client's hearing need. The acknowledgement statement must include language that indicates the client is responsible for paying any hearing aid rental fees if charged. The provider must obtain the signed acknowledgment statement before dispensing the hearing aid device and supplies and must keep the signed acknowledgment statement in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.
- Prior to dispensing a hearing instrument, a provider must enter into a written contract with the client that meets the Texas Department of Licensing and Regulation (TDLR) rule requirements in 16 TAC §112.140. The signed contract should verify that:
  - The client has a 30-day trial period for the hearing aid.
  - If the client is not satisfied with the purchased hearing aid, the client may return it to the provider within the 30-day trial period. If the device is returned within the 30-day trial period, the provider may charge the client a rental fee not to exceed $2.00 per day. This fee is not a benefit of Texas Medicaid. The 30-day trial period and any charged rental fee must meet TDLR rule requirements in 16 TAC §112.140.
  - The contract must be executed prior to dispensing and must be maintained in the client's file.
  - The client must receive a copy of the executed contract.
  - All charges and fees associated with the trial period must be stated in the contract, which shall also include the name, address, and telephone number of TDLR.

After at least 30 days and the successful completion of the trial period, the provider must update the statement to indicate that the trial was successful and the client accepted the dispensed hearing aid device. The updated statement must be maintained in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

For hearing aids that are dispensed in a provider's office, if a client fails to return by the end date of the trial period, the provider must contact the client. After 3 attempts have been made, if the client does not return to the provider's office, the provider must document all attempts to contact the client and must maintain this documentation in the client's file. Retrospective review may be performed to ensure documentation supports the contact attempts and the client's failure to return to the provider's office. This requirement does not apply for services that are rendered to clients who receive hearing aids in other places of service (i.e., nursing homes).

2.2.5.2 Prior Authorization

Prior authorization is not required for fitting and dispensing visits and the first two post-fitting follow-up service visits.

2.2.5.3 Limitations

The following hearing aid visits may be reimbursed by Texas Medicaid:

- The fitting and dispensing visits that encompass a 30-day trial period and include a hearing aid fitting follow-up five weeks after the trial period has been successfully completed
- A first post-fitting follow-up visit as needed after the hearing aid fitting follow-up
- A second post-fitting follow-up as needed after the first post-fitting follow-up visit
- Additional hearing aid checks may be reimbursed within a period of six months after a second post-fitting follow-up visit. Providers must submit a prior authorization request and documentation of medical necessity for the additional hearing aid checks.

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The fitting visit includes the fitting, dispensing, and post-fitting check of the hearing aid. A trial period of up to 30 days is authorized by *Texas Occupations Code* §402.401. The 30-day trial period, and any charged rental fee, must meet the Texas Department of Licensing and Regulation (TDLR) rule requirements in 16 TAC §112.140.

Providers must allow each Texas Medicaid client a 30-consecutive-day trial period that begins with the dispensing date. This trial period gives the client time to determine whether the hearing aid device meets the client's needs. If the client is not satisfied with the purchased hearing aid, the client may return it to the provider, who must accept it. If the device is returned within 30 days of the date it was dispensed, the provider may charge the client a rental fee not to exceed $2 per day. This fee is not a benefit of Texas Medicaid and will not be reimbursed. The client is responsible for paying the hearing aid rental fees if the provider chooses to charge a fee for the rental of returned hearing aid devices.

During the trial period, providers may dispense additional hearing aids as medically necessary until either the client is satisfied with the results of the hearing aid or the provider determines that the client cannot benefit from the dispensing of another hearing aid. The dispensing date of each additional hearing aid starts a new trial period.

A fitting follow-up check should be performed within 5 weeks of the initial hearing aid fitting visit. This evaluation is considered part of the hearing aid fitting visit and is not reimbursed separately.

The first and second post-fitting follow-up visits are available if additional visits are required after the post-fitting check.

- *First post-fitting follow-up visit (procedure code 92636).* The first post-fitting follow-up visit must include a hearing aid check.
- *Second post-fitting follow-up visit (procedure code 92636).* The second post-fitting follow-up visit is available as needed after the fitting follow-up visit and the first post-fitting follow-up visit. The second post-fitting follow-up visit must include either a real ear measurement or aided sound field testing according to the guidelines specified for the hearing evaluation. If the aided sound field test scores suggest a decrease in hearing acuity, the provider must include pure tone and speech audiometry readings from the first evaluation.

Services for residents in an SNF, ICF, or ECF must be ordered by the attending physician. The order must be on the client's chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

Home visit hearing evaluations and fittings are permitted only with documentation of client need in the physician's, advanced practice registered nurse (APRN) or a physician assistant (PA) written order.

Note: *APRN or a PA under physician supervision and delegation may also perform the evaluation.*

2.3 Documentation Requirements

All services, including hearing services, require documentation to support the medical necessity of the service rendered. Hearing services are subject to retrospective review and recoupment if documentation does not support the service billed.

Required forms for nonimplantable hearing devices and services, which are indicated in the specific sections above, are not submitted with the claim to TMHP, but the forms must be completed and maintained in the client's medical record and made available upon request by HHSC or TMHP for retrospective review.

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2.4 Claims Filing and Reimbursement

2.4.1 Claims Filing

Hearing services 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.

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.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 1.7.12, "Billing Clients" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Providers must file all claims electronically or on the appropriate Centers for Medicare & Medicaid Services (CMS) paper claim form after providing the services.

Exception: *Claims for non-implantable hearing aid devices must be submitted on the CMS-1500 paper claim form because electronic claim submissions do not allow for the submission of attachments.*

Claims must include the following information:

- The most appropriate *International Classification of Diseases,* Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code that represents the purpose for the service.
- The most appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code(s) that represent the service(s) provided.
- The appropriate information as indicated on the provider enrollment letter (Electronic claims must also include the most appropriate attested taxonomy code.)

Note: *For Texas Medicaid managed care clients, all hearing aid benefits and otology, and audiometry services are administered by the client's Medicaid managed care organization (MCO).*

2.4.1.1 Non-implantable Hearing Aid Devices

To be reimbursed for a non-implantable hearing aid device, providers must submit documentation with the paper claim showing their cost for the hearing aid device. The Texas Health and Human Services Commission (HHSC) requires providers to submit non-implantable hearing aid claims using the CMS-1500 paper claim form because electronic claim submissions do not allow for the submission of attachments.

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Providers must use the net acquisition cost as the amount billed on the claim. The net acquisition cost is the actual price the provider paid for the device, including the wholesale cost plus sales tax, shipping and handling, and any reductions resulting from discounts or rebates. Providers must not use usual and customary fees as the amount billed.

The documentation submitted with the claim must be a manufacturer invoice showing the net acquisition cost of the non-implantable hearing aid device. An original invoice that includes the manufacturer name, model number, serial number, and warranty expiration date must be submitted. Invoice templates will not be accepted.

An invoice printed from an email or the Internet will not be accepted and should not be submitted with the claim as documentation to show the net acquisition cost of the hearing aid device unless the invoice reflects the actual price the provider paid for the hearing aid device.

2.4.1.2 Third Party Liability

Standard third party liability (TPL) rules apply to all hearing services claims.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

2.4.2 Reimbursement

Hearing aid devices and all hearing and audiological services are reimbursed in accordance with 1 TAC §355.8141. To be reimbursed for both audiology services and hearing aid fitting and dispensing services, audiologists must enroll with Texas Medicaid as audiologists and also as hearing aid fitters and dispensers. Audiology services must be billed using the audiologist provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Audiologist," and hearing aid and fitting and dispensing services must be billed with the hearing aid provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Hearing Aid."

Requested items that are not represented by a specific procedure code must be prior authorized and are priced manually during the authorization process. Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP SMPA Department. The reimbursement will be determined based on either the MSRP less 18 percent or based on the provider's documented invoice cost if there is no MSRP available.

Manually priced items are indicated with "Note Code 5" in the Texas Medicaid fee schedule.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

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3 Implantable Hearing Devices and Related Services

3.1 Enrollment

To enroll in Texas Medicaid, hearing services professionals who provide implantable hearing devices and services must be appropriately enrolled according to their licensure and scope of practice.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

3.2 Services, Benefits, Limitations and Prior Authorization

Implantable hearing devices, including the cochlear implant device, the auditory brainstem implant (ABI), and the bone anchored hearing device (BAHD), are benefits of Texas Medicaid for clients of all ages.

The following services and supplies must be provided to Texas Medicaid clients if an implantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting of the device
- The reassessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

Hearing devices are a benefit for clients of any age. Some types of hearing devices are age restricted.

3.2.1 Cochlear Implants

The following procedure codes may be reimbursed for the cochlear implant device, separate components, and services:

Procedure Codes									
69930	L7368	L8499	L8614	L8615	L8616	L8617	L8618	L8619	L8621
L8622	L8623	L8624	L8627	L8628	L8629				

The following procedure codes may be reimbursed for diagnostic analysis of the cochlear implant:

Procedure Codes									
92601	92602	92603	92604						

Note: *ASCs are paid based on a global fee, with the exception that certain pieces of equipment may be reimbursed separately from the ASC or HASC global rate.*

3.2.1.1 Prior Authorization

Prior authorization is required for the following:

- Cochlear implant surgery, device, and replacement parts
- Sound processor repair or replacement
- Battery recharger unit
- Replacement batteries beyond the limitations outlined in the sections below

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Requests for prior authorization must be submitted by the provider to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Note: *Requests for clients who are 20 years of age or younger who do not meet the medical necessity criteria may be considered through Comprehensive Care Program (CCP).*

Documentation submitted for review must indicate who will be providing the cochlear implant device (i.e., the facility or the Durable Medical Equipment (DME) or medical supplier). The supplier's provider number must be included on the prior authorization request.

Prior authorization for a unilateral or bilateral cochlear implant may be granted for clients who are 9 months of age and older with documentation of all of the following criteria:

- Cognitive ability to use auditory cues and written documentation of agreement by the client or the client's parent or guardian that the client will participate in a program of post-implantation auditory rehabilitation. This documentation must be maintained in the client's medical record.
- Postlingual deafness or prelingual deafness.
- Freedom from middle-ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system.
- No contraindications to surgery.
- Inability to derive benefit from appropriately fitted hearing aid devices.
- Documentation of poor speech discrimination and a recommendation for cochlear implant candidacy and the most appropriate ICD-10-CM diagnoses for severe-to-profound bilateral sensorineural hearing loss.

