Texas Medicaid

Provider Procedures Manual

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Provider Handbooks

Inpatient and Outpatient Hospital 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.

INPATIENT AND OUTPATIENT HOSPITAL SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for Texas Medicaid hospital (medical and surgical acute care facility) providers and covers services that take place only in an inpatient or outpatient hospital setting. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to acute care hospitals, including military hospitals.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: The *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about services offered in settings such as rural health clinics (RHCs), Federally Qualified Health Centers (FQHCs), dialysis centers, and other similar facilities.

1.1 National Drug Codes (NDC)

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

1.2 Medicaid Managed Care Services

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

2 Enrollment

To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with the Health and Human Services Commission (HHSC), and have completed the Texas Medicaid & Healthcare Partnership (TMHP) enrollment process.

2.1 Hospital Eligibility Through Change of Ownership

Under procedures set forth by the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS), a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

- The provider must obtain recertification as a Title XVIII (Medicare) hospital.
- The hospital under new ownership must submit a new signed and dated HHSC Medicaid Provider Agreement between the hospital and HHSC.

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

Refer to: Subsection 1.4, "Provider Reenrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.1.1 Hospital-based Ambulatory Surgical Center (HASC) Enrollment

All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an HASC provider number at the time of enrollment.

2.2 Hospital-based Rural Health Clinic Enrollment

To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. An RHC can also apply for enrollment as a family planning agency.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA are not reimbursed for laboratory services.

Refer to: Subsection 9.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for RHC benefit and limitation information.

Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures, including information on Changes of Ownership.

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

3 Inpatient Hospital (Medical/Surgical Acute Care Inpatient Facility)

This section contains benefit, limitation, authorization, and claims filing information for inpatient hospital facility accommodation and ancillary services.

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more comprehensive information about claims filing and appeals.

"Section 7: Appeals" (*Vol. 1, General Information*) for more comprehensive information about claims filing and appeals.

Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.

3.1 General Information

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Texas Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of patients. Services must be medically necessary and are subject to Texas Medicaid's utilization review requirements. Claims submitted to TMHP must comply with the applicable Texas Medicaid policies and procedures.

3.1.1 Reimbursement Limitations

For clients who are 21 years of age and older, Texas Medicaid reimbursement for acute care inpatient hospital services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments that exceed $200,000 are recouped.

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This $200,000 limitation does not apply to the following:

- Services related to certain organ transplants.
- Services rendered to Texas Health Steps (THSteps) clients when provided through the Comprehensive Care Program (CCP).

For clients who are 20 years of age and younger, dollar limitations do not apply.

3.1.2 Spell of Illness

Reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively.

After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

Exceptions to the spell of illness are as follows:

- A prior-approved solid organ transplant. The 30-day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.
- THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.

Texas Medicaid will conduct a quarterly utilization review of inpatient claims to determine whether the claims were paid outside of the spell-of-illness limitation.

The first of these utilization reviews were for claims with dates of service from April 27, 2010, through January 6, 2012.

3.1.3 Take-Home Drugs, Self-Administered Drug, or Personal Comfort Items

Take-home drugs and comfort items that are provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

Take-home drugs and supplies may be a benefit through the Vendor Drug Program (VDP) when supplied by prescription.

Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements. Self-administered drugs provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

The client cannot be billed for take home drugs, comfort supplies or self-administered drugs that are provided by the hospital during an inpatient hospital stay.

3.1.4 Services Included in the Inpatient Stay

The following services are included in the inpatient stay and are not separately reimbursed:

- *Whole blood and packed red blood cells.* Inpatient services include whole blood and packed red blood cells that are reasonable and necessary for treatment of illness or injury. Whole blood and packed red blood cells that are available without cost are not reimbursed by Texas Medicaid.

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- *Laboratory, radiology, and pathology services.* Inpatient services include all medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology services.

  Note: *Ultrasound interpretations in the inpatient hospital setting will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.*

  Note: *All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.*

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

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

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

3.1.5 Outpatient Observation Services

Outpatient observation services are not a substitute for a medically appropriate inpatient admission. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay.

Refer to: Subsection 4.2.4, "Outpatient Observation Room Services" in this handbook for more information.

