



Texas Medicaid Provider Procedures Manual

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2

Provider Handbooks

Children's Services Handbook

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

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 1.6, "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.

Referto: *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/pages/topics/rates.aspx.

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 provider identifier 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.

Referto: Subsection 3.7.3.14, "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

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 2.5, "Clinician-Directed Care Coordination Services (CCP)" in this handbook.
- Subsection 2.10, "Medical Nutrition Counseling Services (CCP)" in this handbook.
- Subsection 2.8, "Early Childhood Intervention (ECI) Services" in this handbook.
- Subsection 2.11, "Personal Care Services (PCS) (CCP)" in this handbook.
- Subsection 2.16, "Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP)" in this handbook.
- Subsection 2.17, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in this handbook.

Referto: *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

Referto: Subsection 1.6.16, "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

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 1-512-491-1429.
- 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.

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.*

Referto: 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.

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.*

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 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.

2.3 Breastfeeding Support Services

Referto: 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.

2.4 Certified Respiratory Care Practitioner Services (CCP)

Referto: The *Certified Respiratory Care Practitioner (CRCP) Services Handbook (Vol. 2, Provider Handbooks)* for information about CRCP (CCP) services.

2.5 Clinician-Directed Care Coordination Services (CCP)

2.5.1 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 99339, 99340, 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.
- 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.

2.5.1.1 Non-Face-to-Face Services

2.5.1.1.1 Non-Face-to-Face Medical Conferences

Procedure code 99367 must be used when billing for medical team conferences.

2.5.1.1.2 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.

2.5.1.1.3 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.

2.5.1.1.4 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.

2.5.1.1.5 Other Non-Face-to-Face Supervision

Procedure code 99339 or 99340 must be used when billing for services requiring interaction with an independently-enrolled nurse or other provider (e.g., not a home health agency, nursing facility, or hospice provider).

2.5.1.1.6 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 the first hour of prolonged services and must be billed with the appropriate physician E/M procedure code listed in the following table. Prolonged services of less than 30 minutes are considered part of the physician's E/M service being provided.

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99221	99222	99223	99231	99232	99233	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255	99304	99305	99306	99307
99308	99309	99310	99318	99324	99325	99326	99327	99328	99334
99335	99336	99337	99341	99342	99343	99344	99345	99347	99348
99349	99350								

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.

2.5.1.1.7 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								
99339	99340	99358	99374	99375	99377	99378	99379	99380

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 identifier and prior authorization number must be submitted on the claim.

2.5.1.1.8 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.

2.5.1.1.9 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 or domiciliary (procedure codes 99339 and 99340), home health agency (procedure codes 99374 and 99375), hospice (procedure codes 99377 and 99378), or nursing facility (procedure codes 99379 and 99380).

Procedure code 99339 is denied when billed on the same date of service by the same provider as procedure code 99340.

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.

Only one clinician-directed care plan oversight service (procedure codes 99339, 99340, 99374, 99375, 99377, 99378, 99379 or 99380) will be reimbursed per client, per calendar month to any provider.

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.

2.5.1.1.10 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.

2.5.1.2 Face-to-Face Services

2.5.1.2.1 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									
99339	99340	99358	99359	99367	99374	99375	99377	99378	99379
99380									

2.5.2 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

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. 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.

2.5.2.1 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

2.5.2.2 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 least 15 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
- Provider information for the specialist's or subspecialist's and the clinician providing the medical home

2.5.3 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.

Referto: “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.

2.5.4 Reimbursement

Clinician-directed care coordination services are reimbursed in accordance with 1 TAC §355.8441.

2.6 Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)

Referto: *The Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook (Vol. 2, Provider Handbooks)* for more information about CCP therapy services.

2.7 Durable Medical Equipment (DME) Supplier (CCP)

2.7.1 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)*.

2.7.1.1 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 <http://opl.tmhp.com/ProviderManager/AdvSearch.aspx>.

Referto: Subsection 2.1.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

“Appendix B: Vendor Drug Program” (*Vol. 1, General Information*)

Section 2, “Texas Medicaid (Title XIX) Home Health Services” in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)* for details about coverage through Texas Medicaid (Title XIX) Home Health Services.

2.7.2 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.

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 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.
- The specific type of supply needed.
- The length of time needed.

2.7.2.1 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.

2.7.3 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.

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.

Referto: Section 2.2.29, "Procedure Codes That Do Not Require Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)* for details about specific procedure codes that do not require prior authorization through Texas Medicaid (Title XIX) Home Health Services.

2.7.3.1 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.

2.7.3.2 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 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.

2.7.3.3 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.

2.7.3.4 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.

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.

2.7.3.5 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.

Referto: [DME Certification and Receipt Form](#) on the TMHP website at www.tmhp.com.

2.7.3.6 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 that includes the shipping date and delivery date must be printed from the carrier's website as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or corresponding invoice.

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.

2.7.3.7 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.

Referto: [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.

2.8 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 <https://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.

2.8.1 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.

To participate in Texas Medicaid, an ECI contractor must submit a copy of the current contract award from the Texas HHS ECI program.

Referto: Subsection 1.1, "Provider Enrollment and Reenrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about the procedures for enrolling as a Medicaid provider.

2.8.2 Services, Benefits, and Limitations

Prior authorization is not required for evaluations, re-evaluations, seating assessments, therapy services, SST, and TCM. The IFSP Services Pages identify the amount, duration, and scope for the provision of 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 targeted case management (TCM) and specialized rehabilitative services (SRS), which includes occupational therapy (OT), physical therapy (PT), speech therapy (ST), and specialized skills training (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 HHSC (40 TAC, Part 2, Chapter 108), 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 40 TAC, Part 2, Chapter 108, and are family-centered.

The interdisciplinary team must document ECI eligibility decisions in accordance with 40 TAC, Part 2, Chapter 108. 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 early childhood intervention 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).

2.8.2.1 Physical, Occupational, and Speech Therapies and Specialized Skills Training (PT, OT, ST, and SST)

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.

ECI services are performed in accordance with 40 TAC, Part 2, Chapter 108.

To the maximum extent possible, ECI services are provided in the client's natural environment, as defined in 34 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, Prescribed Pediatric Extended Care Center (PPECC)) must be documented in the client's record.

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 40 TAC, Part 2, Chapter 108).

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 40 TAC, Part 2, Chapter 108 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 40 TAC, Part 2, Chapter 108.

2.8.2.2 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

2.8.2.2.1 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.

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

2.8.2.2.2 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

2.8.2.2.3 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

2.8.2.3 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.

Referto: 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.

2.8.2.3.1 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

2.8.2.3.2 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		

2.8.2.3.3 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

The following PT and OT group therapy code may be reimbursed as an untimed procedure code, payable per encounter, and reimbursed once per date of service per discipline.

Procedure Codes
97150

2.8.2.3.4 Encounter-Based Speech Therapy Procedure Codes

The following 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.

Procedure Codes	
92507	92526

The following ST group treatment code may be reimbursed as an untimed procedure code, payable per encounter, and reimbursed once per date of service.

Procedure Codes
92508

2.8.2.3.5 Modifier Requirements for PT, OT, or ST Services

The following modifiers must be submitted for PT, OT, and ST treatment services:

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
UB	Services delivered by a therapy assistant under supervision of a licensed therapist
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-treatment services.

Modifier	Description
U3	Not used by an ECI contractor

2.8.2.3.6 Seating Assessments

Seating assessments are reimbursed in 15-minute increments (units) and must be billed with the following procedure code:

Procedure Codes
97542

The PT completing the assessment must submit procedure code 97542 with modifiers GP and UC in order to bill for the seating assessment.

Modifier	Description
GP	Services delivered under an outpatient physical therapy plan of care
UC	Assessment performed by an OT or PT

The OT completing the assessment must submit procedure code 97542 with modifiers GO and UC in order to bill for the seating assessment:

Modifier	Description
GO	Services delivered under an outpatient occupational therapy plan of care
UC	Assessment performed by an OT or PT

2.8.2.3.7 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 40 TAC Part 2, Chapter 108.

SST services must be submitted with the following procedure codes and modifiers, and they must be billed in 15-minute increments:

Procedure Code	Description	Modifier
T1027	Individual setting	U1
T1027	Group setting	

2.8.2.3.8 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 40 TAC, Part 2, Chapter 108.

ECI services must be billed under the ECI contractor's Texas Provider Identifier, National Provider Identifier, and benefit code of ECI as the insured's policy group when submitting claims.

Referto: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about benefit codes.

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.

Referto: Subsection 2.2.16, "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.

2.8.2.4 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 40 TAC, Part 2, Chapter 108.

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 40 TAC Part 2, Chapter 108.

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 40 TAC, Part 2, Chapter 108. The place of service is the location of the service coordinator at the time of service delivery.

TCM services must be submitted with the following procedure codes and modifiers, and they must be billed in 15-minute increments:

Procedure Code	Description	Modifier
T1017	Face-to-face interaction	U1
T1017	Telephone interaction	

TCM services may be delivered face-to-face or by telephone.

2.8.2.4.1 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 40 TAC, Part 2, Chapter 108.

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.

2.8.2.5 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.

2.8.3 Claims Filing and Reimbursement

2.8.3.1 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.

Referto: "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.

2.8.3.1.1 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

Units	Number of 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

2.8.3.1.2 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.

2.8.3.2 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.

2.9 Health and Behavior Assessment and Intervention

2.9.1 Services, Benefits, and Limitations

Health and Behavior Assessment and Intervention (HBAI) services are a benefit of Texas Medicaid for clients 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 client.

In many cases, the treating physician, PA, NP, or CNS will be the client's primary care provider; however, a specialist seeing a client regularly may function in a similar role to a primary care provider and may also make HBAI referrals to a co-located LPHA.

These 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 client meets all of the following criteria:

- The client 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 client is alert, oriented, and, depending on the client's age, has the capacity to understand and to respond meaningfully during the in-person evaluation.
- The client 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 client's family are a benefit when the family member directly participates in the overall care of the client.

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 client. 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					
96150	96151	96152	96153	96154	96155

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 (99201, 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.

HBAI services are limited to four 15-minute units (one hour) per day, any procedure, any provider. A unit is defined as 15 minutes of in-person evaluation time. An in-person evaluation is defined as a patient evaluation conducted by a provider who is at the same physical location as the client. 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
96150	Limited to a maximum of four 15-minute units (one hour) per client, per rolling 180 days, any provider
96151	Limited to a maximum of four 15-minute units (one hour) per client, per rolling 180 days, any provider
96152, 96153, 96154, 96155	Limited to a maximum of sixteen 15-minute units (four hours), per client, per rolling 180 days, any provider

Rural Health Clinics and Federally Qualified Health Centers may be reimbursed for client in-person evaluation visits based on encounter rates.

For re-assessment (procedure code 96151), providers must maintain documentation in the client's medical record that details the change in the mental or medical status warranting reassessment of the client's capacity to understand and cooperate with the medical interventions that are necessary to the client's health and well-being.

Clients 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 (procedure code 96150), if the client 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 client.

Referto: Section 4, “Outpatient Mental Health Services” in the *Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks)* for more information about behavioral health services beyond the acute care limitations outlined in this section.

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

After the initial 180 days of HBAI services, the client may receive another episode of HBAI with the same medical diagnosis if there is a newly identified behavioral health issue. The client may have two episodes of HBAI 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 client should be referred for those additional services that would meet the client’s biopsychosocial needs.

2.9.2 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 client 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 HBAI 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.

2.9.3 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.

Referto: “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.

2.9.4 Reimbursement

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.10 Medical Nutrition Counseling Services (CCP)

2.10.1 Enrollment

Independently practicing licensed dietitians may enroll in Texas Medicaid to provide services to CCP-eligible clients. Dietitians who provide nutrition assessments and counseling must be currently licensed by the Texas State Board of Examiners of Dietitians in accordance with the Licensed Dietitians Act, Chapter 701, Texas Occupations Code.

Referto: Subsection 2.1.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

2.10.2 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
- 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.

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 Texas State Board of Examiners of Dietitians, 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
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

2.10.3 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.

2.10.4 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.

Referto: "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 \(CCP Only\)](http://www.tmhp.com) on the TMHP website at www.tmhp.com for a claim form example.

2.10.5 Reimbursement

Dietitian services are reimbursed in accordance with 1 TAC §355.8441.

2.11 Personal Care Services (PCS) (CCP)

2.11.1 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 a TPI and a National Provider Identifier (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.

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 a TPI 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.

Referto: Subsection 2.1.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

2.11.2 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
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).

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.

2.11.2.1 Place of Services

PCS may be provided in the following settings if medically necessary:

- The client's home
- The client's school
- The client's daycare facility
- 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.

2.11.2.2 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)
- 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.

2.11.2.2.1 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.

2.11.2.2.2 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-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.

2.11.2.3 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.

2.11.3 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.*

2.11.3.1 PCS Provider Responsibilities

PCS providers must comply with all applicable federal, state, and local laws and regulations.

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.

2.11.3.2 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.

2.11.4 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.

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.

2.11.5 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.

2.11.5.1 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.

2.11.5.2 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

2.11.6 Reimbursement

Providers of PCS are reimbursed in accordance with 1 TAC §355.8441.

2.12 Community First Choice (CFC) Services

2.12.1 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.*

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.*

2.12.2 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.
- 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.

HMA tasks 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.
- 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.
- 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
Modifier	U3 (CFC attendant care for PCS - CDS Option, each 15 minutes) <i>Note: This modifier will be used for individuals receiving attendant care only.</i>
	U4 (CFC Habilitation for PCS - CDS Option, each 15 minutes) <i>Note: This modifier will be used for individuals receiving attendant care and habilitation.</i>
	U5 (CFC CDS, per month) <i>Note: This modifier is used for the administrative fee for CFC provider under the CDS option.</i>

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.

2.12.2.1 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.

2.12.3 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.

2.12.4 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.

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.

2.12.4.1 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.

2.12.4.2 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.

2.12.5 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.

2.12.5.1 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.

2.13 Private Duty Nursing (PDN)(CCP)

Referto: The *Home Health Nursing and Private Duty Nursing Services Handbook (Vol. 2, Provider Handbooks)* for information about private duty nursing (PDN) (CCP) services.

2.14 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 Skilling Nursing (SN) 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 authorization and medical necessity requirements, including a prescription from the client's ordering physician, 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.

2.14.1 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). When the services duplicate, PPECC services must be a one-to-one replacement of private duty nursing (PDN) hours, 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. A face-to-face 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. 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 plan of care 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

Referto: *The Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook (Vol. 2, Provider Handbooks)* for additional information about CCP therapy services.

Referto: *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 private duty nursing (PDN), personal care services (PCS), home health skilled nursing (HHSN), home health aide (HHA), and therapies (PT, OT, ST), as well as certified respiratory care practitioner services and early childhood intervention (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 private duty nursing and/or home health skilled nursing, home health aide services, personal care services, 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
 - Personal care services to assist with activities of daily living or instrumental activities of daily living while in the PPECC
 - 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.
 - Transportation services needed by a client to access PPECC services.
 - Transportation must be provided by a PPECC when a client has a stated need or a prescription for transportation to the PPECC.
 - When a PPECC provides transportation to a PPECC client, Registered Nurse (RN) or Licensed Vocational Nurse (LVN) employed by the PPECC must be on board the transport vehicle.
 - The client does not need to be accompanied by the client's responsible adult when a PPECC provides transportation.
 - When a client has a stated need or prescription for transportation, the client must be able to utilize transportation services offered by the PPECC with the assistance of a PPECC nurse 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 may decline a PPECC's transportation, and choose to be transported by other means, including his or her responsible adult.*

- Direct care staff, defined in licensure regulations, provides assistance with personal care services.
- 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;

- 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.

2.14.1.1 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, 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 prescription for PPECC services signed and dated by an ordering physician who has personally examined the client within 30 calendar days prior to admission and reviewed all appropriate medical records;
- 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.
- 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) and
- Hospice provider.