The initial lithium-ion battery recharger unit, additional medically necessary units, and additional replacement batteries beyond the limitations indicated in the following sections may be reimbursed with prior authorization. Documentation must be submitted with the prior authorization request to support medical necessity for the request.

Refer to: Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

3.2.1.2 Limitations

Surgery

Procedure code 69930 with the appropriate modifier LT or RT may be reimbursed for unilateral cochlear implantation. Procedure code 69930 with modifier 50 may be reimbursed for bilateral cochlear implantation performed simultaneously.

Device and Components

Procedure codes L8627, L8628, and L8629 for the cochlear implant device and components may be reimbursed for clients who are 9 months of age and older as follows:

- The device must be approved by the Food and Drug Administration (FDA) and be age-appropriate for the client.
- One per day may be reimbursed with prior authorization.

The cochlear implant device and the surgery to implant the device may be reimbursed separately.

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Replacement Batteries and Related Items

Replacement batteries and related items for the cochlear implant device include non-rechargeable batteries, rechargeable batteries, and recharger units as follows:

Procedure Code	Prior Authorization	Limitation
L8621 (Zinc air non-rechargeable)	Not required	Maximum of 50 per month
L8622 (Alkaline non-rechargeable)	Not required	Maximum of 31 per month
L8623 (Lithium-ion rechargeable)	Not required	2 batteries per calendar year
L8624 (Lithium-ion rechargeable)	Not required	2 batteries per calendar year
L7368 (Battery recharger unit for lithium-ion rechargeable batteries)	Required	1 replacement unit every 5 rolling years

Replacement batteries for clients with bilateral cochlear implants and two sound processors may be reimbursed when billed with the applicable battery procedure code and the appropriate LT or RT modifier.

Replacement batteries for the cochlear device are limited to clients with a cochlear implant procedure, device, or supply that has been billed within the past five rolling years. Replacement batteries for clients who did not receive the cochlear implant through Texas Medicaid will be considered for reimbursement on appeal with a physician's statement documenting medical necessity.

Additional batteries and lithium-ion battery recharger units beyond these limitations may be reimbursed with prior authorization.

3.2.1.3 Auditory Rehabilitation

Auditory rehabilitation is a benefit of Texas Medicaid when it is medically necessary for clients who have received a surgically implanted hearing device, or who have prelingual or postlingual hearing loss when the treating physician has determined that auditory rehabilitation would be beneficial.

The following procedure codes may be reimbursed for auditory rehabilitation:

Procedure Codes									
92626	92627	92630	92633						

One auditory rehabilitation evaluation and 12 visits per 180 day period may be reimbursed without prior authorization. Additional visits during a six rolling month period for clients who are 12 months of age through 20 years of age require prior authorization.

Procedure code 92627 is an add-on procedure and must be billed with the primary procedure code 92626 to be considered for reimbursement.

Procedure code 92627 may be reimbursed up to four times per day to the same provider.

Note: *Additional therapy services may be a benefit through the Texas Medicaid speech therapy benefit.*

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about speech therapy.

Personal frequency modulated (FM) systems are not benefits of Texas Medicaid.

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3.2.2 Auditory Brainstem Implant (ABI)

The following procedure codes may be reimbursed for the ABI, related components, and services:

Procedure Codes									
92640	L8499	L8614	L8621	L8622	S2235				

3.2.2.1 Prior Authorization

The following implantable hearing devices and services require prior authorization:

- ABI surgery, device, and replacement parts
- Sound processor repair or replacement
- Replacement batteries beyond the limitations outlined in the sections below

Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Prior authorization requests and claims for ABI is limited to clients with a condition of neurofibromatosis, type II or Schwannomatosis.

Refer to: Subsection 2.2.1, "Limitations and Required Forms" in this handbook for additional information about replacement batteries.

Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.2.2 Limitations

ABI is a benefit for clients who are 12 years of age and older.

Diagnostic analysis of the ABI (procedure code 92640) is limited to 2 hours per day when billed by any provider.

Zinc air batteries (procedure code L8621) are limited to a maximum of 50 per month. Alkaline batteries (procedure code L8622) are limited to a maximum of 31 per month.

Non-rechargeable batteries (procedure codes L8621 and L8622) do not require prior authorization. Procedure codes L8621 and L8622 must be billed using a left (LT) or right (RT) modifier. Since the ABI is not ear-specific, procedure codes L8621 and L8622 may be billed using either the LT or RT modifier.

Replacement batteries for the ABI are limited to clients with an ABI surgical procedure, device, or replacement part that has been billed within the past 5 rolling years. Replacement batteries for clients who did not receive their ABI through Texas Medicaid are considered for reimbursement on appeal with a physician's statement documenting medical necessity.

3.2.3 Bone-Anchored Hearing Device (BAHD)

The following procedure codes must be submitted for the BAHD and related components:

Procedure Codes										
69714	69716	69717	69719	69726	69727	69728	69729	69730	92622	92623
L8625	L8690	L8691	L8692	L8693	L8694	V5266				

3.2.3.1 Prior Authorization

The following implantable hearing devices and services require prior authorization:

- BAHD implant surgery, revision, device, and replacement parts
- Sound processor repair or replacement

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Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Providers should use the Special Medical Prior Authorization (SMPA) Request Form for all prior authorization requests.

Prior authorization requests may be granted for clients who are 5 years of age and older with all of the following:

- Documentation of previous attempts at hearing aid devices and why these devices are inadequate or have failed
- Documentation of scores on hearing tests for bone conduction thresholds and on maximum speech discrimination
- Documentation of audiological testing showing good inner ear function
- Documentation of a multidisciplinary assessment including physical, cognitive, communicative, and behavioral limitations describing the client's auditory disability and expected benefit with use of the BAHD implant
- Documentation of an appropriate diagnosis.

Benefit-eligible conditions may include, but are not limited to the following:

- Conductive hearing loss
- Sensorineural hearing loss
- Other anomalies of external ear with impairment of hearing
- Anomalies of skull and face bones

Refer to: Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.3.2 Limitations

Implanted BAHDs are a benefit for clients who are 5 years of age and older.

A BAHD sound processor that is specifically worn on a soft headband is a benefit for clients five years old or younger. If chosen by a client, a BAHD sound processor worn on a soft headband is also a benefit for clients who are five years of age or older. The BAHD sound processor is not implanted. A BAHD sound processor worn on a soft headband may be reimbursed using procedure code L8692.

Replacement batteries for the BAHD (procedure code V5266) do not require prior authorization. The replacement batteries are limited to clients with a hearing device that has been billed within the past five rolling years. Replacement batteries for clients who did not receive the hearing device through Texas Medicaid will be considered for reimbursement on appeal with a physician's statement documenting the medical necessity.

Procedure codes L8691, L8692, L8693, and L8694 will be denied as part of another service when billed by any provider with the same date of service as procedure code L8690.

Procedure code L8692 for the BAHD device and components may be reimbursed once per day with prior authorization.

Bilateral BAHD procedures are not benefits of Texas Medicaid.

3.2.4 Sound Processor Replacement and Repair

3.2.4.1 Prior Authorization

Replacement and repair of a sound processor require prior authorization.

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Documentation by the provider must explain the need for the replacement of the sound processor. The processor must be used for a minimum of 12 months before replacement of the unit will be considered.

The prior authorization request must include evidence of the purchase, such as the manufacturer's warranty.

Repair of a sound processor will be considered for prior authorization with documentation of medical necessity for the requested repair. Repair of a sound processor will be manually priced at the time the prior authorization is reviewed and granted. If the actual cost of the repair differs from the prior authorized fee, the provider must contact the SMPA Department to update the authorization before filing a claim for the repair services.

3.2.4.2 Limitations

Procedure code L8499 with modifier RB may be reimbursed for sound processor repair.

Repair or replacement of a sound processor is not a benefit during the manufacturer's warranty period.

Procedure code 92623 is an add-on procedure and must be billed with the primary procedure code (92622) on the same day, by the same provider to be considered for reimbursement.

3.2.5 Electromagnetic Bone Conduction Hearing Device - Removal Only

The removal of the electromagnetic bone conduction hearing aid may be reimbursed by Texas Medicaid using procedure code 69711.

The removal or repair of an electromagnetic bone conduction hearing device is limited to two procedures per lifetime when billed by any provider.

The implantation of the device is not a benefit of Texas Medicaid.

3.3 Documentation Requirements

All implantable hearing aid services require documentation to support the medical necessity of the service rendered. Hearing services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.4 Claims Filing and Reimbursement

3.4.1 Claims Filing

Hearing services 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.

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.

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Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 1.7.12, "Billing Clients" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Note: *For Texas Medicaid managed care clients, all implantable hearing devices and services are administered by the client's Medicaid MCO.*

3.4.1.1 Third Party Liability

Standard TPL rules apply to all hearing services claims.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

3.4.2 Reimbursement

Implantable hearing aids and related services are reimbursed in accordance with 1 TAC §355.8141.

Implantable hearing aids and related services are reimbursed at the lesser of the billed charges or the published Texas Medicaid fee. Unless otherwise indicated, providers may not make additional charges to the client for covered services; such charges constitute a breach of the Texas Medicaid contract.

Requested items that are not represented by a specific procedure code must be prior authorized and are priced manually during the authorization process. Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP SMPA Department. The reimbursement will be determined based on either the MSRP less 18 percent or based on the provider's documented invoice cost. Manually priced items are indicated with "MP" in the reimbursement rate table at the end of this article.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

3.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

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4 Vision Care Professionals

4.1 Enrollment

To enroll in Texas Medicaid, optometrists (doctors of optometry [ODs]) and ophthalmologists must be licensed by the licensing board of their profession to practice in the state where the service is performed, at the time the service is performed, and be enrolled as Medicare providers.