3.2 Services, Benefits, Limitations, and Prior Authorization - Acute Care

Inpatient hospital services include the following:

- Bed and board
- Whole blood and packed red blood cells
- All medically necessary services ordered by a physician to include laboratory, radiology, and pathology
- All medically necessary supplies ordered by a physician
- Medically necessary emergency and non-emergency ambulance transports during the inpatient stay
- Maternity care
- Newborn care
- Inpatient surgery and rehabilitation
- Organ and tissue transplant services
- Colorectal cancer screening services

3.2.1 Bed and Board

Inpatient bed and board include semiprivate accommodations or accommodations in an intensive care or coronary care unit. The accommodations include:

- Meals
- Special diets

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- General nursing services

Private accommodations including meals, special diets, and general nursing services may be reimbursed up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations may be reimbursed in full if required for medical reasons as certified by the physician. The hospital must document the medical necessity for a private room (i.e., the existence of a critical or contagious illness, a condition that could result in disturbance to other patients). The medical necessity for the private accommodations must be included in Block 80 of the UB-04 CMS-1450 paper claim form or added as an attachment to the claim submission.

3.2.2 Hysterectomy Services

Hysterectomy services are considered for reimbursement when the claim is filed with a signed Hysterectomy Acknowledgment Form or submitted documentation indicates that the Hysterectomy Acknowledgment Form could not be obtained.

Claims for services related to the hysterectomy cannot be reimbursed unless the signed Hysterectomy Acknowledgement Form is on file; consequently, to avoid claim denials, each individual provider is encouraged to submit a copy of the valid Hysterectomy Acknowledgement Form and not rely on another provider to do so.

Refer to: Subsection 6.13.1, "Hysterectomy Acknowledgment" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information.

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

3.2.3 Maternity Care

Inpatient maternity care includes usual and customary care for all female clients.

3.2.3.1 Emergency Coverage

For women with a family income at or below 198 percent of the Federal Poverty Level (FPL), hospital facility charges are paid through Emergency Medicaid. A client must be determined eligible for Emergency Medicaid by HHSC for a claim to be paid to a Medicaid provider. Claims are sent to Texas Medicaid & Healthcare Partnership (TMHP) for processing.

3.2.3.2 Mother and Newborn Hospital Stay

Circumstances that require the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a cesarean section must be documented in the clients' medical records.

Continuation of hospitalization is a benefit for the infant when the mother is required to remain hospitalized for medical reasons. The reason for the continuation of hospitalization must be documented in the client's medical record.

3.2.3.3 Children's Health Insurance Program (CHIP) Perinatal Coverage

For clients who are eligible for CHIP perinatal services as determined by HHSC, CHIP perinatal services include newborn services and inpatient hospital charges related to the delivery of the newborn. Preterm or false labor that does not result in a birth are not CHIP perinatal services.

Inpatient services limited to labor with delivery for women with income at or below 202 percent of FPL will be covered under CHIP perinatal. Newborn services will also be covered under CHIP perinatal.

For CHIP perinatal newborns with a family income at or below 198 percent of the federal poverty level, TMHP will process newborn transfer hospital claims even if the claim from the initial hospital stay has not been received. The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay.

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Transfer claims must be filed to TMHP using the admission type 1, 2, 3, or 5 in block 14; source of admission code 4 or 6 in block 15; and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.

Refer to: Subsection 6.19.1, "CHIP Perinatal Newborn Transfer Hospital Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

3.2.4 Newborn Care

Newborn care includes routine newborn care, routine screenings, and specialized nursery care for newborns with specific problems.

Hospital providers must provide all state-mandated newborn screenings and vaccinations.

Refer to: Subsection 4.3.12.2.3, "Hearing Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

3.2.4.1 Newborn Eligibility

A child is deemed eligible for Texas Medicaid through 12 months of age if the mother is receiving Medicaid at the time of the child's birth, and the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant. Therefore, it is not acceptable for a hospital to require a deposit for newborn care from a Medicaid client. The child's eligibility ends if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household.

Hospitals must complete Hospital Report (Newborn Child or Children) (Form 7484) on the TMHP website at www.tmhp.com to provide information about each child born to a mother who is eligible for Medicaid. If the newborn's name is known, the name must be on the form.

Important: *If the newborn's name is not known, the name may be left blank. The use of "Baby Boy" or "Baby Girl" delays the assignment of a number.*

The form must be completed by the hospital no later than five days after the child's birth and sent to HHSC at the address identified on the form. The form should not be completed for stillbirths. Hospitals should duplicate the form as needed, because they are not supplied by HHSC or TMHP.