Note: For clients who receive their PPECC services through a Medicaid managed care organization, 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 home health skilled nursing visits.

Referto: 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.

2.14.1.1.1 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 Texas Medicaid 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 services 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 on a daily, weekly, or hourly basis.

Consistent with PPECC licensure requirements, an initial nursing assessment must be completed, signed and dated by the PPECC Registered Nurse (RN) no earlier than 3 business days before the SOC at the PPECC. The initial nursing assessment must be performed by a PPECC RN and cannot be delegated. The initial nursing assessment is used to establish the POC and must support medical necessity for the client to receive on-going skilled nursing care. The assessment must include, but is not limited to the following:

- 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.

Note: *The PPECC provider may be asked to submit additional documentation to support medical necessity as defined in this section.*

Initial prior authorization requests for PPECC services must include 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 (POC) form signed and dated by the ordering physician, the PPECC RN completing the POC, and client or client's responsible adult. A PPECC may also submit the POC on their own form, but the POC must contain the elements listed in this 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 receipt by the Texas Medicaid Claims Administrator.
- 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 ordering physician, RN completing the assessment, and client or client's responsible adult. This completed form must include:
 - Updated problem list
 - Updated rationale and summary page
 - A contingency plan
 - A 24-hour daily care flow sheet
 - Physician and client acknowledgment
 - A written or verbal order for PPECC services from the ordering physician. A physician's order (written or verbal) must be in place by the SOC. If the PPECC has a verbal order at the time the prior authorization request is submitted, dated documentation of this verbal order must be submitted separately, or it must be included on the POC.
- Per PPECC licensure requirements, the physician order must include:
 - Client's name, date of birth, gender, and Medicaid ID number
 - Provider name, address, phone number, TPI number, and NPI 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
 - Transportation authorization, if applicable
 - Other services, if applicable
 - Approval of the client's admission to the PPECC.

Note: *For authorization purposes, a physician signature on the PPECC plan of care serves as the physician order. However, the physician order as outlined above must be maintained in the client's medical records.*

- Signed and dated consent of the client or client's responsible adult documenting his/her choice of PPECC services. The signed consent must include an acknowledgement by the client or the client's responsible adult that he/she has been informed that their private duty nursing 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 must also be obtained.
 - A client 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 POC must be developed by a PPECC RN, in collaboration with an interdisciplinary team, in compliance with PPECC licensure requirements. The POC, using either the Prescribed Pediatric Extended Care (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, TPI, NPI, and hours of operation, as well as address, phone, and fax numbers
 - The ordering physician's name, phone number, TPI and NPI
 - Date the PPECC nursing assessment was completed and name, title, and credentials of the RN who completed the POC and his/her dated signature
 - Name, title and credentials of the team member who completed the POC and his/her dated signature
 - Date the client was last seen by the ordering physician
 - The requested SOC date for PPECC 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.
 - Other prescribed services, including amount, duration, and frequency
 - Nutritional requirements, including type, method of administration, and frequency
 - Medications, including the dose, route, frequency and any medication-related allergies if known
 - Treatments, including amount and frequency
 - Wound care orders and measurements
 - Safety measures to protect against injury
 - Functional developmental services and psychosocial services, including amount, duration and frequency
 - Name, phone number and signature of responsible adult when the client is a minor child
 - Client 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
- 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, skilled home health, 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 (TxHmL), and Community Living Assistance and Support Services (CLASS)).

Note: *Services provided under these programs will not prevent a client from obtaining medically necessary services.*

- Client-specific measurable goals, including, if receiving PDN, the goal of ensuring coordination of ongoing skilled nursing services with the PDN provider, if receiving PDN
- Responsible adult training needs
- Prior and current functional or medical limitations
- Permitted activities
- Client's scheduled days and hours of attendance
- Confirmation of a discharge plan, including instructions for timely discharge or referral
- Emergency contact information
- Method of transportation
- Private Duty Nursing provider name, TPI, NPI, phone, address and fax number, if known
- Ordering physician signature and date of signature

The ordering physician, PPECC RN and client or client responsible adult signatures must be current. Current is defined as signed and dated within the 30 calendar day period before the SOC. To be current, the ordering physician's dated signature must be within the 14 calendar day period following the receipt of the authorization request by the Texas Medicaid claims administrator, when services are initiated by verbal order. All the following documentation requires the ordering physician's signature with date, the CCP Prior Authorization Request form, the Prescribed Pediatric Extended Care Center (PPECC) Plan of Care, and the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form.

If documentation is submitted solely with the ordering physician's verbal order, it must be resubmitted with the ordering physician's dated signature within 14 calendar days of the receipt of the authorization request by the Texas Medicaid Claims Administrator.

If the request is not received with a dated physician signature within 14 calendar days of the receipt of the authorization request by the Texas Medicaid Claims Administrator, the prior authorization will be considered incomplete and will be denied.

When there is documentation of a verbal order, if all required documentation is not signed and dated by the ordering physician and received by the Texas Medicaid Claims Administrator within 14 calendar days of the receipt of the authorization request, claims with dates of services prior to the receipt of the signed and dated documentation will be denied.

Requests for authorizations of PPECC services should always be commensurate with the client's medical needs.

- 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 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.*

2.14.1.1.2 Revisions to the Plan of Care

The PPECC provider may request a revision to the plan of care 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.

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 Texas Medicaid 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 dates of service 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, a reassessment performed by a PPECC RN is required. A reassessment is not necessary if there is not a change in the client's condition.

The PPECC provider must notify the Texas Medicaid 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.

Revisions require all the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the ordering physician.
- An updated Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form signed and dated by the ordering physician, the PPECC RN completing the POC, and client or client's responsible adult. A PPECC may also submit the POC on its own form, but the POC must contain all required elements listed under Initial Authorizations in this 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 Texas Medicaid Claims Administrator.
- 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 ordering physician, RN completing the assessment, and client or client's responsible adult. This completed form must include:
 - Updated problem list
 - Updated rationale and summary page
 - A contingency plan
 - A 24-hour daily care flow sheet

- Physician and client acknowledgment
- A written or verbal order for PPECC services from the ordering physician. A physician's order (written or verbal) must be in place by the revised SOC. If the PPECC has a verbal order at the time the prior authorization request is submitted, dated documentation of this verbal order must be submitted separately or it must be included on the POC. The signed, dated order must be received within 14 calendar days of the receipt of the authorization request by the Texas Medicaid Claims Administrator.

Note: For authorization purposes, a physician signature on the PPECC plan of care serves as the physician order. However, the physician order, as detailed in "Initial Authorizations," must be maintained in the client's medical records.

- Signed and dated consent of the client or client's responsible adult documenting his/her choice of PPECC services. The signed consent must include an acknowledgment by the client or the client's responsible adult that he/she has been informed that their private duty nursing 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 must also be obtained.

Note: A client 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 must be current. Current is defined as signed and dated within the 30 calendar day period before the SOC. To be current, the ordering physician dated signature may be submitted within the 14 calendar day period following the receipt of the authorization request by the Texas Medicaid Claims Administrator, when services are initiated by verbal order. All the following revision documentation requires the ordering physician's dated signature: the CCP Prior Authorization Request Form, the Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form, and the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form.
- 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.

When there is a revision request, and documentation is submitted solely with the ordering physician's verbal order, it must be resubmitted with the ordering physician's signature and date within 14 calendar days of the receipt of the authorization request by the Texas Medicaid Claims Administrator. If the request is not received with a dated physician signature within 14 calendar days of the receipt of the authorization request by the Texas Medicaid Claims Administrator, the prior authorization will be considered incomplete and will be denied.

When there is documentation of a verbal order and all of the required documentation is not signed and dated by the ordering physician and received by TMHP within 14 calendar days of the receipt of the authorization request by the Texas Medicaid Claims Administrator, claims with dates of services prior to receipt of the signed and dated documentation will be denied.

2.14.1.1.3 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, clients may not receive PPECC services beyond the limitations outlined in this section.

2.14.1.1.4 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. Revision 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 nursing assessment 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 no more than 30 calendar days and no fewer than 7 calendar days before a current authorization period will expire. Requests received after the current authorization expires will be denied for dates of service that occurred before the date the request is received. The following documentation is required for a recertification request:

- A completed CCP Prior Authorization Request form signed and dated by the ordering physician within 30 calendar days prior to the SOC date.
- A completed Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form, signed and dated by the ordering physician, the PPECC RN completing the POC, and client or client's responsible adult within 30 calendar days prior to the SOC date. A PPECC may also submit the POC on their own form, but the POC must contain the elements listed under "Initial Authorization Request" requirements in this section.
 - The PPECC provider is responsible for ensuring that the ordering 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.
- 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 ordering physician, RN completing the assessment, and client or client's responsible adult within 30 calendar days prior to the SOC date. The addendum must include an updated 24-hour nursing services flow sheet and if there are changes, an updated problem list, and updated rationale summary page, a contingency plan, and a signed physician and client acknowledgment.
- A written order for PPECC services signed and dated by the client's ordering physician. A physician's order must be in place by the SOC.

Note: *For authorization purposes, a physician signature on the PPECC plan of care serves as the physician order. However, the physician order, with elements outlined in "Initial Authorization Requests," must be maintained in the client's medical record.*

- Signed, dated consent of the client or client's responsible adult documenting their choice of PPECC services. The signed consent must include an acknowledgment by the client or the client's responsible adult that he/she has been informed that other services such as private duty nursing 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, as needed to ensure coordination of care, must also be obtained.

Note: *A client 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 provider may request a revision of a recertification at any time during the recertification period. Revisions must follow the instructions outlined under Revisions in this section. 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 recertification.

2.14.1.1.5 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 PA request from the new provider.
- After receiving PPECC services, the client opts to decline PPECC services and receive his or her 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.

2.14.1.1.6 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 Medicaid 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 3 business days for initial, or revision requests; and no more than seven calendar days for recertification requests when additional documentation is submitted.

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 not 20 years of age or younger.
- The client's needs are not beyond the scope of services available through Medicaid Title XIX Home Health SN 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.
- The signed and dated POC is not received by the claims administrator within fourteen business days from the SOC.
- 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.

Prior authorization requests must be submitted for processing to the Texas Medicaid Claims Administrator Prior Authorization Department (fee-for-service clients).

Note: *Clients enrolled in a managed care health plan may receive services from a PPECC. Prior authorization requests for these clients must be submitted solely to the client's managed care organization.*

2.14.1.1.7 Documentation Requirements

In addition to documentation requirements outlined in the "Authorization Requirements" section, the following documentation requirements apply. Services not supported by documentation are subject to recoupment.

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.

PPECCs must maintain documentation in the client's medical record, including but not limited to the following:

- Evidence that the client's condition will allow safe delivery of PPECC services as described in the POC.
- The PPECC nursing assessment.
- The client's individualized PPECC plan of care and documentation of medical necessity.
- The physician's specific, written, signed and dated orders for PPECC services. Documentation of verbal orders must also be maintained.
- All prior authorization request forms for Medicaid.
- The signed, dated consent of the client or the client's responsible adult.
- The PPECC must provide documentation that the client or the client's responsible adult has been informed about how care will be coordinated between the client's providers (e.g., client signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers).
- The PPECC must maintain evidence in the medical record that client or the client's responsible adult has been involved in the development of the POC. (e.g., client signature on the Prescribed Pediatric Extended Care Center [PPECC] Plan of Care).
- Evidence of PDN provider notification when a child receives PDN, and the date notification was provided.
- 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 child was hospitalized; or the client's responsible adult was ill and could not provide services that he or she would normally provide.
- For each day that PPECC services are provided, the client's medical record must identify:
 - The names of the specific person (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.

- The PPECC must be able to calculate the cost by practitioner and type of service provided as requested by HHSC.

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 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.

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 must sign, date, and indicate the time the client is boarded on PPECC transportation, and the time when the client arrives at the PPECC. The PPECC must also sign, date, and indicate the time when the client is boarded for a return trip from PPECC services, as well as the arrival time at the client's destination. 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.

For any Medicaid client that is in transport for longer than one hour, the PPECC must document the reason for the extended time in transport.

A responsible adult must sign and confirm the time that the client is boarded on PPECC transportation, as well as when a client returns from the PPECC. If a responsible adult provides the transportation, the responsible adult must sign and indicate the date and time that the client is dropped off and picked up from a PPECC. The PPECC provider must keep these records in case of an audit or monitoring.

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 and/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 and/or the client's responsible adult, and
- The client's ordering physician was notified of the date of transfer or discharge.

The PPECC and the therapy provider must have a written agreement for each client 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 responsibilities of both parties, and how the parties will coordinate related to the client's plan of care. The written agreement must be kept in the client's medical record.

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 responsibilities of both parties, and how the parties will coordinate related to the client's plan of care. The written agreement must be kept in the client's medical record.

2.14.1.1.8 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 early childhood intervention services.
 - Durable medical equipment (DME), medical supplies, nutritional products provided to the client by Medicaid's DME and medical supply service providers.
 - Private duty nursing, skilled nursing and home health aid 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.

2.14.1.1.9 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 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 T1025. At a minimum, four hours and fifteen minutes of services must be provided before T1025 may be billed.

Procedure code T2002 is not allowed without a PPECC service on the same day, same provider.

For procedure code T1026, a minimum of 15 minutes of service is required to round up to a full hour after the first hour.

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

PCS services provided in a PPECC are considered part of the PPECC billable rate. PCS services rendered in a client's home may be billed before or after PPECC services on the same day.

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 Texas Medicaid 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 situation and needs. 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.

2.15 Therapy Services (CCP)

Referto: 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 CCP therapy services.

2.16 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.

Referto: Subsection 3.4, "Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)*.

2.17 Inpatient Rehabilitation Facility (Freestanding) (CCP)

2.17.1 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.

Referto: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.17.1.1 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 download the HHSC Medicaid Provider Agreement from the TMHP website at www.tmhp.com.

2.17.2 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.

2.17.2.1 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.

2.17.3 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.
- 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.

2.17.4 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.

Referto: “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 \(Freestanding\) \(CCP Only\)](http://www.tmhp.com) on the TMHP website at www.tmhp.com for a claim form example.

2.17.5 Reimbursement

Reimbursement for care provided in the freestanding inpatient rehabilitation facility is made under the Texas Diagnosis-Related Group (DRG) Payment System.

A new provider is given a reimbursement interim rate of 50 percent until a cost audit has been performed. Payment is calculated by multiplying the standard dollar amount (SDA) for the hospital's payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Important: *Outpatient services are not reimbursed.*

The DRG payment may be enhanced by an adjusted day or cost outlier payment, if applicable. For example, the limit per spell-of-illness under Texas Medicaid guidelines is waived for clients who are birth through 20 years of age. An outlier payment may be made to compensate for unusual resource utilization or a lengthy stay.

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 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.

To establish a cost outlier, TMHP determines the outlier threshold by using the greater of the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universe mean of the current base year data multiplied by 11.14 or the hospital's SDA multiplied by 11.14.

The calculation that yields the greater amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under the TEFRA principles and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

If an admission qualifies for both a day and a cost outlier, the outlier resulting in the highest payment to the hospital is paid.

The Remittance and Status (R&S) Report reflects the outlier reimbursement payment and defines the type of outlier paid, day or cost.

Providers should call the TMHP provider relations representative for their area with questions about the outlier payment.

2.17.5.1 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.

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 School Health and Related Services (SHARS)

3.1 Overview

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as SHARS. The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services provided to students in special education under IDEA that are documented in a student's Individualized Education Program (IEP).

Important: *CMS requires school districts to be enrolled as a SHARS Medicaid provider, participate in the Random Moment Time Study (RMTS), claim on an interim basis, and submit an annual SHARS Cost Report.*

SHARS reimbursement is provided for students who meet all of the following requirements:

- Are 20 years of age and younger and eligible for Medicaid
- Meet eligibility requirements for special education described in IDEA
- Have IEPs that prescribe the needed services

Services covered by SHARS includes:

- Audiology services
- Counseling
- Nursing services
- Occupational therapy (OT)
- Personal care services (PCS)
- Physical therapy (PT)
- Physician services
- Psychological services, including assessments
- Speech therapy (ST)
- Transportation in a school setting

These services must be provided by qualified personnel who are under contract with or employed by the school district.