An optometrist or ophthalmologist cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Provider Responsibilities

Suppliers of eyewear must comply with all Medicaid provider responsibilities and adhere to the following guidelines:

- Do not delay the ordering of eyewear or the dispensing of eyeglasses to the client while payment is pending from TMHP.
- Deliver the eyewear in a reasonable amount of time (usually two or three weeks from the date the order is placed by the client).
- Check the client's eligibility
- Visit TexMedConnect or access the Medicaid Client Portal for providers to determine whether eyeglasses have been reimbursed by Texas Medicaid within the last 24 months. Providers should ask clients if they recently received vision care services that may not be documented in My Account yet.
- Submit claims for eyewear services as soon as possible so the client's record indicates that eyewear or eyeglasses have been dispensed.
- Have the client, parent, or guardian sign and date the Medicaid Vision Eyewear Client Certification Form and retain it in their records. When a client chooses an eyeglass or contact lens option beyond the program limitations, or if eyeglasses or contact lenses are replaced because of loss or destruction, the client must acknowledge their choice and his/her liability for the cost difference by signing the Medicaid Vision Eyewear Client Certification Form. The form must remain in the provider's records.
- Do not charge a Medicaid client more than a patient not enrolled in Texas Medicaid for noncovered services (e.g., tints, oversized lenses, or frames).
- Keep invoices on file for a minimum of five years.
- Submit claims using the date eyeglasses were ordered as the date of service (DOS) (the start of the 95-day filing period), not the date the eyeglasses were dispensed.

4.3 Services, Benefits, Limitations, and Prior Authorization

Examination and treatment of eye conditions, including prescribing and dispensing of medically necessary eyeglasses or contact lenses, are benefits of Texas Medicaid and may be reimbursed to optometrist, ophthalmologist, and optician providers within the scope of practice for each.

The following services are included in other services and will not be considered for separate reimbursement:

- Vision screening conducted to meet State screening requirements, such as the DSHS School Vision and Hearing Screening Program.

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- Expenses for medical supplies, equipment, and other items that are not specifically made-to-order for the client are considered to have been incurred on the date the item is delivered.

Note: *Medicaid clients 22 years old and younger who have been determined by their provider to have a vision impairment that may require intensive or comprehensive vision impaired related services should be referred to the Texas Health and Human Services Commission (HHSC) Blind Children's Vocational Discovery and Development Program. Adults, youths and students who have been determined by their provider to have a vision impairment that may require intensive or comprehensive vision impaired related services should be referred to the Texas Workforce Commission (TWC).*

Note: *Vision Services requests for clients birth through 20 years of age who do not meet criteria as outlined in this handbook may be considered through the Texas Health Steps (THSteps)-Comprehensive Care Program (CCP).*

Ophthalmologist and Optometrist

Examination and treatment services rendered by an ophthalmologist or optometrist are not limited to the procedure codes included in this handbook.

Refer to: The Texas Medicaid fee schedules on the TMHP web site at www.tmhp.com for a complete list of procedure codes that may be reimbursed by Texas Medicaid.

Optician

Services rendered by an optician are limited to fitting and dispensing of medically necessary eyeglasses and contact lenses.

Note: *In accordance with the Omnibus Reconciliation Act of 1986, Section 9336, a Doctor of Optometry is considered a physician, with respect to the provision of any item or service the optometrist is authorized to perform by state law or regulation.*

4.3.1 Services Performed in Long-Term Care Facilities

Ophthalmological, optometric, and eyeglass or contact lens services provided in a skilled or intermediate care facility may be reimbursed when the client's attending physician has ordered the service and the signed order is included in the client's medical record at the nursing facility.

The ordering physician's name and National Provider Identifier (NPI) and taxonomy code must be documented on the claim when ophthalmological, optometric, and eyeglasses or contact lenses services are performed in a skilled or intermediate care facility.

4.3.2 Services Performed in Federally Qualified Healthcare Centers (FQHC)

Vision services rendered by FQHC providers may be reimbursed based on an all-inclusive rate per visit.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about vision services that may be reimbursed to FQHC providers.

4.3.3 THSteps Medical Checkup Vision Screening

A vision screening must be completed during each THSteps medical checkup with standardized screenings performed at specific ages, as listed in the THSteps Periodicity Schedule. Providers may perform a vision screening during an acute care visit with the appropriate screening tools or refer at-risk infants and children to an optometrist or ophthalmologist who is experienced with the pediatric population and who can perform further testing, diagnosis, and treatment.

Refer to: Subsection 4.3.12.2.4, "Vision Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about THSteps medical checkup vision screenings.

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4.3.3.1 Vision Screening Outside of a THSteps Preventive Care Medical Checkup

Vision screening for clients who are birth through 20 years of age may be completed at any primary care provider's office visit upon the following:

- Request from a parent
- Referral from a school vision screening program
- Referral from a school nurse

Clients who are birth through 20 years of age must be screened for eye abnormalities by history, observation, and physical exam. Clients who are identified as high risk must be referred to a Medicaid-enrolled optometrist or ophthalmologist.

4.3.4 Noncovered Services

The following services and supplies are not a benefit of Texas Medicaid:

- Artificial eyes for clients who are 21 years of age and older.

  Note: *Artificial eyes for clients who are birth through 20 years may be considered under Texas Health Steps-Comprehensive Care Program (THSteps-CCP).*

- Eyeglasses for residents of institutions where the reimbursement formula and vendor reimbursement include this service.
- Eyeglasses or contact lenses prescribed or dispensed to clients at a hospital or nursing facility without documented orders of the attending physician in the client's medical records.
- Low vision aids.

  Note: *Clients may be referred to TWC for low vision aids.*

- Optional eyeglass features that are requested by the client but that do not increase visual acuity (e.g., lens tint, industrial hardening, and decorative accessories or lettering).
- Plano sunglasses.
- Extended color vision examination, dark adaptation examination, and vision screening.
- Spectacle (eyeglass) fitting services when billed separately.

Clients may be billed for noncovered frames and other items beyond Medicaid benefits. Providers must have the client sign and date the Medicaid Vision Eyewear Client Certification Form and retain it in the provider's records. The client payment amount is not considered other insurance and must not be entered as a credit amount in the electronic field.

Example: *Texas Medicaid may reimburse providers a total of $32.55 for eyeglass frames that are within the provider's selection for Medicaid reimbursement plus the allowed cost per lens. If the client chooses a pair of frames (such as $200 frames) that are outside of the provider's selections for Medicaid reimbursement and if the client chooses other items or services that are not a benefit of Texas Medicaid (such as tinted lenses for an extra $10 charge), the client is responsible for and may be billed for the balance of the cost of the frames ($172.07) and the other items that are not a benefit of Medicaid ($10 for tinted lenses).*

The provider may withhold the noncovered eyewear, contacts, or eyeglasses until the client pays for those items. If the client fails to pay for the noncovered items or has not returned for finished eyewear within a reasonable length of time (two to three months), the provider may return any reusable items to stock. Any payment made by TMHP for frames or lenses must be refunded to Texas Medicaid. If a client requests eyewear that is beyond program benefits (for example, scratch-resistant coating), Medicaid allows reimbursement up to the maximum fee. The provider may charge the client the difference

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between the Medicaid payment and the customary charge for the eyewear requested, when the client has been shown the complete selection of Medicaid-covered eyewear and when the following conditions are met:

- The client rejects the Medicaid-covered eyewear and wants eyewear that complies with Texas Medicaid specifications, but is not included in the selection of Medicaid-covered eyewear.
- The client indicates a willingness to pay the difference between the Medicaid payment and the actual charge. The provider must have the client sign the Medicaid Vision Eyewear Client Certification Form and retain it in the provider's records.

4.3.5 Vision Testing

Vision testing and examination and treatment of eye conditions are benefits of Texas Medicaid and may be reimbursed to ophthalmologist or optometrist providers.

Routine eye examinations with refraction testing may be reimbursed using the following procedure codes:

Procedure Codes									
S0620	S0621								

Medical evaluation and examination may be reimbursed when accompanied by a medical condition other than refractive error using the following procedure codes:

Procedure Codes									
92002	92004	92012	92014	92015					

Procedure codes 92002, 92004, 92012, and 92014 are limited to one service per day by any provider.

Procedure codes 92002 and 92004 are limited to one new client visit every three years when no other professional services have been billed by the physician, or another physician of the same specialty in the same group practice, within the past three years.

A new client is defined as one who has not received any professional services from a physician or physician within the same group practice, of the same specialty, within the past three years.

An established client is one who has received professional services from a physician or physician within the same group practice, of the same specialty, within the past three years.

Refer to: Subsection 9.2.60.1.1, "New and Established Patient Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about new patient and established patient E/M services.

Vision testing procedure codes are subject to the CMS NCCI relationships. Claims that are submitted by physicians with the same specialty who are in the same group practice are processed as if they were the same provider. Providers should refer to the *Current Procedural Terminology (CPT) Manual* for additional information about intermediate and comprehensive ophthalmological services.

4.3.5.1 Routine Vision Testing

Procedure codes S0620 and S0621 are considered routine eye examinations and are limited to diagnosis codes Z0100 or Z0101.

Procedure codes S0620 and S0621 will be denied if billed with the same date of service as procedure codes 92020, 92265, 92270, 92273, 92274, 92285, 92286, and 92287.

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Clients who are birth through 20 years of age are eligible for a routine eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every 12 months. The limitation for refraction testing can be exceeded for clients who are birth through 20 years of age only when:

- The parent, teacher, or school nurse requests the refraction testing and it is medically necessary.
- There is a significant change in vision, and documentation supports a diopter (d) change of 0.5 or greater in the sphere, cylinder, prism measurements, or axis changes.

Clients who are 21 years of age and older are eligible for a routine eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every 24 months. The limitation for refraction testing can be exceeded for clients who are 21 years of age and older only when there is a significant change in vision, and documentation supports a diopter change of 0.5 or more in the sphere, cylinder, prism measurements, or axis changes.

4.3.5.2 Medically Necessary Eye Examinations

An eye examination with or without refraction (procedure code 92002, 92004, 92012, 92014, or 92015) may be reimbursed for medical evaluations and examinations of the eye. Procedure codes 92002, 92004, 92012, 92014, and 92015 will not be reimbursed for routine exams.

Documentation in the client's medical record must support the medical necessity of the service performed.

Procedure codes 92002, 92004, 92012, and 92014 may be reimbursed when it is medically necessary to ophthalmologist or optometrist providers for medically necessary eye examinations without refraction.

Procedure code 92015 may be reimbursed to ophthalmologist or optometrist providers for refraction in addition to the eye examination procedure code 92002, 92004, 92012, or 92014. A refractive state (procedure code 92015) will be denied as part of another service if it is billed with the same date of service by any provider as procedure code S0620 or S0621.