Hospitals that submit the birth certificate information using the Department of State Health Services (DSHS), Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth software and the HHSC Form 7484, receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies that provide outpatient prescription benefits for medically-needy newborns.

For additional information about obtaining a newborn Medicaid identification number, providers may call 1-888-963-7111, Ext. 7368 or 1-512-458-7368.

After receiving a completed form, HHSC verifies the mother's eligibility. Within 10 days of receiving the completed form, HHSC sends notices to the hospital, mother, caseworker, and attending physician, if identified. The notice includes the child's Medicaid client number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification (Form H3087).

Claims submitted for services provided to a newborn child who is eligible for Medicaid must be filed using the newborn child's Medicaid client number.

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Newborns who are from families with an income at or below 198 percent of the FPL and who receive CHIP perinatal benefits are assigned a client number for Texas Medicaid. This number is only assigned for reimbursement of the newborn's hospital facility charges (on a UB-04 CMS-1450 paper claim form) for the initial hospital stay after delivery. Claims for the newborn's hospital facility charges should be sent to TMHP.

3.2.5 Organ and Tissue Transplant Services

3.2.5.1 Transplant Facilities

A facility that renders organ transplants must be a designated children's hospital or a facility in continuous compliance with the criteria set forth by the following:

- Organ Procurement and Transportation Network (OPTN)
- United Network for Organ Sharing (UNOS)
- National Marrow Donor Program (NMDP)

Facilities whose status of "good standing" has been suspended for any reason by the national credentialing bodies will not be reimbursed by Texas Medicaid for transplant services until the status of "good standing" is restored.

If a Medicaid client receives a transplant in an in-state or out-of-state facility that is not approved by Texas Medicaid, the client must be discharged from the facility to be considered to receive other medical and hospital benefits under Texas Medicaid. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable.

Texas Medicaid will not pay for routine post-transplant services for transplant patients in facilities that are not approved by Texas Medicaid.

3.2.5.1.1 Out-of-state Transplant Facilities

Out-of-state facilities may be reimbursed for transplants rendered to Texas Medicaid clients under certain conditions. In order for Texas Medicaid to reimburse for an out-of-state transplant, the out-of-state facility and professional providers must enroll as Texas Medicaid providers. The out-of state transplant facilities must submit proof of transplant facility UNOS or NMDP certification as required by the Texas HHSC.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Physicians who are licensed by the state of Texas may request prior authorization for transplant services to be performed at out-of-state facilities when all of the following criteria are met:

- The required organ transplant is not available in Texas
- The facility is nationally recognized as a Center of Excellence
- The services are medically necessary, reasonable, and federally allowable
- The client is enrolled in Texas Medicaid

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The pretransplant evaluation must be performed by a Texas facility. If it is medically necessary that the pretransplant evaluation be performed at the out-of-state facility as well, the prior authorization request for the out-of-state pretransplant evaluation must be submitted with a copy of the evaluation that was performed by the Texas facility. The documentation must support the need for an out-of-state pretransplant evaluation.

Important: *Texas Medicaid does not cover transplant services provided out-of-state that are available in Texas.*

3.2.5.2 Transplant Benefits and Limitations

If a transplant has been authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during Title XIX spell of illness may be a benefit, beginning with the actual first day of the transplant. This benefit is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Refer to: Subsection 3.1.2, "Spell of Illness" in this handbook for additional information about the 30-day spell of illness period.

Reimbursement for transplant is limited to an initial transplant as a lifetime benefit and one subsequent re-transplant because of rejection. Expenses incurred by a living donor will not be reimbursed.

All transplants require prior authorization. If a solid organ transplant is not prior authorized, services that are directly related to the transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the transplant surgery will be paid separately.

If the organ is rejected, the re-transplant requires its own prior authorization. If the re-transplant is not prior authorized, services that are directly related to the re-transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the re-transplant surgery will be paid separately.

Note: *The re-transplant is not included in the prior authorization for the initial transplant. The subsequent re-transplant must be prior authorized separately.*

Refer to: Subsection 9.2.51 *, "Organ/Tissue Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.2.5.3 Prior Authorization for Organ and Transplant Services

All solid organ transplant services provided by facilities and professionals must be prior authorized. If a solid organ transplant is not prior authorized, services directly related to the transplant within the three day pre-operative and six-week postoperative period also will be denied, regardless of who provides the service, (e.g., laboratory services, status-post visits, and radiology services). Services unrelated to the transplant surgery will be paid separately.