3.1.1 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 three annual RMTS quarters, and compliance with participation requirements for selected sampled moments. The three annual RMTS quarters are October through December, January through March, and April through June. A July through September RMTS is not conducted.

An existing school district can only become a SHARS provider effective October 1, each year and they must participate in all three RMTS quarters for that annual period. SHARS providers that do not participate in all three 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 school district can return to participating in the SHARS program the following federal fiscal year beginning on October 1.

A new school district (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.

School districts can access the Texas Time Study Guide, on the HHSC website at www.hhsc.state.tx.us/rad/time-study/ts-isd.shtml and refer to the link titled Guides/Manuals.

SHARS providers can contact the HHSC Time Study Unit by email at TimeStudy@hhsc.state.tx.us or by telephone at 1-512-491-1715.

3.1.2 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.

3.2 Enrollment

3.2.1 SHARS Enrollment

To enroll in Texas Medicaid as a SHARS provider, school districts, including public charter schools, must employ or contract with individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS to provide program services. Since public school districts are government entities, they should select "public entity" on the enrollment application.

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. Most SHARS providers currently 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 (school district) provide a required 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.

Referto: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in “Section 2: Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*) for more information.

3.2.2 Private School Enrollment

A private school may not participate in the SHARS program as a SHARS provider.

3.3 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, physician services, nursing services, psychological services, OT, PT, or ST services, personal care services, and transportation.

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.*

3.3.1 Audiology

Audiology evaluation services include:

- 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 habilitation of hearing
- Determination of the child’s need for group and individual amplification

Audiology therapy services include the provision of habilitation activities, such as language habilitation, auditory training, audiological maintenance, speech reading (lip reading), and speech conversation.

Audiology services must be provided by a professional who holds a valid state license as an audiologist or by an audiology assistant who is licensed by the state when the assistant is acting under the supervision of a qualified audiologist. State licensure requirements are equal to American Speech-Language-Hearing Association (ASHA) certification requirements.

Audiology evaluation is billable on an individual (procedure code 92620) basis only. Audiology evaluation (procedure code 92620) is limited to a combined maximum total of twelve units in a 30-day period.

Audiology therapy is billable on an individual (procedure code 92507) and group (procedure code 92508) basis.

Only the time spent with the student present is billable; time spent without the student present is not billable.

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).

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.

3.3.1.1 Audiology Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Assistant
1, 2, or 9	92507 with modifier U9	Individual	Licensed audiologist
1, 2, or 9	92507 with modifier U1	Individual	Licensed assistant
1, 2, or 9	92508 with modifier U9	Group	Licensed audiologist
1, 2, or 9	92508 with modifier U1	Group	Licensed assistant
1, 2, or 9	92620	Individual	Licensed audiologist

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Referto: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for audiology evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct audiology therapy (individual or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.2 Counseling Services

Counseling services are provided to help a child with a disability benefit from special education and must be listed in the IEP. 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
- Health and behavior interventions 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

Counseling services must be provided by a professional who has one of the following certifications or licensures: a licensed professional counselor (LPC), a licensed clinical social worker (LCSW), or a licensed marriage and family therapist (LMFT).

Counseling services are billable on an individual (procedure code 96152) or group (procedure code 96153) basis. Session notes are required and documentation must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency counseling services as long as the student’s IEP includes a behavior improvement plan that documents the need for emergency services.

3.3.2.1 Counseling Services Billing Table

POS*	Procedure Code	Individual or Group
1, 2, or 9	96152 with modifier UB	Individual
1, 2, or 9	96153 with modifier UB	Group

*Place of Service: 1 = Office; 2 = Home; 9 = Other Locations

Providers must use a 15-minute unit of service for billing.

Referto: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time (individual or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.3 Psychological Testing and Services

3.3.3.1 Psychological Testing

Evaluations or assessments include activities related to the evaluation of the functioning of a student for the purpose of determining eligibility, the needs for specific SHARS services, and the development or revision of IEP goals and objectives. An evaluation or assessment 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.

Evaluations or assessments (procedure code 96101) 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 34 CFR §300.136(a)(1).

Evaluation or assessment 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/teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities
- Time spent without the student present for the interpretation of testing results
- Report writing

Time spent gathering information without the student present or observing a student is not billable evaluation or assessment time.

Session notes are not required; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note which assessment activity was performed (e.g., testing, interpretation, or report writing).

3.3.3.1.1 Evaluation or Assessment Billing Table

POS*	Procedure Code	Individual/Group	Unit of Service
1, 2, or 9	96101	Individual	1 hour
*Place of Service: 1=office; 2=home; 9=other locations			

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.

Referto: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

When billing, minutes of Evaluations or Assessments are not accumulated over multiple days. Minutes of Evaluations or Assessments can only be billed per calendar day.

The recommended maximum billable time for psychological testing is eight hours (8.0 units) over a 30-day period. Time spent for the interpretation of testing results without the student present is billable time. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.3.2 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. Nothing in this rule prohibits 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. School districts 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 school district. 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(1)(B).

All psychological services are billable on an individual (procedure code 96152) or group (procedure code 96153) basis.

Session notes are required. 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.

School districts may receive reimbursement for emergency psychological services as long as the student's IEP includes a behavior improvement plan that documents the need for the emergency services.

3.3.3.2.1 Psychological Services Billing Table

POS*	Procedure Code	Individual or Group
1, 2, or 9	96152 with modifier AH	Individual
1, 2, or 9	96153 with modifier AH	Group
*Place of Service: 1=office; 2=home; 9=other locations		

Providers must use a 15-minute unit of service for billing.

Referto: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time for direct psychological therapy (individual or group) is a total of one hour per day for nonemergency situations. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.4 Nursing Services

Nursing services are SN tasks, as defined by the Texas BON, that are included in the student's IEP. Nursing services may be direct nursing care or medication administration. 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
- Tube feeding
- Suctioning
- Client training
- Assessment of a student's nursing and personal care services needs

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 must be provided by an RN, an APRN (including NPs and CNSs), LVN, LPN, or a school health aide or other trained, unlicensed assistive person delegated by an RN or APRN.

Nursing services are billable on an individual or group basis. Only the time spent with the student present is billable. Time spent without the student present is not billable. Session notes are not required for nursing services; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of nursing service that was performed.

3.3.4.1 Nursing Services Billing Table

POS*	Procedure Code	Individual or Group	Unit of Service
1, 2, or 9	T1002 with modifier TD	Individual	15 minutes
1, 2, or 9	T1002 with modifier TD and UD	Group	15 minutes
1, 2, or 9	T1502 with modifier TD		Medication administration, per visit
1, 2, or 9	T1002 with modifier U7	Delegation, Individual	15 minutes
1, 2, or 9	T1002 with modifier U7 and UD	Delegation, group	15 minutes
1, 2, or 9	T1502 with modifier U7		Delegation, medication administration, per visit
1, 2, or 9	T1003 with modifier TE	Individual	15 minutes
1, 2, or 9	T1003 with modifier TE and UD	Group	15 minutes
1, 2, or 9	T1502 with modifier TE		Medication, administration per visit

*Place of Service: 1=office; 2=home; 9=other locations
 Modifier TD = nursing services provided by an RN or APRN
 Modifier U7 = nursing services delivered through delegation
 Modifier TE = nursing services delivered by an LVN/LPN
 Modifier UD = nursing services delivered on a group basis

The Medicaid-allowable fee is determined based on 15-minute increments. Providers must use a 15-minute unit of service for billing.

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. Do not convert minutes of nursing services separately for each nursing task that was performed.

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 is less than eight minutes for a calendar day, then no unit of service can be billed for that day, and that day's minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.

Referto: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time for direct nursing services is four hours per day. The recommended maximum billable units for procedure code T1502 with modifier TD, T1502 with modifier U7, or T1502 with modifier TE is a total of four medication administration visits per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.5 Occupational Therapy (OT)

3.3.5.1 Referral

In order for a student to receive OT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribed the OT must be provided.

3.3.5.2 Description of Services

OT evaluation services include determining what services, assistive technology, and environmental modifications a student requires for participation in the special education program.

OT includes:

- 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.

OT must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners or an occupational therapy assistant (OTA) acting under the supervision of a qualified occupational therapist.

OT evaluation is billable on an individual (procedure code 97165, 97166, or 97167) basis only. Procedure codes 97165, 97166, and 97167 may be submitted for initial evaluations and reevaluations. OT is billable on an individual (procedure code 97530) or group (procedure code 97150) basis.

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 COTA 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.

Session notes are not required for procedure codes 97165, 97166, and 97167; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., OT evaluation).

Session notes are required for procedure codes 97530 and 97150. 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.

3.3.5.3 Occupational Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Assistant
1, 2, or 9	97165, 97166, and 97167	Individual	Licensed therapist
1, 2, or 9	97150 with modifier GO	Group	Licensed therapist
1, 2, or 9	97150 with modifier GO and U1	Group	Licensed therapy assistant
1, 2, or 9	97530 with modifier GO	Individual	Licensed therapist
1, 2, or 9	97530 with modifier GO and U1	Individual	Licensed therapy assistant

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Referto: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for OT evaluation is three hours, which may be billed over several days within a 30 day period. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.6 Personal Care Services

Personal care services are provided to help a child with a disability or chronic condition benefit from special education. Personal care services include a range of human assistance provided to persons with disabilities or chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a functional, cognitive, or behavioral impairment.

Referto: Subsection 2.11, “Personal Care Services (PCS) (CCP)” in this handbook for a list of ADLs and IADLs.

For personal care services to be billable, they must be listed in the student’s IEP. Personal care services are billable on an individual (procedure code T1019 with modifier U5 or U6) or group (procedure code T1019 with modifier U5 and UD or U6 and UD) basis.

Session notes are not required for procedure codes T1019 with modifier U5 or T1019 with modifier U5 and UD; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of personal care service that was performed.

Procedure codes T1019 with modifier U6 and T1019 with modifier U6 and UD are billed using a one-way trip unit of service.

3.3.6.1 Personal Care Services Billing Table

POS*	Procedure Code	Individual or Group	Unit of Service
1, 2, or 9	T1019 with modifier U5	Individual, school	15 minutes
1, 2, or 9	T1019 with modifier U5 and UD	Group, school	15 minutes
1, 2, or 9	T1019 with modifier U6	Individual, bus	Per one-way trip
1, 2, or 9	T1019 with modifier U6 and UD	Group, bus	Per one-way trip

*Place of Service: 1=office; 2=home; 9=other locations

Referto: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable units for T1019 with modifier U6 or T1019 with modifier U6 and UD is a total of four one-way trips per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended units of service are billed.

3.3.7 Physical Therapy (PT)

3.3.7.1 Referral

In order for a student to receive PT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribes the PT must be provided.

3.3.7.2 Description of Services

PT evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems.

PT is provided for the purpose of preventing or alleviating movement dysfunction and related functional problems.

PT must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners or a licensed physical therapist assistant (LPTA) acting under the supervision of a qualified physical therapist.

PT evaluation is billable on an individual (procedure code 97161, 97162, or 97163) basis only. Procedure codes 97161, 97162, and 97163 may be submitted for initial evaluations and reevaluations. PT is billable on an individual (procedure code 97110) or group (procedure code 97150) basis.

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 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.

Session notes are not required for procedure codes 97161, 97162, and 97163; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., PT evaluation). Session notes are required for procedure codes 97110 and 97150.

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.

3.3.7.3 Physical Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Assistant
1, 2, or 9	97161, 97162, and 97163	Individual	Licensed therapist
1, 2, or 9	97110 with modifier GP	Individual	Licensed therapist
1, 2, or 9	97110 with modifier GP and U1	Individual	Licensed therapy assistant
1, 2, or 9	97150 with modifier GP	Group	Licensed therapist
1, 2, or 9	97150 with modifier GP and U1	Group	Licensed therapy assistant

POS*	Procedure Code	Individual or Group	Therapist or Assistant
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*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Referto: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for PT evaluation is three hours, which may be billed over several days within a 30 day period. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.8 Physician Services

Diagnostic and evaluation services are reimbursable under SHARS physician services. Physician services must be provided by a licensed physician (M.D. or D.O.). A physician prescription is required before PT or OT services may be reimbursed under SHARS. ST services require either a physician prescription or a referral from a licensed SLP before the ST services may be reimbursed under the SHARS program. The school district must maintain the prescription or referral. The prescription or referral must relate directly to specific services listed in the IEP. If a change is made to a service on the IEP that requires a prescription or referral, the prescription or referral must be revised accordingly.

The expiration date for the physician prescription is the earlier of either the physician’s designated expiration date on the prescription or three years, in accordance with the IDEA three-year re-evaluation requirement.

SHARS physician services are billable only when they are provided on an individual basis. The determination as to whether or not the provider needs to see the student while reviewing the student’s records is left up to the professional judgment of the provider. Therefore, billable time includes the following:

- The diagnosis or evaluation time spent with the student present
- The time spent without the student present reviewing the student’s records for the purpose of 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

Session notes are not required for procedure code 99499; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the medical activity that was performed.

3.3.8.1 Physician Services Billing Table

POS*	Procedure Code
1, 2, or 9	99499

*Place of Service: 1 = Office; 2 = Home; 9 = Other Locations

Providers must use a 15-minute unit of service for billing.

Referto: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.9 Speech Therapy (ST)

3.3.9.1 Referral

The name and complete address or the provider identifier or license number of the referring licensed physician or licensed SLP is required before ST services can be billed under SHARS. A licensed SLP's evaluation and recommendation for the frequency, location, and duration of ST serves as the speech referral.

3.3.9.2 Description of Services

ST evaluation services include the identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language disorders. ST services include the provision of speech and language services for the habilitation or prevention of communicative disorders.

ST evaluation is billable on an individual (procedure codes 92521, 92522, 92523, and 92524) basis only. ST is billable on an individual (procedure code 92507) or group (procedure code 92508) basis.

Procedure codes 92521, 92522, 92523, and 92524 are limited to a total of 12 units and may be reimbursed for each client per provider in a 30-day period.

Procedure code 92522 will be denied if it is submitted with the same date of service as procedure code 92523.

Procedure code 92523 will be denied if it is submitted with 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. Session notes are not required for procedure codes 92521, 92522, 92523, and 92524; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., speech evaluation).

Session notes are required for procedure codes 92507 and 92508. 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.

3.3.9.3 Provider and Supervision Requirements

ST services are eligible for reimbursement when they are provided by a qualified SLP, who holds a Texas license or an ASHA-equivalent SLP (has a master's degree in the field of speech-language pathology and a Texas license). ST services are also eligible for reimbursement when provided by an SLP with a state education agency certification, a licensed SLP intern, a grandfathered SLP when acting under the supervision or direction of an SLP, or a licensed assistant in speech-language pathology acting under the supervision or direction of an SLP.

The supervision must meet the following provisions:

- The supervising SLP must provide supervision that is sufficient to ensure the appropriate completion of the responsibilities that were assigned.
- The direct involvement of the supervising SLP in overseeing the services that were provided must be documented.
- 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 State Board of Examiners for Speech-Language Pathology and Audiology which relate to Licensed Interns or Assistants in Speech-Language Pathology.

CMS interprets “under the direction of a speech-language pathologist,” as an SLP who:

- Is directly involved with the individual under his direction.
- Accepts professional responsibility for the actions of the personnel he agrees to direct.
- Sees each student at least once.
- Has input about the type of care provided.
- Reviews the student’s speech records after the therapy begins.
- Assumes professional responsibility for the services provided.