4.3.6 Special Ophthalmological Services and Diagnostic Testing

4.3.6.1 Ophthalmological Examination and Evaluation with General Anesthesia

An ophthalmological examination and evaluation under general anesthesia (procedure codes 92018 and 92019) performed by an ophthalmologist may be medically necessary when a client has significant injury or cannot otherwise tolerate the procedure while conscious.

Procedure codes 92018 and 92019 may be reimbursed once per service, per day, when billed by any provider.

4.3.6.2 Ophthalmic Ultrasound

Ophthalmic ultrasound is a diagnostic test that uses high frequency sound waves to provide additional information about the interior of the eye and surrounding areas. The following procedure codes may be reimbursed for ophthalmic ultrasound services:

Procedure Codes									
76510	76511	76512	76513	76514	76516	76519	76529	76999	

Procedure codes 76510, 76511, 76512, 76513, 76516, are limited to two services per calendar year by any provider.

Corneal pachymetry (procedure code 76514) is used to determine the corneal thickness. Procedure code 76514 (unilateral or bilateral code) may be reimbursed once per lifetime, when billed by any provider, and is restricted to the following diagnosis codes:

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Diagnosis Codes							
H1811	H1812	H1813	H1820	H18211	H18212	H18213	H18221
H18222	H18223	H18231	H18232	H18233	H18461	H18462	H18463
H18511	H18512	H18513	H18521	H18522	H18523	H18531	H18532
H18533	H18541	H18542	H18543	H18551	H18552	H18553	H18591
H18592	H18593	H18601	H18602	H18603	H18611	H18612	H18613
H18621	H18622	H18623	H21551	H21552	H21553	H40001	H40002
H40003	H40011	H40012	H40013	H40021	H40022	H40023	H40031
H40032	H40033	H40041	H40042	H40043	H40051	H40052	H40053
H40061	H40062	H40063	H4010X0	H4010X1	H4010X2	H4010X3	H4010X4
H401110	H401111	H401112	H401113	H401114	H401120	H401121	H401122
H401123	H401124	H401130	H401131	H401132	H401133	H401134	H401210
H401211	H401212	H401213	H401214	H401220	H401221	H401222	H401223
H401224	H401230	H401231	H401232	H401233	H401234	H401310	H401311
H401312	H401313	H401314	H401320	H401321	H401322	H401323	H401324
H401330	H401331	H401332	H401333	H401334	H401410	H401411	H401412
H401413	H401414	H401420	H401421	H401422	H401423	H401424	H401430
H401431	H401432	H401433	H401434	H40151	H40152	H40153	H4020X0
H4020X1	H4020X2	H4020X3	H4020X4	H40211	H40212	H40213	H402210
H402211	H402212	H402213	H402214	H402220	H402221	H402222	H402223
H402224	H402230	H402231	H402232	H402233	H402234	H40231	H40232
H40233	H40241	H40242	H40243	H4031X0	H4031X1	H4031X2	H4031X3
H4031X4	H4032X0	H4032X1	H4032X2	H4032X3	H4032X4	H4033X0	H4033X1
H4033X2	H4033X3	H4033X4	H4041X0	H4041X1	H4041X2	H4041X3	H4041X4
H4042X0	H4042X1	H4042X2	H4042X3	H4042X4	H4043X0	H4043X1	H4043X2
H4043X3	H4043X4	H4051X0	H4051X1	H4051X2	H4051X3	H4051X4	H4052X0
H4052X1	H4052X2	H4052X3	H4052X4	H4053X0	H4053X1	H4053X2	H4053X3
H4053X4	H4061X0	H4061X1	H4061X2	H4061X3	H4061X4	H4062X0	H4062X1
H4062X2	H4062X3	H4062X4	H4063X0	H4063X1	H4063X2	H4063X3	H4063X4
H40811	H40812	H40813	H40821	H40822	H40823	H40831	H40832
H40833	H40841	H40842	H40843	H4089	H409	H42	H44511
H44512	H44513	T868401	T868402	T868403	T868411	T868412	T868413
Q150	Q8788	Z947					

The one per lifetime limitation for procedure code 76514 does not apply when submitted with the following diagnosis codes:

Diagnosis Codes							
H1811	H1812	H1813	H18211	H18212	H18213	H18231	H18232
H18233	H18511	H18512	H18513	H21551	H21552	H21553	T868401
T868402	T868403	T868411	T868412	T868413	Z947		

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When billing for two or more services, providers must bill with one of the diagnosis listed as an exception to the limit.

Procedure code 76999 is limited to one service per day, same procedure, same provider, and may be reimbursed with prior authorization.

Ophthalmic ultrasounds may be reimbursed when they are billed with the same date of service by the same provider as an eye examination visit or consultation.

Ophthalmic ultrasounds (procedure codes 76514 and 76516) are limited to one service, per day, by any provider.

Ophthalmic coherence biometry with intraocular lens power calculation will be considered medically necessary when the measurements are used to calculate the intraocular lens power prior to cataract extraction.

Ophthalmic biometry procedure codes 76519 and 92136 are duplicative tests and cannot be performed together. Procedure codes 76519 and 92136 are limited two services per lifetime, any provider, any combination.

Procedure code 76519 is defined as a bilateral service for the technical component and unilateral service for the professional component. The professional component is only billed when a decision to remove the cataract has been made by the patient and surgeon.

- Two services per day are allowed when the professional component is performed on both eyes on the same date.
- One physician may do the technical component and another physician the professional component. Each will need to use the appropriate modifier. The professional component should also have the anatomic modifier (LT or RT) appended.

When the scan is performed with a calculation done on the first eye, the provider must bill the total component for procedure code 76519 with modifier LT or RT to identify the eye on which the service was performed, or bill procedure code 76519 with total component plus procedure code 76519 with professional component and modifier LT or RT.

When the calculation is performed on the second eye, the provider must only bill procedure code 76519 with professional component and modifier LT or RT to identify the eye on which the service was performed.

If the technical and professional components are performed on both eyes on the same date, the provider must bill procedure code 76519 with the LT or RT modifier and procedure code 76519 with professional component and the corresponding LT or RT modifiers.

Ophthalmic biometry may be repeated after 12 months if the patient decides to have the surgery later or the procedure is performed by a different provider. Requests for a second ophthalmic biometry in less than 12 months will not be payable without documentation of significant change in vision. Documentation must include at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

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Prior Authorization Requirements

Procedure code 76999 requires prior authorization. Prior Authorization requests must be submitted on the SMPA Request Form and must include the following documentation:

- A clear, concise description of the ophthalmic ultrasound being performed.
- Reason for recommending this particular procedure.
- A statement confirming that a CPT or HCPCS code is not available for the procedure requested.
- The client's diagnosis.
- Documentation that this procedure is not investigational or experimental.
- The physician's intended fee for this procedure, including a comparable CPT or HCPCS code.

Note: *Services and procedures that are investigational or experimental are not a benefit of Texas Medicaid.*

4.3.6.3 Gonioscopy

Gonioscopy is an eye examination to look at the front part of the eye (anterior chamber) between the cornea and the iris. A microscope (slit lamp) is used to look inside the eye.

Procedure code 92020 will be denied as part of another service if billed on the same date of service by the same provider as procedure codes S0620 and S0621.

Procedure code 92020 may be reimbursed for gonioscopy when billed with one of the diagnosis codes in the following table:

Diagnosis Codes							
H20011	H20012	H20013	H20021	H20022	H20023	H20031	H20032
H20033	H20041	H20042	H20043	H20051	H20052	H20053	H2010
H2011	H2012	H2021	H2022	H2023	H20811	H20812	H20813
H20821	H20822	H20823	H209	H2101	H2102	H2103	H211X1
H211X2	H211X3	H21211	H21212	H21213	H21221	H21222	H21223
H21231	H21232	H21233	H21241	H21242	H21243	H21251	H21252
H21253	H21261	H21262	H21263	H21271	H21272	H21273	H2129
H21301	H21302	H21303	H21311	H21312	H21313	H21321	H21322
H21323	H21331	H21332	H21333	H21341	H21342	H21343	H21351
H21352	H21353	H2141	H2142	H2143	H21501	H21502	H21503
H21511	H21512	H21513	H21521	H21522	H21523	H21531	H21532
H21533	H21541	H21542	H21543	H21551	H21552	H21553	H21561
H21562	H21563	H2181	H2182	H22	H31401	H31402	H31403
H31411	H31412	H31413	H31421	H31422	H31423	H3411	H3412
H3413	H348110	H348111	H348112	H348120	H348121	H348122	H348130
H348131	H348132	H348310	H348311	H348312	H348320	H348321	H348322
H348330	H348331	H348332	H35031	H35032	H35033	H35051	H35052
H35053	H3521	H3522	H3523	H3582	H36821	H36822	H36823
H36829	H3689	H47231	H47232	H47233	H40001	H40002	H40003
H40011	H40012	H40013	H40021	H40022	H40023	H40031	H40032
H40033	H40041	H40042	H40043	H40051	H40052	H40053	H40061

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Diagnosis Codes							
H40062	H40063	H4010X0	H4010X1	H4010X2	H4010X3	H4010X4	H401110
H401111	H401112	H401113	H401114	H401120	H401121	H401122	H401123
H401124	H401130	H401131	H401132	H401133	H401134	H401210	H401211
H401212	H401213	H401214	H401220	H401221	H401222	H401223	H401224
H401230	H401231	H401232	H401233	H401234	H401310	H401311	H401312
H401313	H401314	H401320	H401321	H401322	H401323	H401324	H401330
H401331	H401332	H401333	H401334	H401410	H401411	H401412	H401413
H401414	H401420	H401421	H401422	H401423	H401424	H401430	H401431
H401432	H401433	H401434	H40151	H40152	H40153	H4020X0	H4020X1
H4020X2	H4020X3	H4020X4	H40211	H40212	H40213	H402210	H402211
H402212	H402213	H402214	H402220	H402221	H402222	H402223	H402224
H402230	H402231	H402232	H402233	H402234	H40231	H40232	H40233
H40241	H40242	H40243	H4031X0	H4031X1	H4031X2	H4031X3	H4031X4
H4032X0	H4032X1	H4032X2	H4032X3	H4032X4	H4033X0	H4033X1	H4033X2
H4033X3	H4033X4	H4041X0	H4041X1	H4041X2	H4041X3	H4041X4	H4042X0
H4042X1	H4042X2	H4042X3	H4042X4	H4043X0	H4043X1	H4043X2	H4043X3
H4043X4	H4051X0	H4051X1	H4051X2	H4051X3	H4051X4	H4052X0	H4052X1
H4052X2	H4052X3	H4052X4	H4053X0	H4053X1	H4053X2	H4053X3	H4053X4
H4061X0	H4061X1	H4061X2	H4061X3	H4061X4	H4062X0	H4062X1	H4062X2
H4062X3	H4062X4	H4063X0	H4063X1	H4063X2	H4063X3	H4063X4	H40811
H40812	H40813	H40821	H40822	H40823	H40841	H40842	H40843
H4089	H409	H42	Q150				

4.3.6.4 Corneal Topography

Corneal topography is a computer assisted diagnostic tool that creates a three-dimensional map of the shape and curvature of the cornea. Procedure code 92025 may be reimbursed for corneal topography. Procedure code 92025 is considered medically necessary to diagnose, monitor, and treat various visual conditions such as, the following:

- Pre-operatively for evaluation of irregular astigmatism prior to cataract surgery
- Monocular diplopia
- Bullous keratopathy
- Post-surgical or post traumatic astigmatism, measuring at a minimum of 3.5 diopters
- Post penetrating keratoplasty surgery
- Corneal dystrophy
- Complications of transplanted cornea
- Post traumatic corneal scarring
- Keratoconus
- Pterygium and/or corneal ectasia that cause visual impairment

Corneal topography may be reimbursed when it is billed with the same date of service by the same provider as an eye examination visit or consultation.