A transplant request signed by a physician associated with transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution's transplant protocol.

Refer to: Subsection 9.2.51 *, "Organ/Tissue Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

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3.2.5.4 Transplants for Medicare-Eligible Clients

Transplants are also a benefit under the Medicare program; therefore, for clients eligible for Medicare and Medicaid, Texas Medicaid will pay only the deductible or coinsurance portion as applicable according to current payment guidelines. Prior authorization must be obtained for Medicaid-only clients; authorization will not be given for Medicare/Medicaid-eligible clients. Texas Medicaid will not pay for a transplant service denied by Medicare for a Medicare-eligible client.

3.2.5.5 Experimental or Investigational Services

Benefits are not available for any experimental or investigational services (including xenotransplantation and artificial/bioartificial liver transplants), supplies, or procedures.

3.2.5.6 Reimbursement for Transplant Services

The hospital diagnosis related group (DRG) payment for the transplant includes procurement of the organ and services associated with the organ procurement. Section 1138 of the Social Security Act defines the conditions of participation for institutions in the organ procurement program. Organ procurement costs are not reimbursed to a hospital that fails to meet the conditions of participation. The specific guidelines may be found in the appropriate areas of the Code of Federal Regulations (CFR) Title 42, Parts 405, 413, 441, 482, and 485. Documentation of organ procurement must be maintained in the hospital's medical record.

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

3.2.5.7 Nonsolid Organ Transplants

Under current Texas Medicaid policy, procedures are considered to be medically necessary and reasonable based on safety and efficacy, as demonstrated by scientific evidence and controlled by clinical studies.

Nonsolid organ transplants that are benefits of Texas Medicaid include:

- Allogeneic and autologous stem cell transplantation
- Allogeneic and autologous bone marrow transplantation
- Autologous islet cell transplantation

All nonsolid organ transplants require prior authorization and must be performed in a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP).

Experimental or investigational services, supplies, or procedures are not a benefit of Texas Medicaid.

3.2.5.7.1 Inpatient Hospitalization

For a nonsolid organ transplant that has been prior authorized for clients who are 21 years of age and older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness is covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes but is included under one DRG payment.

Autologous harvesting of stem cells (single or multiple sessions) are reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient facility setting. Harvesting of stem cells performed in a hospital inpatient setting is included in the DRG and is not reimbursed separately.

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Refer to: Subsection 9.2.51.9, "Nonsolid Organ Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.3 Services, Benefits, Limitations, and Prior Authorization - Inpatient Rehabilitation Services

Inpatient rehabilitation services are a benefit of Texas Medicaid when provided as part of a general acute care inpatient admission, or with prior authorization for clients who are 20 years of age and younger in a freestanding rehabilitation facility.

Inpatient rehabilitation services in an acute care setting are included in the hospital DRG payment. All rehabilitation services are subject to Medicaid benefit limitations including the spell of illness. Exceptions to those limitations may be offered under CCP.

Refer to: Subsection 1.7.18, "Physical, Occupational, and Speech Therapy Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.18, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

3.4 Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services

3.4.1 Enrollment

Acute care hospitals and publicly-operated psychiatric facilities, i.e. state hospitals, must:

- Be certified by Medicare.
- Have a valid provider agreement with the Texas Health and Human Services Commission (HHSC).
- Complete the TMHP enrollment process.

Refer to: Subsection 6.1, "Enrollment" in this handbook for more information about acute care hospital enrollment.

Privately-operated psychiatric facilities must:

- Be licensed by HHSC.
- Providers must be accredited by a CMS-approved accrediting organization for psychiatric hospitals.

To be eligible to participate in the Comprehensive Care Program (CCP) to render services to Texas Health Steps clients, privately- and publicly-operated psychiatric facilities (henceforth, referred to as 'psychiatric facilities') must:

- Be accredited by a CMS-approved accrediting organization for psychiatric hospitals.
- Have a valid provider agreement with HHSC.
- Complete the TMHP enrollment process.

Note: *Acute care hospitals cannot enroll as CCP facilities.*

Refer to: Section 2, "Medicaid Children's Services Comprehensive Care Program (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

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Psychiatric facilities must enroll in Texas Medicaid as Institutions for Mental Disease (IMD).