3.3.9.4 Speech Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Assistant
1, 2, or 9	92521, 92522, 92523, or 92524 with modifier GN	Individual	Licensed therapist
1, 2, or 9	92507 with modifier GN and U8	Individual	Licensed therapist
1, 2, or 9	92507 with modifier GN and U1	Individual	Licensed assistant
1, 2, or 9	92508 with modifier GN and U8	Group	Licensed therapist
1, 2, or 9	92508 with modifier GN and U1	Group	Licensed assistant

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Referto: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.10 Transportation Services in a School Setting

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
- The special transportation service is included in the student’s IEP

A specially adapted vehicle is one that has been physically modified (e.g., addition of a wheelchair lift, addition of seatbelts or harnesses, addition of child protective seating, or addition of air conditioning). A 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. Specialized transportation services reimbursable under SHARS requires the Medicaid-eligible 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

Children with special education needs who ride the regular school bus to school with other nondisabled children are not required to have the transportation services in a school setting listed in their IEP. Also, the cost of the regular school bus ride cannot be billed to SHARS. Therefore, the fact that a child may receive a service through SHARS does not necessarily mean that the transportation services in a school setting may be reimbursed for them.

Reimbursement for covered transportation services is on a 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 district
- From a provider's office that is contracted with the district to the student's residence
- From the school to a provider's office that is contracted with the district
- From a provider's office that is contracted with the district 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). Documentation of each one-way trip provided must be maintained by the school district (e.g., trip log). This service must not be billed by default simply because the student is transported on a specially adapted bus.

3.3.10.1 Transportation Services in a School Setting Billing Table

POS*	Procedure Code	Unit of Service
1, 2, or 9	T2003	Per one-way trip
*Place of Service: 1=office; 2=home; 9=other locations		

The recommended maximum billable units for procedure code T2003 is a total of four one-way trips per day.

3.3.11 Prior Authorization

Prior authorization is not required for SHARS services.

3.4 Documentation Requirements

3.4.1 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 billings must be maintained by the school district until all audit questions, appeal hearings, investigations, or court cases are resolved. Records must be stored in a 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)

- 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
- Supervision logs
- Special transportation logs
- Claims submittal and payment histories

All services require documentation to support the medical necessity of the service rendered, including SHARS services. SHARS services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.5 Claims Filing and Reimbursement

During the cost report period, school districts participating in SHARS are reimbursed on an interim claiming basis using SHARS interim rates. It is important that SHARS providers understand that SHARS interim payments are provisional in nature. The total allowable costs for providing services for SHARS must be documented by submitting the required annual cost report.

3.5.1 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 (i.e., January 3), whichever comes first.

Referto: “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.

3.5.1.1 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 client’s name and Medicaid number.

3.5.1.2 Billing Units Based on 15 Minutes

All claims for reimbursement 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 (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour.

Reminder: *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, $68 \text{ total billable minutes} / 15 = 4 \text{ units} + 8 \text{ minutes}$. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, $68 \text{ total billable minutes} = 5 \text{ units of service}$.

Examples:

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

3.5.1.3 Billing Units Based on an Hour

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. 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.

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 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:

Minutes	Units
0 mins–3 mins	0 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

Other examples:

Minutes	Units
58 mins–63 mins	1 unit
64 mins–69 mins	1.1 units
70 mins–75 mins	1.2 units

Minutes	Units
76 mins–81 mins	1.3 units
82 mins–87 mins	1.4 units
88 mins–93 mins	1.5 units

3.5.2 Managed Care Clients

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 MCO.

3.5.3 Reimbursement

Providers are reimbursed for medical and transportation services provided under the SHARS Program on a cost basis using federally mandated allocation methodologies in accordance with 1 TAC §355.8443.

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. The interim claims are based on SHARS interim rates but are provisional in nature.

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.

If a provider's interim payments exceed 99 percent of the provider's federal portion of the total certified Medicaid allowable costs, the provider must repay the over payments or HHSC will offset all of the provider's future claims payments until the amount is recovered.

If 99 percent of the provider's federal portion of the total certified Medicaid allowable costs exceeds the interim Medicaid payments, HHSC will pay the difference to the provider in accordance with the final actual certification agreement.

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.

School districts can access SHARS interim rates and published cost report guidance documents, on the HHSC website at <https://rad.hhs.texas.gov/acute-care/school-health-and-related-services-shars>.

For additional information SHARS providers can contact a SHARS Rate Analyst by email at ra_shars@hhsc.state.tx.us or by telephone at 1-512-730-4300.

Referto: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information.

Subsection 2.9, "Federal Medical Assistance Percentage (FMAP)" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

3.5.3.1 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 federal fiscal year (October 1 through September 30). The purpose of the statement is to verify that the school district 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 federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the date of service and not the date of payment.

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 1-800-925-9126.

Referto: “Subsection A.12.4, “TMHP Provider Relations” in “Appendix A: State, Federal, and TMHP Contact Information” (*Vol. 1, General Information*)” for more information about provider relations representatives.

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 1-800-925-9126 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 3.6, “Cost Reporting, Cost Reconciliation, and Cost Settlement” in this handbook for additional information about cost reporting.

3.6 Cost Reporting, Cost Reconciliation, and Cost Settlement

CMS requires annual cost reporting, cost reconciliation, and cost settlement processes for all Medicaid SHARS services delivered by school districts. CMS requires that school districts, 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.

3.6.1 Cost Reporting

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous federal fiscal year (October 1 through September 30). The cost report is due on or before April 1 of the year following the reporting period.

School districts can access published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml.

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.

For additional information, SHARS providers can contact a SHARS Rate Analyst by email at ra_shars@hhsc.state.tx.us or by telephone at 1-512-730-7400.

3.6.2 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.

3.6.3 Informal Review of Cost Reports Settlement

An ISD or the Superintendent, Chief Financial Officer, Business Officer, or other ISD 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 district disputes, the ISD'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.

School districts can access published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml. For additional information, SHARS providers can contact a SHARS Rate Analyst by email at ra_shars@hhsc.state.tx.us or by telephone at 1-512-730-7400.

4 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*.

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.

Referto: The *Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks)* or to the HHSC website at www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml, 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.

4.1 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.
- Complete the Dental Provider Enrollment Application and return it to TMHP.

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).

Providers can download and print dental provider enrollment application forms from the TMHP website at www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 to request them.

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.

A dentist must complete the Dental Provider Enrollment Application for each separate practice location and will receive a unique provider identifier for each practice location if the application is approved.

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 orthodontic services must be enrolled as a dentist or orthodontist provider for THSteps and must have at least one of the following qualifications.

THSteps dental providers may perform and be reimbursed for orthodontic services if they have attested to at least one of the following requirements:

- Completion of a dental pediatric specialty residency
- 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.)

Orthodontist providers are eligible to provide orthodontic services. In order to comply 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.

Referto: “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.

4.1.1 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

4.1.2 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.

Referto: Subsection 4.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

4.1.3 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.

4.1.4 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 a Medicaid provider identifier.
- Enroll as a Medicaid provider with a limited physician provider identifier.

4.1.5 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.

4.1.6 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.

4.2 Services, Benefits, Limitations, and Prior Authorization

4.2.1 THSteps Dental Services

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

THSteps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients 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.

Referto: The *Medical Transportation Program Handbook (Vol. 2, Provider Handbooks)* for information about transportation arrangements.

4.2.1.1 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.

4.2.1.2 Parental Accompaniment

Children who are 14 years of age and younger must be accompanied to THSteps dental appointments by a parent, legal guardian, or another adult who is authorized by the parent or guardian unless the services are provided by an exempt entity as defined by the Human Resources Code. For additional information and exceptions, see Subsection D.5, "Parental Accompaniment" in this handbook.

4.2.2 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. 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 National Provider Identifier (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.

4.2.2.1 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.

Procedure Code	Limitations
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.	
D0120*	A Birth–20. Limited to one every six months by the same provider. Denied when submitted for the same DOS as D0145 by any provider.
D0140*	Used for problem-focused examination of a specific tooth or area of the mouth. Limited to one service per day by the same provider or to two services per day by different providers. Denied when submitted for the same DOS as D0160 by the same provider. A Birth–20, N
D0145*	Limited to one service per day and ten times a lifetime, with a minimum of 60 days between dates of service. Providers must be certified by Texas Health Steps staff to perform this procedure. Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, or D8660 will be denied when submitted by any provider for the same DOS. A 6–35 months
D0150*	Used for a comprehensive oral evaluation. Limited to one service every three years by the same provider. Denied when submitted for the same DOS as D0145 by any provider. A Birth–20
D0160*	Used for a problem focused, detailed and extensive oral evaluation. Limited to one service per day by the same provider. Not payable for routine postoperative follow-up. Denied when submitted for the same DOS as D0145 by any provider. A 1–20, N, CCP
D0170*	Limited to one service per day by the same provider. When used for emergency claims, refer to General Information. Denied when submitted for the same DOS as procedure code D0140 or D0160 by the same provider. Denied when submitted for the same DOS as D0145 by any provider. A Birth–20
D0180*	Used for periodontal evaluation. Denied when submitted for the same DOS as D0120, D0140, D0145, D0150, D0160 or D0170 by the same provider. A 13–20
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	

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 is submitted for reimbursement. 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)

Procedure Code	Limitations
Radiographs/Diagnostic Imaging (Including Interpretation)	
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 Panorex 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.	
D0210	Limited to one service every three years by the same provider. Will be denied when submitted on an emergency claim. A 2–20
D0220	Limited to one service per day by the same provider. A 1–20
D0230	The total cost of periapicals and other radiographs cannot exceed the payment for a complete intraoral series. A 1–20
D0240	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. May be submitted as an emergency service. A Birth–20
D0250	Limited to one service per day by the same provider. A 1–20, N, CCP
D0270	Limited to one service per day by the same provider. 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	

Procedure Code	Limitations
D0272	Limited to one service per day by the same provider. Denied when submitted for the same DOS as D0210 by any provider. A 1–20
D0273	Limited to one service per day by the same provider. Denied when submitted for the same DOS as D0210 by any provider. A 1–20
D0274	Limited to one service per day by the same provider. Denied when submitted for the same DOS as D0210 by any provider. A 2–20
D0277	Limited to one service per day by the same provider. Not to be submitted within 36 months of D0210 or D0330. Denied when submitted for the same DOS as D0330 by the same provider. Denied when submitted for the same DOS as D0210 by any provider. A 2–20
D0310	A 1–20, N, CCP
D0320	A 1–20, N, CCP
D0321	A 1–20, N, CCP
D0322	A 1–20, N, CCP
D0330*	Limited to one service per day, any provider, and to one service every three years by the same provider. Not allowed on emergency claims unless third molars or a traumatic condition is involved. For clients who are 2 years of age and younger, must document the necessity of a panoramic film. The Panorex 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. A 3–20
D0340*	Limited to one service per day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A 1–20, N, CCP
D0350*	Limited to one service per day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A Birth–20
D0367	Prior authorization is required. Limited to a combined maximum of three services per year, any provider. Additional services may be considered with documentation of medical necessity. A Birth-20
<i>Note: Radiograph codes do not include the exam. If an exam is also performed, providers must submit the appropriate ADA procedure code.</i>	
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	

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			

Procedure Code	Limitations
Tests and Examinations	
D0415	A 1-20, N, CCP
D0425	Not reimbursable separately. Considered part of another dental procedure.
D0460	Limited to one service per day by the same provider. Not payable for primary teeth. Will deny when submitted for the same DOS as any endodontic procedure. A 1-20, N, CCP
Tests and Examinations continued	
D0470*	Not reimbursable separately when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup is performed. A 1-20, N, CCP
Oral Pathology Laboratory	
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	A 1-20, N, CCP
D0999	A 1-20, 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	

4.2.2.2 Preventive Services

Procedure Code	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. A 13-20
D1120*	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, or with procedure code D0145. A 6 months-12 years
Topical Fluoride Treatment (Office Procedure)	
D1206	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 or with procedure code D0145. A 6 months-20 years, N, CCP
D1208	Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. A 6 months-20 years, 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	

Procedure Code	Limitations
Other Preventive Services	
D1310	Denied as part of all preventative, therapeutic and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to a THSteps primary care physician.
D1320	A client requiring tobacco counseling may be referred to a THSteps primary care provider.
D1330	Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure refers to services above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the client's care. 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 deciduous (baby or primary) teeth or permanent teeth. Indicate the tooth numbers and surfaces 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. Sealants and replacement sealants are limited to one every 3 years per tooth by the same provider or provider group. Dental sealants performed more frequently than once every three years by a different provider are also a benefit if the different provider is not associated with the provider or provider group that initially placed the sealant on the tooth. If submitted on emergency claim, procedure code will be denied. A Birth-20
D1352	Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. A 5-20
Space Maintenance (Passive Appliances)	
Space maintainers are a benefit of Texas Medicaid after premature loss of primary or secondary molars (TID A, B, I, J, K, L, S, and T for clients who are 1 through 12 years of age, and after loss of permanent molars (TID 3, 14, 19, and 30) for clients who are 3 through 20 years of age. Limited to 1 space maintainer per TID, per lifetime, per client. When procedure code D1510 or D1515 have been previously reimbursed, the recementation of space maintainers (procedure code D1550) may be considered for reimbursement to either the same or different THSteps dental provider. Replacement space maintainers may be considered upon appeal with documentation supporting medical necessity. Removal of a fixed space maintainer is not payable to the provider or dental group practice that originally placed the device.	
D1510*	A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), MTID
Space Maintenance (Passive Appliances) continued	
D1515*	A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), MTID
D1520*	A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), 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	

Procedure Code	Limitations
D1525*	A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), MTID
D1550	A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), MTID
D1555*	A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), MTID
D1575	A 3-7 (TIDs #A, J, K, T), MTID
<p>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</p>	

4.2.2.3 Therapeutic Services

Medicaid reimbursement is contingent on compliance with the following limitations:

- Documentation requirements

Referto: Subsection 4.3, "Documentation Requirements" in this handbook.

- The total reimbursement for restorative services of a primary tooth over a 6-month period cannot exceed the fee for a stainless steel crown (with the exception of D2335 and D2933), when provided by the same dentists within a dental group. An exception will be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity of the retreatment dental services during pre-payment review.
- Restoration of a primary tooth through the use of a stainless steel crown is considered to be a once-in-a-lifetime restoration. An exception will be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity of the replacement of the stainless steel crown during pre-payment review.
- All fees for tooth restorations include local anesthesia and pulp protective media, where indicated, without additional charges. These services are considered part of the restoration.
- 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 4.3, "Documentation Requirements" in this handbook.

Direct pulp caps may be reimbursed separately from any final tooth restoration performed on the same tooth (as noted by the TID) on the same DOS by the same provider.

4.2.3 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 4.2.2.1, "Diagnostic Services" in this handbook.

4.2.4 Children's Medicaid Dental Plan Choices

Children's Medicaid dental services benefits are administered by two dental managed care organizations (i.e., dental plans) across the state of Texas.

Medicaid Managed Care Dental Plan Dental Plan Provider Services	
DentaQuest	1-800-685-9971
MCNA Dental	1-855-776-6262

Note: Services provided to Medicaid managed care clients must be provided by their main dentist.

4.2.5 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.

4.2.6 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.

Referto: Subsection 4.2.13, "Medicaid Dental Benefits, Limitations, and Fee Schedule" in this handbook.

4.2.6.1 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.

4.2.6.2 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.

Paper claims and requests for prior authorization must be mailed to:

DentaQuest
12121 North Corporate Parkway
Mequon, WI 53092
Fax: 1-262-241-7150 or 1-888-313-2883

4.2.7 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 25 TAC §33.6 and §33.20, 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."

4.2.8 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 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:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present

- Caries risk assessment
- Dental anticipatory guidance

Clients who are from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home provider.

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 Texas Health Steps 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, D1120, D1206, 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 ten services per client lifetime with at least 60 days between visits by any provider to prevent denials of the service.