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Corneal topography (procedure code 92025) is limited to one service, per day, and two services per calendar year, by any provider.

4.3.6.5 Sensorimotor Examination

A sensorimotor examination is an evaluation of the function of the ocular neuro-muscular system. This exam consists of interpretation and reporting of multiple ocular deviation measurements, including:

- Visual motor integration
- Reversal frequency (letters and numbers)
- Motor speed and precision
- Visual memory
- Visualization to test eye movement and control
- Focusing ability
- Eye teaming ability
- Depth perception
- Visual perception skills

Sensorimotor examination (procedure code 92060) is limited to one service per day and two services per calendar year by any provider. Procedure code 92060 may be reimbursed in addition to an eye examination visit.

4.3.6.6 Orthoptic Training

Orthoptics, a component of vision training or vision therapy, are exercises designed to improve the function of the eye muscles with an emphasis on binocular vision and eye movements.

Procedure codes 92065 and 92066 may be reimbursed for orthoptic training when it is billed with one of the following diagnosis codes:

Diagnosis Codes							
H50011	H50012	H50021	H50022	H50031	H50032	H50041	H50042
H5005	H5006	H5007	H5008	H50111	H50112	H50121	H50122
H50131	H50132	H50141	H50142	H5015	H5016	H5017	H5018
H5021	H5022	H50311	H50312	H5032	H50331	H50332	H5034
H50411	H50412	H5042	H5043	H5051	H5052	H5053	H5054
H5055	H50611	H50612	H5069	H50811	H50812	H5089	H5111
H5112	H518	H53011	H53012	H53013	H53021	H53022	H53023
H53031	H53032	H53033	H5501	H5502	H5503	H5504	H5509
H5581	H5582	H5589					

Orthoptic training is limited to 12 services per lifetime per client, when it is billed with one of the diagnosis codes in the above diagnosis table.

Providers must document in the medical record a diagnosis, treatment plan, and the reason for continuous treatment if the client attends multiple training sessions.

Procedure codes 92065 and 92066 may be reimbursed in addition to an eye examination visit.

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4.3.6.7 Visual Field Examinations

The following procedure codes may be reimbursed for visual field examinations:

Procedure Codes		
92081	92082	92083

Procedure codes 92081, 92082, and 92083 may be reimbursed once per day and twice per calendar year by any provider, for any combination of visual field examinations.

Procedure codes 92081, 92082 and 92083 are considered medically necessary under the following conditions:

- Disorder of the eyelids potentially affecting the visual field.
- A documented diagnosis of glaucoma.
- A suspected diagnosis of glaucoma with supporting evidence documented.
- A documented disorder of the optic nerve, the neurologic visual pathway, or retina.
- A recent intracranial hemorrhage, an intracranial mass or a recent measurement of increased intracranial pressure with or without visual symptomatology.
- A recently documented occlusion and/or stenosis of cerebral and precerebral arteries, a recently diagnosed transient cerebral ischemia or giant cell arteritis.
- A history of a cerebral aneurysm, pituitary tumor, occipital tumor or other condition potentially affecting the visual fields.
- A visual field defect demonstrated by gross visual field testing (e.g., confrontation testing).
- An initial workup for buphthalmos, congenital anomalies of the posterior segment or congenital ptosis.
- A disorder of the orbit, potentially affecting the visual field (e.g., orbital tumor, thyroid disease, etc.).
- A significant eye injury.
- A pale or swollen optic nerve documented by a recent examination.
- New functional limitations which may be due to visual field loss (i.e., reports by family that patient is running into things).
- Medication treatment (e.g., hydroxychloroquine) which has a high risk of potentially affecting the visual system.
- Initial evaluation for macular degeneration related to central vision loss or has experienced such loss resulting in vision measured at or below 20/70.

4.3.6.8 Serial Tonometry

Serial tonometry is used to determine the pressure of intraocular fluid in the diagnosis of certain conditions, such as glaucoma. Serial tonometry includes a series of pressure checks over the course of a day to measure peaks and acute elevations in intraocular pressure (diurnal curve).

Procedure code 92100 may be reimbursed once per day and twice per calendar year by any provider.

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4.3.6.9 Computerized Ophthalmic Diagnostic Imaging

The following procedure codes are a benefit of Texas Medicaid when medically indicated and may be reimbursed for Computerized Ophthalmic Diagnostic Imaging (CODI):

Procedure Codes									
92132	92133	92134	92137						

Procedure codes 92132, 92133, 92134, and 92137 are limited to one service per day, and two services per calendar year, any provider.

Procedure code 92132 will be denied as part of another service if billed on the same date of service by any provider as procedure code 76513.

Additional services may be requested for procedure codes 92134 and 91237, with prior authorization, for a total of 12 services per calendar year.

Prior authorization requests must be submitted on a SMPA Request Form and must include documentation of medical necessity for the following circumstances:

- Monitoring patients with conditions affecting the optic nerve (e.g., optic neuropathy) or retinal disease (e.g., macular degeneration, diabetic retinopathy) and in the evaluation and treatment of certain macular abnormalities (e.g., macular edema, atrophy associated with degenerative retinal diseases) including:
- Patients being treated with bevacizumab, aflibercept, pegaptanib sodium, dexamethasone, or ranibizumab for either diabetic retinopathy or macular degeneration.
- Patients being treated with chloroquine (CQ) and/or hydroxychloroquine (HCQ) for the development of retinopathy.

4.3.6.10 Ophthalmic Coherence Biometry

Ophthalmic coherence biometry with intraocular lens power calculation will be considered medically necessary when the measurements are used to calculate the intraocular lens power prior to cataract extraction.

Ophthalmic biometry procedure codes 76519 and 92136 are duplicative tests and cannot be performed together. Procedure codes 76519 and 92136 are limited two services per lifetime, any provider, any combination.

Procedure code 76519 is defined as a bilateral service for the technical component and unilateral service for the professional component. The professional component is only billed when a decision to remove the cataract has been made by the patient and surgeon.

- Two services per day are allowed when the professional component is performed on both eyes on the same date.
- One physician may do the technical component and another physician the professional component. Each will need to use the appropriate modifier. The professional component should also have the anatomic modifier (LT or RT) appended.

When the scan is performed with a calculation done on the first eye, the provider must bill the total component for procedure code 76519 with modifier LT or RT to identify the eye on which the service was performed, or bill procedure code 76519 with total component plus procedure code 76519 with professional component and modifier LT or RT.

When the calculation is performed on the second eye, the provider must only bill procedure code 76519 with professional component and modifier LT or RT to identify the eye on which the service was performed.

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If the technical and professional components are performed on both eyes on the same date, the provider must bill procedure code 76519 with the LT or RT modifier and procedure code 76519 with professional component and the corresponding LT or RT modifiers.

Ophthalmic biometry may be repeated after 12 months if the patient decides to have the surgery later or the procedure is performed by a different provider. Requests for a second ophthalmic biometry in less than 12 months will not be payable without documentation of significant change in vision. Documentation must include at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

4.3.6.11 Ophthalmoscopy, Extended Ophthalmoscopy, and Fluorescein Angiography

Ophthalmoscopy, extended ophthalmoscopy, and fluorescein angiography may be reimbursed using the following procedure codes:

Procedure Codes									
92201	92202	92227	92228	92229	92230	92235	92240	92242	92250
92260									

Procedure codes 92201, 92202, 92227, 92229, 92230, and 92260 are reimbursed for the total component only.

Routine ophthalmoscopy is part of a general and special ophthalmologic service whenever indicated. It is a non-itemized service and is not reported separately.

Extended ophthalmoscopy (procedure codes 92201 and 92202) is a method of examining the posterior portion of the eye when the level of examination requires a complete view of the back of the eye and documentation is greater than that required during routine ophthalmoscopy. Extended ophthalmoscopy must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan.

Extended ophthalmoscopy is considered medically necessary for the following conditions:

- Infants (0-24 months) undergoing treatment and/or monitoring of retinopathy of prematurity
- Histoplasmosis
- Choroidal neoplasms
- Glaucoma
- Optic nerve pathology
- Diabetic retinopathy
- Hypertensive retinopathy
- Vascular occlusion
- Retinal neovascularization
- Macular pathology
- Retinal tear, thinning, schisis or detachment
- Hereditary retinal dystrophies

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- Other visible retinal disorders requiring detailed imaging for adequate documentation

Extended ophthalmoscopy is not medically necessary under the following situations:

- Routine replacement of standard ophthalmoscopy with extended ophthalmoscopy to document the appearance of healthy retinal anatomy.
- Duplicative documentation of retinal pathology with extended ophthalmoscopy in conjunction with fundus photography, fluorescein angiography, etc., unless the additional diagnostic procedures provide new information to assist in clinical decision-making.
- Repeated performance in the presence of controlled and/or stable disease.