Note: *According to TAC Rule §419.373(6) and based on 42 Code of Federal Regulations (CFR) §435.1009, an IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental illness, including medical attention, nursing care, and related services.*

Note: *Acute care hospitals are not considered IMDs, even if the hospital has a psychiatric ward.*

Acute care hospitals must comply with Centers for Medicare & Medicaid Services (CMS) Conditions of Participation for general hospitals.

Psychiatric facilities certified by Medicare must meet accreditation requirements from a CMS-approved accrediting organization for psychiatric hospitals and comply with CMS Conditions of Participation for both general hospitals and psychiatric hospitals.

3.4.2 General Information

Admissions to acute care hospitals for inpatient psychiatric services are a benefit of Texas Medicaid for persons of all ages in fee-for-service (FFS) Medicaid or managed care.

Admissions to psychiatric facilities, i.e. IMDs, for inpatient psychiatric services are a benefit of Texas Medicaid for:

- Persons 20 years of age and younger and 65 years of age and older in FFS Medicaid.
- Persons 21 through 64 years of age enrolled in managed care as an in lieu of service if the MCO and the person receiving services agree to an IMD as the setting for inpatient psychiatric services. The benefit is for a maximum of 15 calendar days per month, not per stay.

Note: *In lieu of services are services substituted for Medicaid State Plan services or settings, as allowed by 42 CFR §438.3(e).*

Admissions to acute care hospitals and psychiatric facilities must be medically necessary. Court orders for inpatient psychiatric services constitute the determination of medical necessity and are not subject to utilization management reviews to include prior authorizations, concurrent reviews or retrospective reviews that have the effect of denying, reducing or controverting the court-ordered service. Court-ordered services include:

- Mental health commitments.
- Condition of probation.

Refer to: Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about court-ordered services.

Upon admission, or once a person who is 20 years of age or younger becomes Medicaid eligible while in the facility, a certification of need for services, as required by Title 42, Code of Federal Regulations (CFR), Section 441.152, must be completed and placed in the person's medical record within 14 days of the admission.

All Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, known as Texas Health Steps in Texas, are available to persons 20 years of age and younger in a Medicaid covered inpatient psychiatric facility, as required by Section 12005 of the 21st Century Cures Act.

3.4.2.1 Documentation Requirements

The certification of need for services (42 CFR §441.152) for persons 20 years of age and younger must specifically address:

- Why community-based services cannot meet the treatment needs of the person.

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- Why inpatient psychiatric services under the care of a psychiatrist are required to treat the acute episode of the person.
- How inpatient psychiatric services can reasonably be expected to improve the condition, or prevent further regression of the person's condition in a proximate period.

Documentation of medical necessity for persons of all ages for inpatient psychiatric services in an acute care hospital or psychiatric facility, to include the certification of need for services (42 CFR §441.152) for persons 20 years of age and younger, must be:

- Documented in the person's medical record.
- Maintained by each facility, as applicable to state and federal guidelines.
- Readily available for review whenever requested by HHSC or designee.

3.4.2.2 Noncovered Services

Inpatient psychiatric services are not a benefit of Texas Medicaid for the following:

- Persons with a single diagnosis of a substance use disorder, as classified in the current edition of the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Persons with a single diagnosis of Intellectual or Developmental Disability, as classified in the current edition of the APA's DSM.
- Persons with a neurocognitive disorder (due to a general medical condition, not a mental disorder), e.g., delirium, dementia, traumatic brain injury, etc.
- Persons who are considered incarcerated, which is defined as when a criminal justice facility, such as a city or county jail or state prison, has custody of the person.

Refer to: Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about court-ordered services.

3.4.2.3 CLIA Certification for Laboratory Services

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate-holders.

Refer to: The CMS website at https://www.cms.gov/medicare/quality/clinical-laboratory-improvement-amendments/cartegorization for information about procedure code and modifier QW requirements.

For waived tests, providers must use modifier QW as indicated on the CMS website.

3.4.3 Initial and Extended Inpatient Psychiatric Services Criteria

3.4.3.1 Initial Inpatient Psychiatric Services

The person must have as the principal reason for admission a psychiatric diagnosis, as listed in the current version of the APA DSM, and documented reasons by a psychiatrist for why an inpatient level of care is required or that outpatient treatment has been attempted and failed.