4.2.9 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.

4.2.10 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.

4.2.10.1 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 www.yourtexasbenefitscard.com, TexMedConnect, 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.

Referto: Subsection 4.2.24.4, "Premature Termination of Comprehensive Orthodontic Treatment" in this section.

4.2.11 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, and Oral Treatment for Children" 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.

Referto: "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.

4.2.11.1 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.

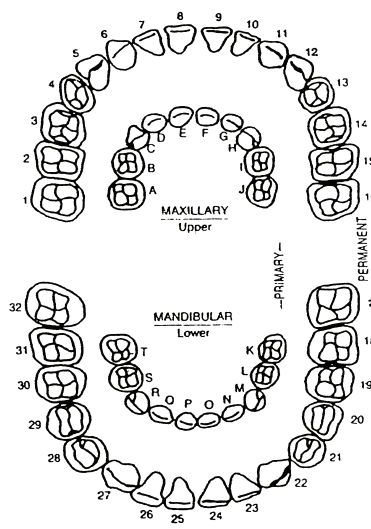
It is the provider's responsibility to verify that the client is eligible for the date that dental services are to be provided. Eligibility may be verified through www.yourtexasbenefitscard.com, TexMedConnect, or the TMHP Contact Center.

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.

4.2.12 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	

4.2.12.1 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

4.2.13 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.

Referto: Subsection 4.3, "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)

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

4.2.14 Restorative Services

Procedure Code	Limitations
Amalgam Restorations (Including Polishing)	
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.	
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
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 inlays/onlays or permanent crowns. Procedure codes D2542, D2543, D2544, and D2662 through D2664 are payable once per client, per tooth every ten years.	
D2510	A 13–20, N, PPXR, CCP
D2520	A 13–20, N, PPXR, CCP
D2530	A 13–20, N, PPXR, CCP
D2542	Same as D2520. 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	

Procedure Code	Limitations
D2543	All materials accepted. A 13–20, N, PPXR, CCP
D2544	All materials accepted. A 13–20, N, PPXR, CCP
D2650	All materials accepted. A 13–20, N, PPXR, CCP
D2651	All materials accepted. A 13–20, N, PPXR, CCP
D2652	All materials accepted. A 13–20, N, PPXR, CCP
D2662	All materials accepted. A 13–20, N, PPXR, CCP
D2663	All materials accepted. A 13–20, N, PPXR, CCP
D2664	All materials accepted. A 13–20, N, PPXR, CCP
Crowns—Single Restorations Only	
For procedure codes D2710 through D2794, single crown restorations (permanent teeth only), the following limitations apply:	
<ul style="list-style-type: none"> • 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) will need to be submitted 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. 	
Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior permanent teeth (6–11, 22–27).	
D2710	All materials accepted. A 13–20, N, PPXR, CCP
D2720	All materials accepted. A 13–20, N, PPXR, CCP
D2721	All materials accepted. A 13–20, N, PPXR, CCP
D2722	All materials accepted. A 13–20, N, PPXR, CCP
D2740	All materials accepted. A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2750*	All materials accepted. A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2751*	All materials accepted. A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2752	All materials accepted. 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
D2790	Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. 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	

Procedure Code	Limitations
D2791*	Posterior teeth only (#1-5, 12-21, and 28-32). All materials accepted. A 13-20, N, PPXR
D2792*	Posterior teeth only (#1-5, 12-21, and 28-32). All materials accepted. A 13-20, N, PPXR, CCP
D2794	A 13-20, N, PPXR, CCP
Other Restorative Services	
D2910	A 13-20, PXR
D2915	A 4-20
D2920	A 1-20, PXR
D2930*	A Birth-20, PXR
D2931*	A 1-20, PXR
D2932*	A 1-20, PXR (primary tooth)
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	Not allowed on primary teeth. 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
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)
<p>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</p>	

Procedure Code	Limitations
D2999	A 1–20, N, CCP, PXR
<p>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</p>	

4.2.15 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.

Procedure Code	Limitations
Pulp Capping	
Procedure codes D3110 and D3120 will not be reimbursed when submitted with the following procedure codes for the same tooth, for the same DOS, by the same provider: D2952, D2953, D2954, D2955, D2957, D2980, D2999, D3220, D3230, D3240, D3310, D3320, or D3330.	
D3110	A 1–20, N, PXR, CCP
D3120	A 1–20, N, PXR, CCP
<p>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</p>	

Procedure Code	Limitations
Pulpotomy	
D3220*	<p>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.</p> <p>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.</p> <p>Note: <i>The identified, original treating dentist or dental group will not be considered for reimbursement.</i></p>
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
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
<p>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</p>	

Procedure Code	Limitations
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), PXR=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	

4.2.16 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.

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	D4320	D4321	D4381	D4910	D4920	D4999			

Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 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.
- 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.

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
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
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	

Procedure Code	Limitations
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	
D4320	A 1–20, PXR
D4321	A 1–20, PXR
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 or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. 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 or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, PC, FMX, N
D4355*	Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. 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 within 90 days after D4355, 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
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	

4.2.17 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
D5281*	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
D5670*	Will be denied as part of procedure codes D5211, D5213, D5281, and D5640. A 6-20
D5671*	Will be denied as part of procedure codes D5212, D5214, D5281, and D5640. A 6-20
Denture Rebase Procedures	
D5710	A 4-20, PXR
D5711	A 4-20, 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	

Procedure Code	Limitations
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
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
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPR=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	

Procedure Code	Limitations
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

4.2.18 Implant Services

Implant services require prior authorization.

Referto: Subsection 4.2.29 *, “Mandatory Prior Authorization” in this handbook for documentation requirements.

4.2.19 Prosthodontic (Fixed) Services

Prosthodontic procedure codes require prior authorization.

Referto: Subsection 4.2.29 *, “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	
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
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	

Procedure Code	Limitations
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	

4.2.20 Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia, suturing, if needed, and visits for routine postoperative care.

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
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.
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	

Procedure Code	Limitations
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
D7282	Permanent TIDs #1–32 only; may not be paid for the same DOS as D7280. A 4–20
D7283	A 1–20
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
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
<p>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</p>	

Procedure Code	Limitations
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
Complicated Suturing	
D7911	A 1-20, N, PXR, CCP
D7912	A 1-20, N, PXR, CCP
Other Repair Procedures	
D7955	A 1-20
D7960	A 1-20, N, PXR, CCP
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
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PXR=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	

Procedure Code	Limitations
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), PXR=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	

4.2.21 Adjunctive General Services

[Revised] Procedure Code	[Revised] Limitations
Unclassified Treatment	
D9110*	Referto: Subsection 4.2.21.1, "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. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. Refer to subsection 4.2.27, "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	
Referto: Criteria for Dental Therapy Under General Anesthesia on the TMHP website at www.tmhp.com for general anesthesia criteria and additional information.	
D9210	Claim form narrative must describe the situation if used as a diagnostic tool. Denied if submitted with D9248. A 1-20, N, CCP
D9211*	Denied if submitted with D9248. A 1-20, N, CCP
D9212*	Denied if submitted with D9248. 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. Denied if submitted with D9248. 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. Denied if submitted with D9248. Providers who do not have proof of anesthesiology residency on file with TMHP will still be eligible for reimbursement. A 1-20
D9230*	May not be submitted more than one per client, per day. Denied if submitted with D9248. A 1-20.
D9239	Primary procedure code indicating first 15 minutes of intravenous moderate (conscious) sedation. Limited to 15 minutes per day, same provider. Denied if submitted with D9222 or D9248. A 1-20
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PXR=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	

[Revised] Procedure Code	[Revised] Limitations
D9243	Add-on procedure code indicating additional 15 minute increments of intravenous moderate (conscious) sedation. Limited to one hour and fifteen minutes per day, same provider. Must be billed with procedure code D9239. Denied if submitted with D9248. A 1-20
D9248*	May be submitted twice within a 12-month period. Denied if submitted with D9420, any provider. 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 Medicaid 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. Referto: "Appendix B: Vendor Drug Program" (Vol. 1, General Information).	
D9610	May not be submitted with code D9248. A 1-20, N
D9612	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, D9248, D9610, and D9920. A 1-20, N
Miscellaneous Services	
D9910	Per whole mouth application, does not include fluoride. Not to be used for bases, liners, or adhesives under or with restorations. Limited to once per year. A 18-20, N, CCP
<p>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</p>	

[Revised] Procedure Code	[Revised] Limitations
D9920	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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). <p>Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. Denied if submitted with D9248. A 1-20</p>
D9930*	Prior authorization is required. A 1-20, N
D9940	A 13-20, N, CCP
D9950	A 13-20, N, CCP
D9951	Full mouth procedure. Limited to once per year, 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
<p>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</p>	

4.2.21.1 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)
- 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 sequestered 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

4.2.22 * 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.
- [Revised] 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 and D9223.

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.

4.2.22.1 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
Level 4	Deep sedation/general anesthesia	Automatically qualifies for Level 1, Level 2, Level 3, and Level 4 permit privileges

Providers will be reimbursed only for those procedure codes that are covered by their anesthesia permit level. 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
D9230	Stand-alone permit for nitrous oxide/oxygen inhalation conscious sedation or Level 1
D9239	Level 3
D9243	Level 3
D9248	Level 2

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.

4.2.22.2 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
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.

4.2.23 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)

Referto: Subsection 4.2.11.1, "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.

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.*

4.2.24 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
- Head-trauma injury involving the oral cavity

- Skeletal anomalies involving the oral cavity

A severe handicapping malocclusion is defined by Texas Medicaid as dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches or teeth that without correction will result in damage to the temporomandibular joint (s) (TMJ) or other supporting oral structures (e.g., bone, tissues, intra- or extra-oral muscles, etc.).

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:

- Interceptive orthodontic treatment services
- 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, if the client is 14 years of age and younger and services are not provided by an exempt entity, THSteps dental providers shall require the client to be accompanied to THSteps dental appointments by a parent, guardian, or other adult who is authorized by the parent or guardian.

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.

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.
- Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

The American Association of Orthodontists classification of occlusion or malocclusion is as follows:

- *Class I:* A Class I occlusion exists with the teeth in a normal relationship when the mesialbuccal cusp of the maxillary first permanent molar coincides with the buccal groove of the mandibular first molar.
- *Class II:* A Class II malocclusion occurs when the mandibular teeth are distal or behind the normal relationship with the maxillary teeth. This can be due to a deficiency of the lower jaw or an excess of the upper jaw and therefore, presents two types:
 - Division I is when the mandibular arch is behind the upper jaw with a consequential protrusion of the upper front teeth.

- Division II exists when the mandibular teeth are behind the upper teeth, with a retrusion of the maxillary front teeth. Both of these malocclusions have a tendency toward a deep bite because of the uncontrolled migration of the lower front teeth upwards.
- *Class III:* A Class III malocclusion occurs when the lower dental arch is in front of (mesial to) the upper dental arch. People with this type of occlusion usually have a strong or protrusive chin, which can be due to either horizontal mandibular excess or horizontal maxillary deficiency. Commonly referred to as an underbite.

4.2.24.1 Benefits and Limitations for Orthodontic Services

Comprehensive orthodontic services must be provided by a board-eligible or board-certified orthodontist.

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.

The diagnostic workup is considered part of the pre-orthodontic treatment visit (procedure code D8660). The following procedure codes are used to submit claims for the diagnostic workup:

Diagnostic Workup Procedure Codes			
D0330	D0340	D0350	D0470

Comprehensive orthodontic services include all of the following:

- Diagnostic workups
- Banding
- Initial brackets
- Replacement brackets
- Monthly visits
- Initial retainers
- Special orthodontic treatment appliance(s)

The following procedure codes are used to submit claims for orthodontic services:

Orthodontic Services Procedure Codes			
D8080	D8660	D8670	D8690

Full banding is allowed on permanent dentition only, and treatment should be accomplished in one stage and is limited to once per lifetime.

Exception: Cases of mixed dentition may be considered when the treatment plan includes extractions of remaining primary teeth or in the case of cleft palate.

4.2.24.2 Crossbite Therapy

Crossbites (anterior and posterior) are defined by the American Academy of Pediatric Dentistry (AAPD) as malocclusions involving one or more teeth in which the maxillary teeth occlude lingually with the mandibular antagonistic (opposing) teeth. A crossbite can be of a dental or skeletal origin or a combination of both.

The intent of crossbite therapy is to prevent the need for comprehensive orthodontic treatment. This treatment may lessen the severity or future effects of a malformation, eliminate its cause, or may include localized tooth movement.

Crossbite therapy (limited orthodontics) is allowed for primary or transitional dentition. Crossbite therapy will not be considered for transitional dentition when there is a need for full banding of the adult teeth.

Crossbite therapy must be submitted with procedure code D8050 or D8060. Clients with special medical conditions may be considered for interceptive orthodontic services of the primary dentition if the services are medically necessary and submitted with procedure code D8050.

Crossbite therapy is an inclusive charge for treating the crossbite to completion. Adjustments, maintenance, diagnostic models, and diagnostic workup procedures are not reimbursed separately.

4.2.24.3 Minor Treatment to Control Harmful Habits

Special orthodontic appliances are a benefit for minor treatment to control harmful habits.

Orthodontic appliances for minor treatment to control harmful habits must be submitted with procedure codes D8210, D8220, and D8670.

Monthly adjustments (procedure code D8670) for minor treatment to control harmful habits are limited up to 10 visits.

Claims for panoramic films (procedure code D0330), cephalometric films (procedure code D0340), oral/facial photographic images obtained intraorally or extraorally (procedure code D0350) and diagnostic models (procedure code D0470) will be denied when they are submitted with procedure code D8210 or D8220.

Each orthodontic appliance (procedure code D8210 and D8220) are limited to once per arch, per lifetime.

4.2.24.4 Premature Termination of Comprehensive Orthodontic Treatment

Premature termination of comprehensive orthodontic treatment includes the following:

- Removal of the brackets and arch wires
- Removal of appliances with the fabrication of retainers
- Delivery of orthodontic retainers

Documentation of one of the following must be retained for premature termination of comprehensive orthodontic treatment:

- Documentation of a lack of cooperation from the client.
- Documentation that the client requested premature removal and a release of liability form has been signed by the parent, guardian, or client if he or she is at least 18 years of age.

Premature termination of comprehensive orthodontic treatment must be submitted with procedure code D8680.

Removal of the appliance (procedure code D8680) will be denied if the claim is submitted by any provider on the same date of service as orthodontic treatment (procedure codes D8050, D8060, and D8080).

Providers must keep a copy of the release of liability form on file and are responsible for this documentation during a review process.

If premature removal of the appliances is requested before completion of treatment, future orthodontic services may not be considered. The provider must document why the premature removal was necessary.

4.2.24.5 Other Orthodontic Services

Replacement brackets (procedure code D8690) are a benefit when the client transfers from one provider to another or when trauma is involved.

Providers are responsible for any replacement brackets that are required as part of the comprehensive orthodontic treatment. Additional reimbursement for replacement brackets (procedure code D8690) is limited to a combined total amount of \$100.00, same provider.

Rebonding or recementing of fixed orthodontic appliances (procedure code D8693) may be reimbursed once per lifetime per orthodontic appliance.

Only one retainer per arch per lifetime (procedure code D8680) is allowed; however, each retainer may be replaced with prior authorization once per lifetime due to loss or breakage. Retainer adjustments are not reimbursed separately.

Appliances required as part of the cleft palate treatment plan may be reimbursed separately.

Special orthodontic appliances may be used with full banding and crossbite therapy when approved by the TMHP Dental Director or Associate Dental Director.

4.2.24.6 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 or D0150).

4.2.24.7 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.

National 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).

When submitting claims for comprehensive orthodontic treatment procedure code D8080, three local codes must be submitted as remarks codes along with procedure code D8080. Local codes (procedure codes Z2009, Diagnostic workup approved; Z2011, Orthodontic appliance, upper; or Z2012, Orthodontic appliance, lower) must be placed in the Remarks Code field on electronic claims or Block 35 on paper claims.