Repeat extended ophthalmoscopy is medically necessary when there is a change in signs, symptoms or specific condition. The frequency for providing extended ophthalmoscopy depends upon the medical necessity in each client which relates to the diagnosis. While most clients will require up to two services per year, in some cases, additional services may be reimbursed up to 12 services per year.

The client's medical record must contain documentation that fully supports the medical necessity for extended ophthalmoscopy. Retinal drawings must meet the following specifications:

- Must be a separate detailed sketch, minimal size of 3-4 inches
- All items must be identified and labeled
- Drawings in four-six standard colors are preferred. However, non-colored drawings are acceptable, if clearly labeled
- All abnormalities should be included in drawing

Procedure codes 92201 and 92202 are limited to one service per day and 12 services per calendar year by any provider.

Remote retinal imaging (procedure codes 92227, 92228, and 92229) is a benefit of Medicaid when the images are obtained by a provider at one facility, and then transmitted electronically, to be reviewed and interpreted at another site by an ophthalmologist or other qualified health care professional under the direction of a retinal specialist.

Procedure codes 92227, 92228, 92229, 92235, 92240, 92242, 92250 and 92260 are limited to one service per day and two services per calendar year by any provider.

Procedure code 92230 must be billed with modifier LT or RT to identify the eye on which the service was performed.

Procedure codes S0620 and S0621 will be denied if billed on the same date of service as procedure codes 92227, 92228, 92229, 92230, 92235, 92240, 92242, 92250 or 92260.

Fundus photography (procedure code 92250) is considered medically necessary when an existing clinical condition is subject to change in extent, appearance or size with potential direct impact on and the management of client care. These conditions include, but are not limited to the following:

- Macular degeneration
- Glaucoma
- Neoplasms of the retina or choroid
- Chorioretinal inflammation, scars, and other disorders of choroid
- Retinal hemorrhages
- Ischemia
- Retinal detachment

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- Diabetic retinopathy
- Assessment of recently performed retinal laser surgery
- Lupus erythematosus
- Hypertension
- Multiple sclerosis
- Rheumatoid arthritis
- Sickle-cell anemia

Note: *Fundus photography performed for a routine screen of a normal eye, in the absence of a clinical condition, that is subject to change in extent, appearance or size is not a benefit of Texas Medicaid.*

4.3.6.12 Other Specialized Vision Services

The following procedure codes may be reimbursed by Texas Medicaid when the services are medically necessary:

Procedure Codes									
92265	92270	92273	92274	92285	92286	92287			

Procedure code 92265 is performed to evaluate nerve and muscle function of the eye muscles and considered medically necessary when performed for the diagnosis and evaluation of myasthenia gravis as well as other neuromuscular conditions effecting eye movement.

Procedure code 92273 is an acceptable alternative adjunctive modality useful in establishing loss of retinal function and distinguishing retinal from optic nerve lesions.

Procedure code 92274 is considered medically necessary for detecting chloroquine (Aralen) and hydroxychloroquine (Plaquenil) toxicity.

Procedure code 92285 may be indicated when photo-documentation is required to track the progression or lack of progression of an eye condition, or to document the progression of a particular course of treatment. This procedure should not be used to simply document the existence of a condition in order to enhance the medical record.

Procedure codes 92286 and 92287 are performed to evaluate the integrity of the cornea, iris and other anterior segment structures.

Texas Medicaid considers procedure code 92286 medically necessary for patients who meet one or more of the following criteria:

- Slit lamp evidence of endothelial dystrophy
- Slit lamp evidence of corneal edema
- Are about to undergo a secondary intraocular lens implantation
- Previous intraocular surgery requiring cataract surgery
- Are about to undergo a surgical procedure associated with a higher risk to corneal endothelium, i.e., phacoemulsification or refractive surgery
- Evidence of posterior polymorphous dystrophy of the cornea or iridocorneal-endothelium syndrome
- Will be fitted with extended wear contact lenses after intraocular surgery

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Procedure codes 92265, 92270, 92273, 92274, 92285, 92286, and 92287 may each be reimbursed once per day and twice per calendar year by any provider.

Procedure codes S0620 and S0621 will be denied if billed on the same date of service as procedure codes 92265, 92270, 92273, 92274, 92285, 92286, or 92287.

For other professional services, fitting services are included in the reimbursement for prosthetic eyeglasses or contact lenses.

Microfluidic analysis of tear osmolarity is a CLIA-waived lab test and may be performed by optometrists in the office setting.

Refer to: Subsection 2.2.13, "Urinalysis and Chemistry" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for information about microfluidic analysis (procedure code 83861).

4.3.7 Eyeglasses

Eyeglasses are a benefit of Texas Medicaid when the following criteria are met:

- Medically necessary
- Prescribed by a doctor of medicine, optometry, or osteopathy
- Prescribed to significantly improve vision or correct a medical condition
- In compliance with eyeglass program specifications for frames and lenses as stated in 1 Texas Administrative Code (TAC) §354.1017 and §363.503, Specifications for Eyewear

Eyeglasses may be provided to clients of any age when there is no other option available to correct or ameliorate a visual defect.

Eyeglasses are limited to once every 24 months. Additional services within the 24-month period may be considered when documentation in the client's medical record supports medical necessity for a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes. A new 24-month benefit period for eyewear begins with the placement of the new eyewear.

The prescription for eyeglasses must be given to the client upon request. A provider may not withhold a prescription for eyeglasses from a client even if Medicaid reimbursement for the eye examination has not been received.

The fitting of eyeglasses is considered part of the dispensing procedure and is not separately reimbursed.

4.3.7.1 Frames

The following procedure codes may be reimbursed for eyeglass frames:

Procedure Codes									
V2020	V2025								

Frames are limited to one per 24 calendar months by any provider.

4.3.7.2 Eyeglass Lenses

The following eyeglass lens procedure codes may be reimbursed for single vision lenses:

Procedure Codes									
V2100	V2101	V2102	V2103	V2104	V2105	V2106	V2107	V2108	V2109
V2110	V2111	V2112	V2113	V2114	V2115	V2118	V2121		

The following eyeglass lens procedure codes may be reimbursed for bifocal lens:

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Procedure Codes									
V2200	V2201	V2202	V2203	V2204	V2205	V2206	V2207	V2208	V2209
V2210	V2211	V2212	V2213	V2214	V2215	V2218	V2219	V2220	V2221

The following eyeglass lens procedure codes may be reimbursed for trifocal lenses:

Procedure Codes									
V2300	V2301	V2302	V2303	V2304	V2305	V2306	V2307	V2308	V2309
V2310	V2311	V2312	V2313	V2314	V2315	V2318	V2319	V2320	V2321

The following eyeglass lens procedure codes may be reimbursed for variable asphericity lenses:

Procedure Codes	
V2410	V2430

Eyeglass lenses are limited to one pair per 24 calendar months, any provider.

Providers must bill a quantity of two when billing for bilateral lenses with the same prescription.

4.3.7.3 Add-On Lenses

The following procedure codes may be reimbursed for add-on services:

Procedure Codes									
V2700	V2710	V2715	V2718	V2730	V2755	V2770	V2780		

Add-on procedure codes will not be reimbursed unless they are billed with the appropriate lens procedure code by the same provider for the same date of service.

Procedure code V2755 may be reimbursed for ultraviolet (U-V) protection when billed with one of the following diagnosis codes:

Diagnosis Codes							
H2701	H2702	H2703	H27111	H27112	H27113	H27121	H27122
H27123	H27131	H27132	H27133	Q123	Z961		

Procedure code V2755 will be denied when billed for the same date of service by the same provider as procedure code V2784.

4.3.7.4 * Polycarbonate Lenses

Polycarbonate lenses (procedure code V2784) may be reimbursed when billed with one of the diagnosis codes in the following table:

[Revised] Diagnosis Codes							
D8984	E083521	E083522	E083523	E083531	E083532	E083533	E083541
E083542	E083543	E093521	E093522	E093523	E093531	E093532	E093533
E093541	E093542	E093543	E103521	E103522	E103523	E103531	E103532
E103533	E103541	E103542	E103543	E113521	E113522	E113523	E113531
E113532	E113533	E113541	E113542	E113543	E133521	E133522	E133523
E133531	E133532	E133533	E133541	E133542	E133543	F840	F842
F843	F845	F848	F849	F951	G20A1	G20A2	G20B1

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[Revised] Diagnosis Codes							
G20B2	G20C	G2111	G2119	G213	G214	G218	G3180
G3183	G3184	G3186	G35A	G35B0	G35B1	G35B2	G35C0
G35C1	G35C2	G35D	G3781	G3789	G40001	G40009	G40011
G40019	G40101	G40109	G40111	G40119	G40201	G40209	G40211
G40219	G40301	G40309	G40311	G40319	G40A01	G40A09	G40A11
G40A19	G40B01	G40B09	G40B11	G40B19	G40C01	G40C09	G40C11
G40C19	G40401	G40409	G40411	G40419	G40501	G40509	G40801
G40802	G40803	G40804	G40811	G40812	G40813	G40814	G40821
G40822	G40823	G40824	G40841	G40842	G40843	G40844	G4089
G40901	G40909	G40911	G40919	G7100	G7101	G7102	G7109
G7111	G7112	G7113	G7114	G7119	G7120	G7121	G71220
G71228	G7129	G713	G718	G719	G720	G721	G722
G723	G7241	G7249	G7281	G7289	G729	G737	G800
G801	G802	G803	G804	G808	G809	G90B	G9342
G9344	G9345	H33001	H33002	H33003	H33011	H33012	H33013
H33021	H33022	H33023	H33031	H33032	H33033	H33041	H33042
H33043	H33051	H33052	H33053	H33191	H33192	H33193	H3321
H3322	H3323	H33301	H33302	H33303	H33311	H33312	H33313
H33321	H33322	H33323	H33331	H33332	H33333	H3341	H3342
H3343	H338	H53001	H53002	H53003	H53011	H53012	H53013
H53021	H53022	H53023	H53031	H53032	H53033	H53041	H53042
H53043	H540X33	H540X34	H540X35	H540X43	H540X44	H540X45	H540X53
H540X54	H541131	H541132	H541141	H541142	H541151	H541152	H541213
H541214	H541215	H541223	H541224	H541225	H542X12	H542X21	H542X22
H54413A	H54414A	H5442A3	H5442A4	H54512A	H5452A2	H8101	H8102
H8103	H8109	H8110	H8111	H8112	H8113	H8120	H8121
H8122	H8123	H81311	H81312	H81313	H81319	H81391	H81392
H81393	H81399	H814	H8301	H8302	H8303	H8309	H8311
H8312	H8313	H8319	H832X1	H832X2	H832X3	H832X9	I69012
I69112	I69212	I69312	I69812	I69912	P100	P101	P104
P108	P109	P112	P119	P524	P526	P528	P529
Q8740	Q87410	Q87418	Q8742	Q8743	Q8782	Q8783	Q8784
Q8785	Q8786	Q8787	Q8788	Q87A	Q8981	Q8989	Q900
Q901	Q902	Q909	Q9352	Q99811	Q99812	Q99813	Q99818
Q99819	QA00101	QA00139	QA00141	QA00142	QA00149	QA00151	R4185
S061X0A	S061X1A	S061X2A	S061X3A	S061X4A	S061X5A	S061X6A	S061X7A
S061X8A	S061X9A	S061XAA	S061XAD	S061XAS	S06305A	S06305D	S06305S
S06306A	S06306D	S06306S	S06307A	S06308A	S0630AA	S0630AD	S0630AS
S06371A	S06371D	S06371S	S06372A	S06372D	S06372S	S06373A	S06373D
S06373S	S06374A	S06374D	S06374S	S06375A	S0637AA	S0637AD	S0637AS