Note: *If the remarks code and procedure code D8080 are not submitted, the claim will be denied.*

Each remarks code pays the correct reimbursement rate which, when combined, totals the maximum payment of \$775. Procedure code D8080 must be submitted on three separate details, with the appropriate remarks code, even if the claim submission is for the workup and full banding. Submission of only one detail for a total of \$775 will not be accepted.

Example 1: A client is approved for full banding, but after the initial workup, the client discontinues treatment. This provider would submit the national procedure code D8080 and place the local code Z2009, Diagnostic workup approved, in the Remarks/comment field. The claim would pay \$175.

Example 2: A client is approved for full banding. The provider continues treatment and places the maxillary bands. The provider would submit the national procedure code D8080 and place the local procedure code Z2009, Diagnostic workup approved, and Z2011, Maxillary bands, in the Remarks/comment field. The claim would pay \$475.

All electronic claims for procedure code D8080 must have the appropriate remarks code associated with the procedure code.

Providers must adhere to the following guidelines for electronic claim submission so TMHP can accurately apply the correct remarks code to the appropriate claim detail.

A Diagnostic Procedure Code (DPC) remarks code must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.

Example 1: For a claim with one detail, submitted with procedure code D8080 and remarks code Z2009, enter the information as follows: DPCZ2009. The total submitted would be \$175.

Example 2: For a claim with two details, where details one and two are procedure code D8080 and the remarks codes are Z2009 and Z2011, enter the information as follows: DPCZ2009Z2011. The total submitted would be \$475.

Example 3: For a claim with three details, where all three details are submitted separately with procedure code D8080, enter the remarks code based on the order of the claim detail as follows: DPCZ2009Z2011Z2012. The total submitted would be \$775.

This method ensures accurate and appropriate payment for services rendered and addresses the need for submission of a partial claim.

4.2.24.8 Orthodontic Procedure Codes and Fee Schedule

When submitting claims for orthodontic procedures, use the following procedure codes:

Procedure Code	Limitations
Orthodontic Services	
D0330*, D0340*, D0350*, and D0470*	
D7280	A 1-20
D7997*	Replaces Z2016. Not payable to the dentist who placed the appliance. Includes removal of arch bar and premature removal of braces. A 1-20
Interceptive Orthodontic Treatment	
D8050*	Replaces Z2018 and 8110D. Limited to one per lifetime.
D8060*	Replaces Z2018 and 8120D. Limited to one per lifetime.
Comprehensive Orthodontic Treatment	
D8080*	Replaces Z2009, Z2011, and Z2012. Limited to one per lifetime.
Minor Treatment to Control Harmful Habits	
D8210*	Refer to subsection 4.2.25, "Special Orthodontic Appliances" in this handbook for associated remarks field code.
D8220*	Refer to subsection 4.2.25, "Special Orthodontic Appliances" in this handbook for associated remarks field code.
Other Orthodontic Services	
* = Services payable to an FQHC for a client encounter.	

Procedure Code	Limitations
D8660*	Replaces Z2008. Denied when submitted for the same DOS as D0145 by any provider. Denied when submitted for the same DOS as D0120 or D0150 by the same provider.
D8670*	Replaces Z2013.
D8680*	Replaces Z2014 and Z2015; one retainer per arch per lifetime; may be replaced once because of loss or breakage (prior authorization is required).
D8690*	Bracket replacement.
D8691	Not considered medically necessary.
D8692	Although procedure code D8692 is not a benefit of Texas Medicaid, providers can use procedure code D8680 to submit a claim for retainer(s). Providers must include local code Z2014 or Z2015 on the claim form to indicate upper or lower, as appropriate.
D8693	Limited to once per lifetime per orthodontic appliance.
D8999	
* = Services payable to an FQHC for a client encounter.	

4.2.25 Special Orthodontic Appliances

All removable or fixed special orthodontic appliances must be prior authorized. The prior authorization request must include both the national code and remarks code. However, prior authorization requests may omit the DPC prefix to the eight-digit remarks code.

All removable or fixed special orthodontic appliances must be submitted with national procedure code D8210 or D8220. To ensure appropriate claims processing, the DPC remarks code (local procedure code) reflecting the specific service is also required. The appropriate remarks codes must be entered on the prior authorization request form. Failure to follow the following steps will cause the claims to deny. Failure to enter the DPC remarks code and the appropriate procedure code will not result in claim denial; however, manual intervention is required to process the claim, which may result in a delay of payment.

For paper claim submissions, providers must enter the local procedure code in Block 35 (Remarks) of the 2012 ADA claim form.

For electronic submissions, providers enter the DPC remarks code in the Comments field to ensure correct authorization, accurate records, and reimbursement.

For electronic submissions other than TexMedConnect submissions, providers must use the following instructions to ensure that TMHP accurately applies the correct local procedure code to the appropriate claim detail:

- The DPC prefix must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.
- In bytes 4–8, providers must submit the remark code (local procedure code) based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate the detail is not submitted with D8210 or D8220.

Example: For a claim with three details, where details one and three are submitted with procedure code D8210 and detail two is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D. (The space shows that detail two needs no local code.) If all details require a local code, enter DPC, no spaces, and the appropriate local codes.

To submit using TexMedConnect, providers must enter the local code into the Remarks Code field, located under the details header. The Remarks Code field is the field directly after the Procedure Code field. TexMedConnect submitters are not required to manually enter the DPC prefix as it is placed in the appropriate field on the TexMedConnect electronic claim.

The following table identifies the appropriate DPC remarks codes to use when requesting prior authorization or submitting a claim for procedure code D8210 or D8220:

Procedure Code	Remarks Code	Remarks Code Description
Special Orthodontic Appliances		
D8220*	DPC1000D	Appliance with horizontal projections
D8220*	DPC1001D	Appliance with recurved springs
D8220*	DPC1002D	Arch wires for crossbite correction (for total treatment)
D8220*	DPC1003D	Banded maxillary expansion appliance
D8210*	DPC1004D	Bite plate/bite plane
D8210*	DPC1005D	Bionator
D8210*	DPC1006D	Bite block
D8210*	DPC1007D	Bite-plate with push springs
D8220*	DPC1008D	Bonded expansion device
D8210*	DPC1010D	Chateau appliance (face mask, palatal exp and hawley)
D8210*	DPC1011D	Coffin spring appliance
D8220*	DPC1012D	Crib
D8210*	DPC1013D	Dental obturator, definitive (obturator)
D8210*	DPC1014D	Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)
D8220*	DPC1015D	Distalizing appliance with springs
D8220*	DPC1016D	Expansion device
D8210*	DPC1017D	Face mask (protraction mask)
D8220*	DPC1018D	Fixed expansion appliance
D8220*	DPC1019D	Fixed lingual arch
D8220*	DPC1020D	Fixed mandibular holding arch
D8220*	DPC1021D	Fixed rapid palatal expander
D8210*	DPC1022D	Frankel appliance
D8210*	DPC1023D	Functional appliance for reduction of anterior openbite and crossbite
D8210*	DPC1024D	Headgear (face bow)
D8220*	DPC1025D	Herbst appliance (fixed or removable)
D8220*	DPC1026D	Inter-occlusal cast cap surgical splints
D8210*	DPC1027D	Intrusion arch
D8220*	DPC1028D	Jasper jumpers
D8220*	DPC1029D	Lingual appliance with hooks
D8220*	DPC1030D	Mandibular anterior bridge
D8220*	DPC1031D	Mandibular bihelix (similar to a quad helix for mandibular expansion to attempt nonextraction treatment)
D8210*	DPC1032D	Mandibular lip bumper
D8220*	DPC1036D	Mandibular lingual 6x6 arch wire
D8210*	DPC1037D	Mandibular removable expander with bite plane (crozat)
* = Services payable to an FQHC for a client encounter.		

Procedure Code	Remarks Code	Remarks Code Description
D8210*	DPC1038D	Mandibular ricketts rest position splint
D8210*	DPC1039D	Mandibular splint
D8210*	DPC1040D	Maxillary anterior bridge
D8210*	DPC1041D	Maxillary bite-opening appliance with anterior springs
D8220*	DPC1042D	Maxillary lingual arch with spurs
D8220*	DPC1043D	Maxillary and mandibular distalizing appliance
D8220*	DPC1044D	Maxillary quad helix with finger springs
D8220*	DPC1045D	Maxillary and mandibular retainer with pontics
D8210*	DPC1046D	Maxillary Schwarz
D8210*	DPC1047D	Maxillary splint
D8210*	DPC1048D	Mobile intraoral Arch-Mia (similar to a Bihelix for nonextraction treatment)
D8220*	DPC1049D	Modified quad helix appliance
D8220*	DPC1050D	Modified quad helix appliance (with appliance)
D8220*	DPC1051D	Nance appliance
D8220*	DPC1052D	Nasal stent
D8210*	DPC1053D	Occlusal orthotic device
D8210*	DPC1054D	Orthopedic appliance
D8210*	DPC1055D	Other mandibular utilities
D8210*	DPC1056D	Other maxillary utilities
D8220*	DPC1057D	Palatal bar
D8210*	DPC1058D	Post-surgical retainer
D8220*	DPC1059D	Quad helix appliance held with transpalatal arch horizontal projections
D8220*	DPC1060D	Quad helix maintainer
D8220*	DPC1061D	Rapid palatal expander (RPE), such as quad Helix, Haas, or Menne
D8210*	DPC1062D	Removable bite plate
D8210*	DPC1063D	Removable mandibular retainer
D8210*	DPC1064D	Removable maxillary retainer
D8210*	DPC1065D	Removable prosthesis
D8210*	DPC1066D	Sagittal appliance 2 way
D8210*	DPC1067D	Sagittal appliance 3 way
D8220*	DPC1068D	Stapled palatal expansion appliance
D8210*	DPC1069D	Surgical arch wires
D8210*	DPC1070D	Surgical splints (surgical stent/wafer)
D8210*	DPC1071D	Surgical stabilizing appliance
D8220*	DPC1072D	Thumbsucking appliance, requires submission of models
D8210*	DPC1073D	Tongue thrust appliance, requires submission of models
D8210*	DPC1074D	Tooth positioner (full maxillary and mandibular)

* = Services payable to an FQHC for a client encounter.

Procedure Code	Remarks Code	Remarks Code Description
D8210*	DPC1075D	Tooth positioner with arch
D8220*	DPC1076D	Transpalatal arch
D8220*	DPC1077D	Two bands with transpalatal arch and horizontal projections forward
D8220*	DPC1078D	Appliance

* = Services payable to an FQHC for a client encounter.

4.2.26 Handicapping Labio-lingual Deviation (HLD) Index

The orthodontic provider must complete and sign the HLD Index (Angle classification).

The HLD index requires the use of an HLD score sheet and a Boley gauge for measuring.

Referto: The [Texas Medicaid Handicapping Labio-Lingual Deviation \(HLD\) Index Score Sheet](#) on the TMHP website at www.tmhp.com.

Providers should be conservative in scoring. The client must be considered severe handicapping malocclusion with dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches and/or teeth that, without correction, will result in damage to the temporomandibular joint(s) (TMJ) and/or other supporting oral structures (e.g., bone, tissues, intra and/or extra oral muscles, etc.) and have a minimum of 26 points on the HLD index to be considered for any orthodontic care other than crossbite correction. "Half-mouth" treatment cannot be approved.

With the client or models in the centric position, the HLD index is to be scored as follows. Record all measurements rounded-off to the nearest millimeter (mm). Enter a score of "0" if the condition is absent.

Cleft Palate

A cleft palate case request for mixed dentition will be considered only if narrative justification supports treatment before the client reaches full dentition.

Note: Intermittent treatment requests may exceed the allowable 26 reimbursable treatment visits.

Severe Traumatic Deviations

Refers to facial accidents only. Points cannot be awarded for congenital deformity. Severe traumatic deviations do not include traumatic occlusions for crossbites.

Overjet in Millimeters

Score the case exactly as measured. The measurement must be recorded from the most protrusive incisor, then subtract 2 mm (considered the norm), and enter the difference as the score.

Overbite in Millimeters

Score the case exactly as measured. The measurement must be recorded from the labio-incisal edge of the overlapped anterior tooth or teeth to the point of maximum coverage, then subtract 3 mm (considered the norm), and enter the difference as the score.

Mandibular Protrusion in Millimeters

Score the client exactly as measured. The measurement must be recorded from the "line of occlusion" of the permanent teeth, not from the ectopically erupted teeth in the anterior segment.

Open Bite in Millimeters

Score the case exactly as measured. Measurement must be recorded from the “line of occlusion” of the permanent teeth, not from the ectopically erupted teeth in the anterior segment. *Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse.*

Ectopic Eruption

An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge.

Ectopic eruption does not include teeth that are rotated or teeth that are leaning or slanted especially when the enamel-gingival junction is within the long axis of the alveolar ridge.

Note: *Record the more serious condition. Do not include (score) teeth from an arch if that arch is to be counted in the category of Anterior Crowding. For each arch, either the ectopic eruption or anterior crowding may be scored, but not both.*

Anterior Crowding

Arch length insufficiency must exceed 3.5 mm to be considered as crowding in either arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as crowded.

Excessive Anterior Spacing in Millimeters

The score for this category must be the total, in millimeters, of the anterior spaces.

Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case must be considered dysfunctional and have a minimum of 26 points on the HLD index to qualify for any orthodontic care other than crossbite correction. Half-mouth cases cannot be approved.

The intent of the program is to provide orthodontic care to clients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.

The proposals for treatment services should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch will be reviewed for duplication of purpose.

If attaining a qualifying score of 26 points is uncertain, providers must include a brief narrative when submitting the case. The narrative may reduce the time necessary to gain final approval and reduce shipping costs incurred to resubmit records.

Providers must properly label and protect all records (especially plaster diagnostic models) when shipping. If plaster diagnostic models are requested by and shipped to TMHP, the provider should assure that the models are adequately protected from breakage during shipping. TMHP will return intact models to the provider.

4.2.27 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.*

Referto: Subsection 6.7, “2012 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 9.3, “Doctor of Dentistry Practicing as a Limited Physician” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

Subsection 4.2.13, “Medicaid Dental Benefits, Limitations, and Fee Schedule” in this handbook.

4.2.28 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.

Referto: Subsection 9.3, “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.

4.2.28.1 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.

4.2.28.2 Laboratory Requirements

Dental laboratories must be registered with TSBDE laboratories, and technicians must not be under restrictions imposed by TSBDE or a court.

4.2.29 * Mandatory Prior Authorization

Mandatory prior authorization is required for consideration of reimbursement to dental providers who render the following services:

- Orthodontia
- Implants
- Fixed prosthetic services
- Removable prosthodontics
- Dental general anesthesia
- All inlays/onlays or permanent crowns
- Procedure code D4276
- [Revised] Nonsurgical periodontal service (procedure codes D4341 and D4342)
- Procedure code D7272
- Procedure code D7472
- 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, 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.

Referto: Subsection 9.3, “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.*

Referto: [THSteps Dental Mandatory Prior Authorization Request Form](http://www.tmhp.com) on the TMHP website at www.tmhp.com.

4.2.29.1 Cone Beam Imaging

Prior authorization is required for procedure code D0367.

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

4.2.29.2 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.

Referto: [Criteria for Dental Therapy Under General Anesthesia](http://www.tmhp.com) 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.

4.2.29.2.1 * 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 and D9223), 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, 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.

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 anesthesia (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.

Referto: [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 41899 with modifier U3 is for the facility to use on the claim form. Procedure code 41899 does not require prior authorization for ASCs and Hospital-based Ambulatory Surgical Centers (HASCs).
- An appropriate diagnosis code must be used on the claim form.
- 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.

Referto: [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.

4.2.29.3 Orthodontic Services

Prior authorization is required for all orthodontic services except for rebonding or recementing of fixed retainers (procedure code D8693). Providers must maintain documentation of medical necessity in the client's dental record for rebonding or recementing of fixed retainers.

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.

All prior authorization requests for orthodontic services must be accompanied by an attestation from the requesting provider that the provider is either a pediatric dentist or orthodontist.

General dentists who are requesting prior authorization for orthodontic services must attest and maintain documentation of a minimum of 200 hours of continuing dental education specifically 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. All attestations are subject to compliance review and orthodontic services may be subject to recoupment.

4.2.29.3.1 Initial Orthodontic Services Request

The prior authorization form must include all of the procedures that are required to complete the requested treatment including, but not limited to, the following:

- Diagnostic workup
- Medically necessary extractions (Tooth ID must be included)
- Orthognathic surgery
- Upper and lower appliance
- Monthly adjustments
- Special orthodontic treatment appliances
- Placement of banding and brackets
- Replacement of brackets
- Removal of the brackets and arch wires
- Other special orthodontic appliances
- Fabrication of special orthodontic appliances
- Delivery of orthodontic retainers
- Appliance removal (if indicated)

A completed and scored Handicapping Labio-Lingual Deviations (HLD) Index with a diagnosis of Angle class (a minimum of 26 points are required for approval of non-cleft palate cases). If attaining a qualifying score of 26 points is uncertain, a brief narrative should be provided.

Note: *A score of a minimum 26 points on the HLD index does not indicate an automatic approval for comprehensive orthodontics. Approval will be based on the diagnostic workup supporting the HLD index. Documentation provided must be reviewed by a qualified board eligible or board certified orthodontist.*

When requesting prior authorization, providers must include diagnostic models, radiographs (X-rays), cephalometric X-ray with tracings, photographs, and other supporting documentation with the THSteps Dental Mandatory Prior Authorization Request Form.

All required documents must be submitted together in one package per prior authorization request. Prior authorization requests that are not submitted in one package per request will be considered incomplete.

Note: *All documentation submitted with an incomplete request will be sent back to the provider with a letter that indicates the prior authorization request was incomplete. Providers must resubmit prior authorization requests with all the required documentation within 14 business days of the request receipt date, or the request will be denied as "incomplete."*

4.2.29.3.2 Diagnostic Tools

Prior authorization requests must include the date of service the diagnostic tools were obtained (the date of service the dental records were produced). All diagnostic tools must be properly labeled and protected when shipped by the provider. If any diagnostic tool is damaged during shipment, the provider may be required to reproduce the documentation for consideration of the case for prior authorization.

Note: *If medical necessity cannot be determined from the diagnostic tools that are submitted with the request, the prior authorization request may be denied.*

TMHP will be responsible for retaining an image of each diagnostic tool that is submitted for every complete orthodontic prior authorization request.

Copies of diagnostic models, X-rays, and any other paper diagnostic tools will be accepted and are preferred. Copies will not be returned, but providers will be required to maintain the dental records for retrospective review. Originals will be returned to the submitting provider only when the document is clearly marked "original."

Diagnostic models in the form of plaster casts are preferred; however, providers may choose the positions in which the casts are made. E-models must be in the centric occlusion position.

Radiographs that are submitted must include, but are not limited to, the following:

- Panoramic or a full mouth series
- Cephalometric with tracings

Photographic images must be submitted with the request and must be in a 1:1 ratio format (actual size), including, but not limited to, the following:

- Full face, smiling
- Left and right profiles
- Full maxillary arch (open mouth view)
- Full mandibular arch (open mouth view)
- Right side occluded in centric occlusion
- Left side occluded in centric occlusion
- Anterior occluded in centric occlusion

X-rays must be of diagnostic quality and do not have to be submitted on photographic quality paper.

Submitting providers must attest that radiographs, photographs, and other documentation are unaltered.

4.2.29.3.3 Authorization Extensions

Extensions on allowed time frames may be considered no sooner than 60 days before the authorization expires. Extra monthly adjustments (procedure code D8670) will not be prior authorized, but the time frame may be considered for extension not to exceed 36 months of actual treatment. Providers must submit the following:

- Diagnostic workup.
 - Note: Photographs may be substituted for models.*
- The reason the treatment was not completed in the original time frame.
- An explanation of the treatment plan status.

4.2.29.3.4 Crossbite Therapy

Requests for crossbite therapy (procedure codes D8050 or D8060) require the submission of diagnostic models to receive authorization. An HLD score sheet is not required for crossbite therapy.

Providers that submit requests for crossbite therapy must maintain documentation in the client's record that demonstrates the following criteria:

- Posterior teeth—Are not end-to-end, but the buccal cusp of the upper teeth is lingual to the buccal cusp of the lower teeth.
- Anterior teeth—The incisal edge of the upper teeth are lingual to the incisal edge of the opposing arch.

4.2.29.3.5 Minor Treatment to Control Harmful Habits

A THSteps Dental Mandatory Prior Authorization Form must be completed when requesting prior authorization for orthodontic appliances for minor treatment to control harmful habits. Documentation must support medical necessity of any appliance requested.

Providers must submit diagnostic models when requesting prior authorization for a removable appliance or fixed appliance.

Procedure codes D8210 or D8220 may only be approved for control of harmful habits including, but not limited to, thumb sucking or tongue thrusting and may not be prior authorized for services that are related to comprehensive orthodontic services.

4.2.29.3.6 Premature Termination of Orthodontic Services

Prior authorization for the premature termination of orthodontic services (procedure code D8680) is required.

Premature termination of orthodontic services includes all of the following:

- Removal of the brackets and arch wires.
- Other special orthodontic appliances.
- Fabrication of special orthodontic appliances.
- Delivery of orthodontic retainers.

The prior authorization must include all of the following for consideration:

- Panoramic radiograph (copies are preferred).
- Cephalometric radiograph with tracing (copies are preferred).
- Six intra-oral photographs (copies are preferred).
- Three extra-oral photographs (copies are preferred).

- A narrative documenting why the provider is terminating the orthodontic services early.
- Documentation that the parent, legal guardian, or the client, if he or she is 18 years of age or older or an emancipated minor, understands that the provider is terminating the orthodontic services, and the client is no longer eligible for orthodontic services by Texas Medicaid/THSteps.

In addition to the final record, the provider requesting premature termination of orthodontic services must submit a copy of the signed release form that includes the following:

A signature by one of the following:

- The parent
- Legal guardian
- The client, if he or she is 18 years of age or older or an emancipated minor
- One of the following statements:
 - The client is uncooperative or non-compliant with the treating dentist's directions and does not intend to complete orthodontic treatment.
 - The client requested the premature removal of orthodontic appliances and does not intend to complete orthodontic treatment.

Note: *A client for whom removal of an appliance has occurred due to the client's request, or is uncooperative or non-compliant will not be eligible for any additional Medicaid orthodontic services.*

- The client has requested the premature removal of orthodontic appliances due to extenuating circumstances including, but not limited to, the following:
 - Incarceration.
 - Mental health complications with a recommendation from the treating physician.
 - Foster care placement.
 - Child of a migrant farm worker. With the intent to complete orthodontic treatment at a later date if Medicaid eligibility for orthodontic services continues.
 - Special medical conditions.

Note: *If comprehensive orthodontic services are terminated due to extenuating circumstances, clients will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while the client is eligible for Medicaid.*

The requesting provider will be responsible for removal of the orthodontic appliances, final records, and fabrication and delivery of orthodontic retainers at the time of premature removal or at any future time should the client present to the treating provider's office.

4.2.29.3.7 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

Note: *Photographs may be substituted for models.*

- 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.

4.2.29.3.8 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.

4.2.30 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

4.3 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.
- 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.

4.3.1 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

4.3.2 Orthodontic Services

Requests for orthodontic services must be accompanied by all of the following documentation:

- An orthodontic treatment plan. The treatment plan must include all procedures required to complete full treatment (e.g., extractions, orthognathic surgery, upper and lower appliance, monthly adjustments, anticipated bracket replacements, appliance removal if indicated, special orthodontic appliances). The treatment plan should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch are reviewed for duplication of purpose.
- Diagnostic models.
- Cephalometric radiograph with tracings.
- Completed and scored HLD sheet with diagnosis of Angle class (a minimum of 26 points is required for consideration of approval of non cleft palate cases).
- Facial photographs.
- Full series of radiographs or a panoramic radiograph; diagnostic-quality films are required (copies are preferred and will not be returned to the provider).
- Any additional pertinent information as determined by the dentist or requested by TMHP's Dental Director. Requests for crossbite therapy require the submission of diagnostic models to receive authorization. Providers must maintain documentation in the client's record that demonstrates the following criteria:
 - Posterior teeth. Not end-to-end, but buccal cusp of upper teeth should be lingual to buccal cusp of lower teeth.
 - Anterior teeth. The incisal edge of upper should be lingual to the incisal of the opposing arch.

The dentist should be certain that radiographs, photographs, and other information are properly packaged to avoid damage. TMHP is not responsible for lost or damaged materials.

Referto: [THSteps Dental Mandatory Prior Authorization Request Form](#) on the TMHP website at www.tmhp.com.

4.4 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.

Referto: [25 TAC, §33.72](#) for more information about utilization review.

4.5 Claims Filing and Reimbursement

4.5.1 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/pages/topics/rates.aspx.

4.5.2 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.

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

4.5.3 Third Party Liability

Referto: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

4.5.4 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.

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 performing provider identifier 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 provider identifier is issued, and within 365 days of the DOS.

Providers should submit claims to Texas Medicaid for their usual and customary fees.

Claims for dental services provided to children in foster care must be filed with DentaQuest, the dental claims processor for Superior HealthPlan.

Referto: Subsection 4.2.6.2, "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.

Referto: "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 1.6.9, "Billing Clients" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

4.5.5 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.

Referto: 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.

Referto: 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.

- 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 Medicaid provider identifier is pending.

Note: *Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier 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
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

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 EDI 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.

4.5.6 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.

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 How are orthodontic bracket replacements reimbursed? Can the client be charged for bracket replacements?

A The provider must use orthodontic procedure code D8690 to claim reimbursement for bracket replacement. Medical necessity must be documented in the client record. Payment is subject to retrospective review. The client with current Medicaid eligibility must not be charged for bracket replacement. If the provider charges the client erroneously, the provider must refund any amount paid by the client.

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 provider identifiers.

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 provider identifier 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 provider identifier.

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.
- 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.
- General anesthesia (provided in the dentist office, ambulatory service clinic, and inpatient/outpatient hospital settings) does not require prior authorization, 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.

Referto: Subsection 1.6.9.1, "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.

5 THSteps Medical

5.1 THSteps Medical and Dental Administrative Information

5.1.1 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/thsteps/regions.shtm.

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.

5.1.2 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 1.6.1, “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.

Referto: “Appendix D. Texas Health Steps Statutory State Requirements” in this handbook for more information.

5.1.3 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 \$14.85, is considered for reimbursement.

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.

Note: *Administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with parental consent to a centralized repository of immunization histories for clients younger than 18 years of age. This repository is known in Texas as ImmTrac.*

For additional information about immunizations, providers can refer to the THSteps online educational module “Immunization” at www.txhealthsteps.com.

Referto: “Appendix B. Immunizations” in this handbook.

5.1.4 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) of 1986 requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

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 www.dshs.texas.gov/immunize/forms/vaers_table.pdf.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event. For additional information about NCVIA, providers can refer to www.dshs.texas.gov/immunize/forms/11-11246.

5.1.5 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.

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 is available in Section 2, “Medicaid Title XIX Family Planning Services” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*. 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.

Referto: Section 1 *, “General Information” in the *Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks)* for more information about referrals.

5.1.6 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.

Referto: Subsection 5.3.10, “THSteps Medical Checkups Periodicity Schedule” in this handbook on the THSteps Periodicity Schedule.

Subsection 5.3.11, “Mandated Components” in this handbook for additional information on checkup components.

5.1.7 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.

Referto: 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.

5.2 Enrollment

5.2.1 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.

Referto: Subsection 1.1, "Provider Enrollment and Reenrollment" 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 and must also be enrolled in Texas Medicaid and 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 federal qualified health center (FQHC)
- A rural health clinic (RHC)
- 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.

5.2.1.1 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.

Referto: Subsection 5.2.1, "THSteps Medical Provider Enrollment" in this handbook for more information about enrollment procedures.

5.3 Services, Benefits, Limitations, and Prior Authorization

5.3.1 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 www.yourtexasbenefitscard.com, TexMedConnect, 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.

Managed care organizations are also required to assure existing members of their health plan eligibility requirements to receive timely medical checkups. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date based on the client's birth date. For existing members 36 months of age and older, a checkup is due beginning on the child's birthday and is considered timely if it occurs within 364 calendar days after the child's birthday in a non-leap year or 365 days after the child's birthday in a leap year. Checkups received before the periodic due date are not reportable as timely medical checkups. Providers should contact the appropriate MCO for further details.

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.

Referto: "Subsection 5.3.6, "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.

Referto: Subsection 5.3.7, “Exception-to-Periodicity Checkups” in this handbook for additional details about billing for a checkup performed as an exception-to-periodicity checkup.

5.3.2 Prior Authorization

Prior authorization is not required for preventive care medical checkups.

5.3.3 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.

5.3.4 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.

5.3.5 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.

5.3.6 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.

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 fluoride 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.*

Referto: Subsection 5.3.11.1.3 *, "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.

Referto: The THSteps Medical Checkups Periodicity Schedule which may be found at www.dshs.texas.gov/thsteps/providers.shtm.

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 for checkups and the referral and condition indicators. Condition indicators must be used to describe the results of a checkup. A condition indicator must be submitted on the claim with the periodic medical checkup procedure code. Indicators are required whether a referral was made or not. If a referral is made, then providers must use the Y referral indicator. If no referral is made, then providers must use the N referral indicator.

Procedure Codes	Referral Indicator	Condition Indication
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (Established client preventive visit)	N (no referral given)	NU (not used)
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (established client preventive visit)	Y (yes THSteps or EPSDT referral was given to the client)	S2 (under treatment) or ST* (new services requested)
* 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 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.

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

Section 7, "Rural Health Clinic" in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)* 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 provider identifier on a separate claim without benefit code EP1.

Referto: [Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup](#) on the TMHP website at www.tmhp.com.

[THSteps Preventive Visit Checkup with Immunization and Vaccine Administration](#) on the TMHP website at www.tmhp.com for a claim form example.

5.3.7 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.

5.3.8 Medical Checkup Follow-up Visit

Use procedure code 99211 with the provider identifier 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.*

Referto: 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.

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.

5.3.9 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 provider identifier 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, 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.

Referto: Subsection 9.2.45, “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.

5.3.10 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 DSHS website at www.dshs.texas.gov/thsteps/providers.shtm.

5.3.11 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

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.dshs.texas.gov/thsteps/forms.shtm.

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

5.3.11.1 Comprehensive Health and Developmental History

5.3.11.1.1 Nutritional Screening

Dietary practices must be evaluated at each checkup to identify and address nutritional issues or concerns.

5.3.11.1.2 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.

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) or Parents' Evaluation of Development Status (PEDS)	N/A
18 months	ASQ or PEDS	Modified Checklist for Autism in Toddlers (M-CHAT) or M-CHAT Revised with Follow-Up (M-CHAT R/F)
24 months	ASQ or PEDS	M-CHAT or M-CHAT R/F
3 years	ASQ, Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) or PEDS	N/A
4 years	ASQ, ASQ:SE or PEDS	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.

Referto: 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.

5.3.11.1.3 * 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)
- [Revised] Patient Health Questionnaire (PHQ-A [anxiety, eating problems, mood problems and substance use])

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.

5.3.11.1.4 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.

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
- 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.

5.3.11.1.5 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 DSHS website at www.dshs.texas.gov/thsteps/forms.shtm.

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 a provider identifier 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.

Referto: "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."

5.3.11.2 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.