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[Revised] Diagnosis Codes							
S06890A	S06890D	S06890S	S06891A	S06891D	S06891S	S06892A	S06892D
S06892S	S06893A	S06893D	S06893S	S06894A	S06894D	S06894S	S06895A
S06895D	S06895S	S06896A	S06896D	S06896S	S06897A	S06898A	S06899A
S06899D	S06899S	S0689AA	S0689AD	S0689AS	S069X0A	S069X0D	S069X0S
S069X1A	S069X1D	S069X1S	S069X2A	S069X2D	S069X2S	S069X3A	S069X3D
S069X3S	S069X4A	S069X4D	S069X4S	S069X5A	S069X5D	S069X5S	S069X6A
S069X6D	S069X6S	S069X7A	S069X8A	S069X9A	S069X9D	S069X9S	S069XAA
S069XAD	S069XAS	T8521XA	T8521XD	T8521XS	T8522XA	T8522XD	T8522XS
T8529XA	T8529XD	T8529XS	T85310A	T85310D	T85310S	T85311A	T85311D
T85311S	T85318A	T85318D	T85318S	T85320A	T85320D	T85320S	T85321A
T85321D	T85321S	T85328A	T85328D	T85328S	T85390A	T85390D	T85390S
T85391A	T85391D	T85391S	T85398A	T85398D	T85398S	T8579XA	T8579XD
T8579XS	T85890A	T85890D	T85890S	T85898A	T85898D	T85898S	

In addition to the diagnoses listed in the table, polycarbonate lenses also may be reimbursed when the client meets the following criteria:

- Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness, or aberration
- Monocular vision with functional vision in one eye
- Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment)

Polycarbonate lens claims must include a lens procedure code with lens power in one meridian of -5.25/+4.00d or more.

If the eyeglass lenses are not functional in regular standard glass or plastic due to weight, thickness, or aberration or for diagnosis not listed, providers must submit documentation of medical necessity. If documentation is not submitted with the claim, the polycarbonate lenses will be denied.

Procedure code V2755 will be denied when billed for the same date of service by the same provider as polycarbonate lenses.

4.3.7.5 Dispensing of Eyeglasses

Dispensing of eyeglasses includes the design, verification, fitting, adjustment, sale, and delivery to the client of (1) fabricated and finished spectacle lenses, (2) frames, or (3) other ophthalmic devices, prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

Providers must be able to dispense standard size frames at no cost to the eligible client.

Providers must offer each client the following frame options:

- 20 years of age or younger: a choice of six styles in three colors for each type of frame.
- 21 years of age or older: a choice of three styles in three colors for each type of frameA cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.

The type of frame choices that are a benefit are:

- Metal
- Zylonite

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- Combination of metal and zylonite

When a client chooses eyeglass options beyond the program limitations, the client must be informed their choice is not a benefit of Texas Medicaid and acknowledge his or her liability for the cost difference by signing the Medicaid Vision Eyewear Client Certification form.

4.3.7.6 Repair of Eyeglasses

The eyeglass supplier is required to perform minor repairs on request (without charge) on eyeglasses that they have dispensed regardless of the client's age.

A repair costing $2.00 or less is considered a minor repair and is included in the eyeglass reimbursement.

Repair of eyeglasses is not a benefit for clients 21 years of age and older.

Repair of prosthetic eyeglasses, when the actual cost of materials exceeds $2.00 is a benefit for all ages.

Eyeglass repair costing $2.00 or more may be reimbursed using procedure code V2799 and requires the following:

- The cost of repair supplies cannot exceed the cost of replacement eyeglasses.
- All eyeglass repair materials must be new and at least equivalent to the original item.
- The provider must maintain the following in the client's medical record:
  - An itemized list of repairs
  - The replacement cost to determine whether criteria are met for repair

4.3.7.7 Replacement of Eyeglasses

Replacement of lost or destroyed eyeglasses is a benefit of Texas Medicaid for clients from birth through 20 years of age. If the eyeglasses are lost, stolen, or damaged beyond repair, the provider must have the client sign the Medicaid Vision Eyewear Client Certification Form and the signed form must be maintained in the client's medical record.

Claims for replacement lenses must be submitted with the RB modifier to ensure accurate processing. Prior authorization is not required for the replacement of eyeglasses.

Replacement of eyeglasses within the 24-month period is a benefit only when medically necessary due to a significant change in visual acuity. A new prescription must document at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

4.3.7.8 Undeliverable Eyeglasses

If a client cancels an order for eyeglasses prior to their completion and delivery or if the eyeglasses become unusable because the client dies or his prescription changes prior to completion and delivery of the eyeglasses, the provider is still entitled to reimbursement based on the services furnished and the materials used, up to the time the provider learned of the cancellation of the eyeglasses or the fact that the eyeglasses would not be usable. This applies to lenses only, not to the frames.

4.3.8 Contact Lenses

Contact lenses may be considered for clients of any age if there is no other option available to correct or ameliorate a visual defect.

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Contact lenses are limited to once every 24 months. Additional services within the 24-month period may be considered when documentation in the client's medical record supports medical necessity for a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes. A new 24-month benefit period for eyewear begins with the placement of the new non-prosthetic eyewear.

Prior authorization is required for all contact lenses unless provided in a medical emergency. Prior authorization decisions are based on the provider's written documentation supporting the need for contact lenses as the only means of correcting the vision defect.

The following procedure codes may be reimbursed for contact lenses:

Procedure Codes							
V2500	V2501	V2502	V2510	V2511	V2512	V2513	V2520
V2521	V2522	V2523	V2530	V2531	V2599		

Therapeutic soft (hydrophilic) contact lenses (procedure codes V2520, V2521, V2522, V2523) or gas-permeable fluid ventilated scleral lenses (procedure codes V2530 and V2531) are considered medically necessary prosthetics when used as moist corneal bandages for the treatment of severe ocular surface diseases.

4.3.8.1 Dispensing of Contact Lenses

Dispensing of contact lenses include the fabrication, ordering, adjustment, dispensing, sale, and delivery to the client of the contact lens(es) prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

When a client chooses contact lens options beyond the program limitations, the client must be informed their choice is not a benefit of Texas Medicaid and acknowledge his or her liability for the cost difference by signing the Medicaid Vision Eyewear Client Certification Form.

4.3.8.2 Contact Lens Fitting and Modification

The following procedure codes may be reimbursed for the fitting and modification of a contact lens:

Procedure Codes							
92310	92311	92312	92313	92314	92315	92316	92317
92325	92326						

Procedure codes 92310, 92325, and 92326 are limited to one service per day, any provider.

4.3.8.3 Contact Fitting for Corneal Bandage Lens

A contact lens fitting for placement of a corneal bandage lens may be medically necessary for eye protection and pain control due to a disease or injury.

The following procedure codes may be reimbursed for corneal bandage fitting:

Procedure Codes							
92071	92072						

The emergency condition necessitating a corneal bandage must be documented on the claim.

Procedure code 92071 is limited to one service per eye, per day, by any provider.

Modifier LT or RT must be included on the claim to identify the eye on which the service was performed. When procedure code 92071 is performed on both eyes on the same date of service, one procedure may be reimbursed at the full rate and the second procedure may be reimbursed at half rate.

Procedure code 92072 is limited to one service per lifetime by the same provider.

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Procedure code 92072 will be denied if billed on the same date of service by the same provider as procedure code 92071.

Procedure codes 92071 or 92072 must be billed on the same date of service as one of the following procedure codes V2511, V2512, V2513, V2520, V2521, V2522, and V2523.

4.3.8.4 Prior Authorization Requirements

Prior authorization for contact lenses must be submitted on a SMPA Request Form, signed and dated by the prescribing physician or optometrist and must include the following documentation:

- Diagnosis causing the refractive error (such as keratoconus)
- Current and new prescriptions supporting a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes
- Which eye(s) need to be treated
- The procedure code(s) requested
- A brief statement addressing the medical necessity for vision correction by contact lens(es) and specifying why eyeglasses are inappropriate or contraindicated for this client

Note: *Additional contact lenses may be considered more frequently than the limitations previously outlined in this handbook, when documentation in the client's medical record supports medical necessity for a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes.*

Note: *Non-prosthetic contact lenses for emergency placement do not require prior authorization. The emergency condition necessitating a corneal bandage must be documented on the claim.*

Authorization for contact lenses may be considered for 60 days.

Temporary contact lenses after cataract surgery may be prior authorized for diagnosis code Z961 when medically necessary.

4.3.8.5 Replacement of Contact Lenses

Replacement of lost or destroyed contact lenses is a benefit of Texas Medicaid for clients from birth through 20 years of age. If the contact lenses are lost, stolen, or damaged beyond repair, the provider must have the client sign the Medicaid Vision Eyewear Client Certification Form and the signed form must be maintained in the client's medical record.

Replacement of contacts within the 24-month period is a benefit only when medically necessary due to a significant change in visual acuity. A new prescription must document at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

Prior authorization is required for replacement of contact lenses.

The appropriate eyeglass and frame or contact lens procedure codes must be billed with modifier RB to indicate replacement.

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4.3.9 Eyeglasses and Contact Lenses

4.3.9.1 Medicare Coverage for Eyewear

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses because of refractive errors are not a benefit of Medicare. These services must be filed directly to Texas Medicaid when performed for a Medicaid Qualified Medicare Beneficiary (MQMB) client. Medicare coverage is limited to eye examinations for treatment of eye disease or injury and for a diagnosis of aphakia. When performing an eye examination with refraction for an MQMB client diagnosed with aphakia or disease or injury to the eye, the following procedures must be followed:

- Procedure code 92015 must be used to bill Texas Medicaid for the refractive portion of the examination and is payable with a diagnosis of aphakia or ocular disease only.
- The medical portion of the eye examination (procedure code 92002, 92004, 92012, or 92014) is covered by Medicare and must be billed to Medicare first. Medicare forwards this portion of the examination automatically to TMHP for deductible and coinsurance payment consideration according to current guidelines.

Refer to: Section 2.7, "Medicare Crossover Claim Reimbursement" in the *Section 2: Texas Medicaid Fee-for-Service Reimbursement* (*Vol. 2, Provider Handbooks*) for more information about current coinsurance and deductible payment guidelines.

Important: *Providers performing eye exams for refractive errors on Medicaid Qualified Medicare Beneficiary (MQMB) clients must bill TMHP. Do not send the refraction (procedure code 92015) to Medicare first. Texas Medicaid will not waive the 95-day filing deadline if the claim is billed to Medicare in error, nor will Medicare transfer the refraction to Texas Medicaid for payment.*

Medicare allows payment of one pair of conventional eyewear (contact lens or glasses) for clients who have had cataract surgery with insertion of an intraocular lens (IOL). Medicare considers the IOL the prosthetic device. Texas Medicaid providers must bill Medicare for the conventional (nonprosthetic) eyewear provided following an IOL insertion and bill Texas Medicaid for any replacements of the conventional (nonprosthetic) eyewear using the procedure codes in Section 4.3.7, "Eyeglasses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*)and Section 4.3.8, "Contact Lenses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

4.3.9.2 Prosthetic Eyeglasses or Contact Lenses

Prosthetic eyeglasses or contact lenses are lenses that replace the eye's organic lens when it is absent due to congenital or acquired aphakia. Aphakia may be the result of a congenital abnormality or defect, or an acquired condition as a result of trauma, or cataract removal without IOL insertion.

Prosthetic eyeglasses or contact lenses may be provided based on medical necessity. Prosthetic contact lenses may be provided, with prior authorization, for clients of any age with congenital or acquired aphakia. Eye examinations for aphakia (including congenital aphakia) and disease or injury to the eye may be reimbursed as often as is medically necessary.

Note: *Fitting services are included in the reimbursement for prosthetic eyeglasses.*

One pair of prosthetic eyeglasses or contact lens(es) is a benefit during a client's lifetime.

The following aphakia diagnosis codes must be used when billing for prosthetic eyeglasses:

Diagnosis Codes							
H2701	H2702	H2703	Q123				

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Replacement of prosthetic eyeglasses or contact lens(es) is a benefit of Texas Medicaid regardless of age under the following circumstances:

- Loss or destruction
- Significant change in visual acuity with a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes

The provider must maintain documentation in the client's medical record supporting the medical necessity for the replacement eyeglasses or contact lens(es).

If the prosthetic eyewear is lost, stolen, or damaged beyond repair, the provider must have the client sign the Medicaid Vision Eyewear Client Certification Form and the signed form must be maintained in the client's medical record.

The appropriate eyeglass and frame or contact lens procedure codes must be billed with modifier RB to indicate replacement.

Refer to: Section 4.3.7, "Eyeglasses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) and Section 4.3.8, "Contact Lenses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*)for the eyeglass lens, frame, contact lens procedure codes and dispensing requirements that apply to eyewear.

4.3.9.3 Eyeglasses or Contact Lenses following Cataract Surgery

4.3.9.3.1 Temporary Eyewear

Temporary eyeglasses or contact lenses after cataract surgery may be reimbursed when they are billed with the appropriate lens and frame procedure codes and diagnosis code Z961.

Temporary eyeglasses or contact lens(es) for these clients may be considered up to four months after surgery until the client is ready for permanent eyeglasses or contact lens(es) when medically necessary. The date of surgery is used to determine the convalescence period for temporary eyeglasses or contact lens(es). There are no limitations on the number of temporary contact lens(es) during the postsurgical convalescence period. Temporary eyeglasses or contact lens(es) will be denied if dispensed more than four months after the date of surgery.

4.3.9.3.2 Permanent Eyewear

Permanent eyeglasses or contact lens(es) following cataract surgery may be provided based on medical necessity for clients of any age. Permanent contact lenses require prior authorization.

Note: *Fitting services are included in the reimbursement for permanent eyeglasses.*

One pair of permanent eyeglasses or contact lens(es) is a benefit during a client's lifetime.

Providers must use diagnosis code Z961 to indicate the presence of an IOL when billing for permanent eyewear following cataract surgery.

Replacement of permanent eyeglasses or contact lens(es) is a benefit of Texas Medicaid regardless of age under the following circumstances:

- Loss or destruction
- Significant change in visual acuity with a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes

The provider must maintain documentation in the client's medical record supporting the medical necessity for the replacement eyeglasses or contact lens(es).

If the permanent eyewear is lost, stolen, or damaged beyond repair, the provider must have the client sign the Medicaid Vision Eyewear Client Certification Form and the signed form must be maintained in the client's medical record.

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The date of cataract surgery is not required on the claim for:

- Permanent contact lens(es) or eyeglasses after surgery
- Prosthetic contact lens(es) or eyeglasses after cataract surgery without IOL insertion

Providers must include diagnosis code Z961 to indicate the presence of an IOL on the claim.

4.3.9.4 Intraocular Lens (IOL) and Additional Eyewear

Intraocular lenses are benefits of Texas Medicaid. If conventional eyewear is medically necessary in addition to the IOL, the IOL is considered the prosthetic device, and the eyewear and any replacements are considered nonprosthetic.

Refer to: Section 9.2.49.4, "Intraocular Lens (IOL)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about IOL benefits.

Section 4.3.7, "Eyeglasses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*)and Section 4.3.8, "Contact Lenses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about nonprosthetic eyewear

4.3.9.5 Artificial Eyes

For clients who are birth through 20 years of age, artificial eyes may be considered under CCP.

4.3.10 Surgical Vision Services

Refer to: Subsection 6.55, "Fluocinolone Acetonide (Retisert)" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about fluocinolone acetonide benefits.

Subsection 9.2.49, "Ophthalmology" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about surgical vision services.

4.3.11 Prior Authorization

Prior authorization is required for:

- Unlisted ultrasound procedures.
- Computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina, beyond the maximum limits outlined in this handbook.
- All contact lenses, except corneal bandage lens(es) for emergency placement.
- All services requested through THSteps-CCP.

Requests for prior authorization must be received and approvals must be obtained before services are rendered. Requests received after the service date will be denied.

Prior authorization requests may be submitted to the TMHP Special Medical Prior Authorization Department via 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 request must also attest that electronic

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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 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 Special Medical Prior Authorization (SMPA) Request Form to the TMHP-SMPA department and retain a copy of the signed and dated prior authorization form in the client's medical record.

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

The SMPA form must be signed and dated within 60 days before the date of service. Services will not be authorized prior to the ordering provider's signature date.

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.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies.

4.4 Documentation Requirements

In addition to documentation requirements outlined in the prior authorization sections of this handbook, all services require documentation to support the medical necessity of the service rendered. Vision services are subject to retrospective review and recoupment if documentation does not support the service billed.

The client must sign and date the Medicaid Vision Eyewear Client Certification Form, and the provider must retain it in the provider's records.

When a client chooses an eyeglasses or contact lens option beyond the program limitations, eyeglasses or contact lenses are replaced because of loss or destruction the client must acknowledge their choice and liability for the cost difference by signing the Medicaid Vision Eyewear Client Certification Form and retain it in the provider's records.

The current and previous prescriptions must be documented in the client's medical record.

The provider must make the client's medical record available for review upon request by the following:

- HHSC
- Office of the Attorney General
- TMHP

4.5 Claims Filing and Reimbursement

4.5.1 Claims Filing

Vision care service claims must be submitted to TMHP in an approved electronic format or on a 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. 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.

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When submitting the client's old and new prescriptions to show an axis change or a diopter change of.5 or more, enter the new prescription in Block 24D, line 5, and the old prescription in Block 24D, line 6 of the CMS-1500 paper claim form.

Claims for eye examination services require a diagnosis. Claims for eye examinations that lack a diagnosis are listed as an incomplete claim on the Remittance and Status (R&S) report and must be resubmitted for payment consideration. Electronic claims that lack a diagnosis will be rejected. A letter with the reason for rejection and instructions for resubmission will be mailed the following business day.

When the eye exam limitation is exceeded for clients who are 20 years of age and younger, identify one of the following situations in Block 19 of the CMS-1500 paper claim form:

- A school nurse, teacher, or parent requests the eye examination.
- The eye examination is medically necessary.

4.5.2 Reimbursement

Providers must reflect the highest level of specificity for vision related diagnoses on claims or other documentation. Professional services by an optometrist for contact lenses and prosthetic eyewear are reimbursed in accordance with 1 TAC §355.8001 and §355.8085.

Procedure codes described as bilateral are inclusive codes, and right and left studies billed on the same day will be reimbursed at a quantity of one.

Procedure codes described as "unilateral or bilateral" will be reimbursed for the same amount whether one or both sides are tested.

FQHCs are paid an all-inclusive rate per visit for payable services in accordance with 1 TAC, §355.8261.

Suppliers of lenses and frames are reimbursed the lesser of their billed amount or of the established maximum allowable fee in accordance with 1 TAC, §355.8001. See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Vision Services on the TMHP website at www.tmhp.com for a claim form example.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated 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.

4.5.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

If applicable and consistent with CMS billing guidelines, procedure codes must be billed with modifier LT (left side) or RT (right side) to identify the eye on which the service was performed.

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5 Claims Resources

Refer to the following sections and forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

7 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Physician's Examination Report
Medicaid Vision Eyewear Client Certification Form
Medicaid Vision Eyewear Client Certification Form (Spanish)

8 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Hearing Aid Assessments
Vision Services

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