5.3.11.2.1 Oral Health Screening

Oral health screening is a part of the medical checkup physical examination.

5.3.11.2.2 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.

5.3.11.2.3 Hearing Screening

State-mandated newborn hearing screening is offered by and performed in the birthing 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 (PCP) or medical home.

PCPs or 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 PCP 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 PCP or medical home is responsible for managing and coordinating care for the child. Refer to the American Academy of Pediatrics Position Statement at <http://pediatrics.aappublications.org/content/129/5/996>.*

Newborns who pass the newborn hearing screening must have their hearing monitored per the THSteps periodicity schedule. The PCP 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 PCP or medical home to a Medicaid-enrolled provider for an outpatient follow-up rescreen, unless their PCP 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 PCP or medical home.

Newborns who pass the outpatient rescreen must have their hearing monitored by their PCP 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 PCP or medical home.

***Note:** Additional information about the Texas Pediatric Protocol for Evaluation is available at www.dshs.texas.gov/tehdi/Audiologic-Evaluation-Protocol.aspx.*

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 PCP 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/tehdi/approved-screening-equipment.aspx.*

Evaluation Results

Audiologists must report all diagnostic results to DSHS TEHDI MIS and provide written hearing screening results to the PCP 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 PCP 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
- 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.

5.3.11.2.4 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.

5.3.11.3 Immunizations

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.

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.

Providers may only submit diagnosis code Z23 on the claim if an immunization is the only service provided during an office visit.

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

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 and 90472 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

Procedure codes 90473 and 90474 are benefits for services rendered to clients who are birth through 20 years of age when counseling is not provided for the immunization administered.

The following vaccines and toxoids are a benefit of Texas Medicaid:

Procedure Code	Number of Components**	Procedure Code	Number of Components**	Procedure Code	Number of Components**
90620*	1	90621*	1	90630	1
90632	1	90633*	1	90636	2
90644	2	90647*	1	90648*	1
90649*	1	90650*	1	90651*	1
90654	1	90655*	1	90656*	1
90657*	1	90658*	1	90660*	1

* TVFC-distributed vaccine/toxoid
 ** The number of components applies if counseling is provided and procedure code 90460 and 90461 are submitted.

Procedure Code	Number of Components**	Procedure Code	Number of Components**	Procedure Code	Number of Components**
90661	1	90670*	1	90672*	1
90673	1	90674	1	90680*	1
90681*	1	90682	1	90685*	1
90686*	1	90687*	1	90688*	1
90696*	4	90698*	5	90700*	3
90702*	2	90707*	3	90710*	4
90713*	1	90714*	2	90715*	3
90716*	1	90723*	5	90732*	1
90733	1	90734*	1	90743	1
90744*	1	90746	1	90748*	2
90749	1	90756	1		
* TVFC-distributed vaccine/toxoid					
** The number of components applies if counseling is provided and procedure code 90460 and 90461 are submitted.					

Procedure codes 90655, 90657, 90685, and 90687 are limited to clients who are 6 through 35 months of age.

Procedure codes 90656 and 90658 are limited to clients who are 3 years of age and older.

Procedure codes 90686 and 90688 are limited to clients who are 6 months of age and older.

Procedure code 90682 is limited to clients who are 18 years of age and older.

Procedure code 90756 is limited to clients who are 4 years of age and older.

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

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/toxoid inventory, or clients who are 19 through 20 years of age.

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid 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 or toxoid, the administration of the vaccine or toxoid will be denied.

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 1st component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine or toxoid.

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

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.

Referto: [Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup](#) on the TMHP website at www.tmhp.com.

[THSteps Preventive Visit Checkup with Immunization and Vaccine Administration](#) on the TMHP website at www.tmhp.com for a claim form example.

5.3.11.3.1 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.

Referto: "Appendix B. Immunizations" in this handbook.

The DSHS website for TVFC provider enrollment information at www.dshs.texas.gov/immunize/tvfc/default.shtm.

The THSteps online education module "Immunizations," located on the THSteps website at www.txhealthsteps.com, for more information about immunizations.

5.3.11.4 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.dshs.texas.gov/thsteps/forms.shtm.

5.3.11.5 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, 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.

5.3.11.6 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.

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	87591
* Unless performed using point-of-care testing, the initial lead specimen must be sent to the DSHS Laboratory			

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.

5.3.11.6.1 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 1-888-963-7111, ext. 7661, or download the form online at www.dshs.texas.gov/lab/MRS_forms.shtm.

5.3.11.6.2 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 1-888-963-7111, ext. 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 or 1-888-963-7111, Ext. 7661
Fax: 1-512-776-7672

5.3.11.6.3 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.*

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) that is posted on the DSHS website at www.dshs.texas.gov/lab/MRS_forms.shtm and fax the completed form to 1-512-776-7672.

Providers can call 1-512-776-6030 or toll-free 1-888-963-7111, ext. 6030, for questions about submission requirements such as collection, supplies, and mailing of specimens for THSteps gonorrhea and chlamydia adolescent screening.

5.3.11.6.4 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

5.3.11.6.5 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 1-888-963-7111, Ext. 6030.

5.3.11.6.6 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 1-888-963-7111, Ext. 6236, 6237, or 2628, email ClinicalChemistry@dshs.texas.gov, or visiting the DSHS website at www.dshs.texas.gov/lab/mrs_labtests_toc.shtm.

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/thsteps/forms.shtm. 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 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 Group'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.

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.

Referto: "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 1-888-963-7111, Ext. 6030.

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.*

5.3.11.6.7 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.

5.3.11.6.8 Zika Virus Testing

Referto: Subsection 2.2.13.1, “Zika Virus Testing” in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for information about Zika virus testing.

5.3.12 Non-mandated Components

5.3.12.1 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 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: *The physician must complete the intermediate oral evaluation but can delegate all other components.*

5.4 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.

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.

5.4.1 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.

Referto: [Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup](#) on the TMHP website at www.tmhp.com.

[THSteps Preventive Visit Checkup with Immunization and Vaccine Administration](#) on the TMHP website at www.tmhp.com for a claim form example.

5.5 Claims Filing and Reimbursement

Providers may refer to Volume 1 for general information about claims filing and reimbursement.

Referto: “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.

5.5.1 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.
- If the provider learns that a client has other insurance coverage after Medicaid has paid a claim, 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 \$14.85 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 provider identifier and benefit code EP1 (exception: FQHC providers do not use benefit code EP1)
- The appropriate THSteps medical checkup procedure code (all ages) with diagnosis code Z0000, Z0001, Z00110, Z00111, Z00121, or Z00129. All immunizations must be reported with diagnosis code Z23

- 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

Referto: Subsection 5.3.6, “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 EPI.

5.5.2 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.

6 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	“Appendix D: Acronym Dictionary” (<i>Vol. 1, General Information</i>)
Automated Inquiry System (AIS)	Subsection A.10 *, “TMHP Telephone and Fax Communication” in “Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (<i>Vol. 1, General Information</i>)
State, federal, and TMHP contact information	“Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>)
TMHP electronic claims submission information	Subsection 6.2, “TMHP Electronic Claims Submission” in “Section 6: Claims Filing” (<i>Vol. 1, General Information</i>)
TMHP Electronic Data Interchange (EDI) information	“Section 3: TMHP Electronic Data Interchange (EDI)” (<i>Vol. 1, General Information</i>)

7 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*).

7.1 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.

7.2 TMHP Website

Additional information about Medicaid enrollment, general customer service, and provider education/training is available on the TMHP website at www.tmhp.com.

7.3 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).

7.3.1 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
- Models
- Other tangible documentation
- Review by the TMHP Dental Director

7.4 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. Click on the **Regional Support** link.

7.4.1 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.

7.5 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.dshs.texas.gov/thsteps/default.shtm, 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.

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
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
Texas Medicaid Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet
THSteps Dental Mandatory Prior Authorization Request Form
THSteps Referral Form Instructions
THSteps Referral Form
Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP)

9 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
Comprehensive Outpatient Rehabilitation Facility (CORE) (CCP Only)
Diagnosis and Treatment (Referral from THSteps Checkup)
Durable Medical Equipment (CCP Only)
Early Childhood Intervention Specialized Skills Training (SST)
Early Childhood Intervention Targeted Case Management with Face-to-Face Interaction
Early Childhood Therapy
Inpatient Rehabilitation Facility (Freestanding) (CCP Only)
Medical Checkup Follow-up Visit with Immunization Administration
Medical Checkup Follow-up Visit with TB Skin Test (TST)

Claim Form Examples
Medical Nutrition Counseling (CCP Only)
Occupational Therapists (CCP Only)
Orthotic and Prosthetic Services (CCP Only)
Physical Therapists (CCP Only)
Postpartum Depression Screening During an Infant THSteps Checkup
Private Duty Nurses (CCP Only)
School Health and Related Services (SHARS)
Speech-Language Pathologists (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

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*).

Referto: 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, "2012 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 www.dshs.texas.gov/thsteps/forms.shtm. 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 www.dshs.texas.gov/thsteps/forms.shtm.

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

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* (3rd edition), located at www.brightfutures.org or the Guidelines for Adolescent Preventive Services (GAP) Implementation Materials located at <https://brightfutures.aap.org/materials-and-tools/PerfPrevServ/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.

- 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.

Referto: The TB screening tool on the THSteps website at www.dshs.texas.gov/thsteps/forms.shtm.

“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.

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.immunizetexas.com.

B.1.1 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act of 1986 (NCVIA) requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the 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.

Note: Documentation of the injection site is recommended but not required. For additional information about documentation, providers can refer to www.vaers.hhs.gov.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from <http://vaers.hhs.gov/resources/vaersmaterialspublications>.

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 ImmTrac.

Referto: Subsection B.3.4, “How to Report Immunization Records to ImmTrac, 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.immunizetexas.com.

Referto: Section 5, “THSteps Medical” in this handbook.

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/schedules.

Referto: 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.immunizetexas.com.

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

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 and 90472 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered. Procedure codes 90473 and 90474 are benefits for services rendered to clients who are birth through 20 years of age when counseling is not provided for the immunization administered.

Referto: Subsection 5.3.11.3, "Immunizations" in this handbook for appropriate diagnosis codes for immunization administration.

B.3.2.2 Immunizations (Vaccine/Toxoids)

The following vaccines and toxoids are a benefit of Texas Medicaid:

Procedure Code	Number of Components**	Procedure Code	Number of Components**	Procedure Code	Number of Components**
90620*	1	90621*	1	90630	1
90632	1	90633*	1	90636	2
90644	2	90647*	1	90648*	1
90649*	1	90650*	1	90651*	1
90654	1	90655*	1	90656*	1
90657*	1	90658*	1	90660*	1
90661	1	90670*	1	90672*	1
90673	1	90674	1	90680*	1
90681*	1	90682	1	90685*	1
90686*	1	90687*	1	90688*	1
90696*	4	90698*	5	90700*	3
90702*	2	90707*	3	90710*	4
90713*	1	90714*	2	90715*	3
90716*	1	90723*	5	90732*	1
90733	1	90734*	1	90743	1
90744*	1	90746	1	90748*	2
90749	1	90756	1		
* TVFC-distributed vaccine/toxoid					
** The number of components applies if counseling is provided and procedure code 90460 and 90461 are submitted.					

Procedure codes 90655, 90657, 90685, and 90687 are limited to clients who are 6 through 35 months of age.

Procedure codes 90656 and 90658 are limited to clients who are 3 years of age and older.

Procedure codes 90686 and 90688 are limited to clients who are 6 months of age and older.

Procedure code 90682 is limited to clients who are 18 years of age and older. Procedure code 90756 is limited to clients who are 4 years of age and older.

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: 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/toxoid inventory, or for clients who are 19 through 20 years of age.

B.3.3 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.
- 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 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.3.4 How to Report Immunization Records to ImmTrac, 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 ImmTrac, 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 ImmTrac, providers must first register for registry participation and access.

ImmTrac 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.
- A state agency that has legal custody of the client.

ImmTrac offers two methods for reporting immunizations to DSHS: direct internet entry into ImmTrac's internet application and electronic data transfer (import).

B.3.4.1 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 ImmTrac web application after administering vaccines to the patient.

B.3.4.2 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 ImmTrac. Providers may still have access to the ImmTrac 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 ImmTrac access and receive login credentials from ImmTrac Customer Support. To register for ImmTrac access, providers may obtain and complete an ImmTrac Registration Packet (for providers and schools) from www.immtrac.com or request it from ImmTrac Customer Support at 1-800-348-9158.

B.3.4.3 Obtaining Parental Consent for Registry Participation

Before including a client's immunization information in ImmTrac, 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 ImmTrac participation during the birth certificate regis-

tration process. Written parental consent for ImmTrac participation applies to all past, present, and future immunizations. Texas law also permits a parent, managing conservator, or guardian to withdraw consent for ImmTrac participation at any time.

Providers may offer parents the opportunity to grant consent for their child's participation in ImmTrac using the pre-filled, ImmTrac-generated Immunization Registry (ImmTrac) Consent Form or the manual version (#C-7) of this form, also available from the ImmTrac application. Providers should retain the consent form and affirm parental consent through ImmTrac to establish the client's ImmTrac 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 ImmTrac as required by current Texas law.

B.4 Texas Vaccines for Children Program Packet

Referto: The DSHS website for TVFC information at www.dshs.texas.gov/immunize/tvfc/default.shtm.

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 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 Group’s website at www.dshs.texas.gov/lead/default.shtm.

C.2 Symptoms of Lead Poisoning

Children who have EBLs in the range of 5–45 μ g/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 44 μ g/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 (μ g/dL). In Texas, a BLL requires medical case management and follow-up testing if the level is greater than or equal to 5 μ g/dL.

Blood lead tests, in order of occurrence:

- Screening test—A blood lead test that indicates whether a client may have an EBL. 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 EBL 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 EBL 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 5 μ g/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.

If the screening test is 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.

Referto: [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 5.3.11.6.6, "Required Laboratory Tests Related to Medical Checkups" in this handbook.

Subsection 5.3.9, "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.

9.0.1 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 EBLs 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 EBL.

C.4.1.1 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 EBLs for the client. An EBL 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.4.1.2 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:

- 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 www.dshs.texas.gov/lead/providers.shtm.*

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.

Referto: "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.

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	Lead Around the Home (English and Spanish)
1-308	Lead in Your Food and Remedies (English and Spanish)
1-311	How Lead Affects Your Child's Health (English and Spanish)
1-312	Educator's Brochure
1-313	Getting a Good Specimen (Poster)
1-315	Lead-Safe Cleaning Tips: Keep your home clean by following these tips weekly (English and Spanish)
09-13410	How Pica Affects a Pregnant Woman and Her Unborn Baby (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 Follow-up Blood Lead Testing and Medical Case Management
Pb-110	Lead Risk Questionnaire (English and Spanish)

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 25 Texas Administrative Code (TAC), Part 1, Chapter 33, Subchapter A, Rule §33.1.

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 Texas Pediatric Society website at <https://txpeds.org/sites/txpeds.org/files/documents/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 Texas Pediatric Society website at <https://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf>.

For additional ECI information, providers can visit the HHS ECI website at <https://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, guardian, or other authorized adult during medical and dental checkups and dental treatment. DSHS implemented this requirement through rules found in 25 TAC §33.2 (Definitions) and 25 TAC §33.6 (THSteps Provider Responsibilities).

The DSHS rules require that the parent, guardian, or authorized adult accompany the client to the checkup, and that the parent, 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.*

Referto: HRC §§32.024(s)-(s-1) 25 TAC §33.2 and §33.6.

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 1.6, "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).

- 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.

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

Referto: 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).

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 <https://citysearch.hhsc.state.tx.us>.
- The physician/medical home monitors the child. See the *American Academy of Pediatrics Position Statement* at http://pediatrics.aappublications.org/cgi/content/full/113/Supplement_4/1545.
- 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 <http://pediatrics.aappublications.org/cgi/content/full/120/4/898>.
- 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.

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.