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The person must meet one of the following criteria:

- A present danger to self, e.g., recent suicide attempt, active suicidal ideations with intent to act, recent self-mutilative behaviors that cause or intend to cause significant medical harm, command auditory or visual hallucinations or delusions that are likely to lead to serious self-harm, and other indirect or direct acts that are hazardous to the life of the person.
- A present danger to others (behavior must be attributed to the DSM diagnosis and can be adequately treated in an inpatient setting), e.g., recent life threating actions, homicidal threats with a deadly plan and available means to act on, or carry out, the plan, recent serious assaultive behaviors or active threats of same with a likelihood of acting, or command auditory or visual hallucinations or delusions that are likely to lead to harm to others.
- The person is at risk of substantial physical or mental deterioration because of the mental illness, e.g., acute or chronic psychosis or thought disorganization or severe disorientation to person, place or time.
- The person exhibits behaviors because of the mental illness that prevent, or interfere with, safe or effective treatment in a less restrictive setting.
- The person exhibits psychiatric symptoms, is involved in the legal system, and is ordered by a court to undergo a comprehensive assessment in an inpatient psychiatric setting to clarify the diagnosis and treatment needs.

The proposed treatment must require 24-hour-a-day medical observation, supervision and intervention and include:

- Active supervision, in accordance with facility guidelines, state and federal requirements and accreditation standards, by a psychiatrist with the appropriate credentials, as determined by the Texas Medical Board.
    - For children and adolescents, a psychiatrist must also have documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents.
- Formulation and implementation of a person-centered recovery plan (also known as a plan of care or treatment plan).
- Formulation and implementation of an initial discharge plan, to include documented contact with a community-based mental health provider.
- Provision of services are reasonably expected to improve the person's condition or prevent further regression, so that a lesser level of care may be implemented.

The treatment of the person's psychiatric condition must be provided in the least restrictive appropriate setting available and ambulatory care resources available in the community do not meet the needs of the person.

3.4.3.2 Extended Inpatient Psychiatric Services

Extended inpatient psychiatric services, i.e. extended stays, are considered for persons who require an inpatient level of care beyond the initial five-day admission period, as evidenced by continuing to meet at least one of the medical criteria listed in the initial inpatient psychiatric services section above. Treatment must include:

- Active supervision, in accordance with facility guidelines, state and federal requirements and accreditation standards, by a psychiatrist with the appropriate credentials, as determined by the Texas Medical Board.

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  - For children and adolescents, a psychiatrist must also have documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents.
- Formulation and implementation of an initial discharge plan, to include documented contact with a community-based mental health provider.

Extended stays are considered medically necessary for children and adolescents in the conservatorship of the Texas Department of Family and Protective Services (DFPS) when there are barriers to an immediate return to the child's or adolescent's residence, placement, or next setting for services. The extended stay facilitates an efficient transfer to the new setting without disrupting needed services. If DFPS is in the process of finalizing placement for the child or adolescent, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three 5-day extensions may be authorized.

3.4.4 Prior Authorization and Authorization Requirements

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

To complete the prior authorization process by paper, the provider must fax or mail the completed prior authorization request form to the TMHP Prior Authorization Department and retain a copy of the signed and dated prior authorization form in the person's medical record.

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

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity for the services requested. The physician must maintain documentation of medical necessity in the person's medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services.

Court-ordered inpatient psychiatric services are not subject to the five-day initial admission limitation or the seven-day extended stay limitation.

Providers must submit the following documentation for authorization of court-ordered inpatient psychiatric services no later than seven calendar days after the date on which services began:

- A copy of the court order signed by the presiding judge or magistrate that includes the statute under which the court is ordering services to determine incarceration status of the person.

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Prior authorization is not required for persons in FFS Medicaid admitted to a psychiatric unit in an acute care hospital.

Prior authorization is not required for initial admissions to psychiatric facilities for persons who are birth through 20 years of age or 65 years of age and older in FFS Medicaid for a maximum of five days, based on medical necessity.

Prior authorization is required for extended stays in psychiatric facilities for persons who are birth through 20 years of age and 65 years of age and older in FFS Medicaid for up to seven days per extension request.

Providers must submit a completed Psychiatric Inpatient Extended Stay Request Form that describes the necessary inpatient psychiatric services and reflects the need for an extended stay in relation to the original need for admission to include any change in the diagnosis of the person. Additional documentation or information supporting the need for an extended stay may be attached to the form.

Requests for an extension of stay must be received on or before the fifth day of an initial admission and/or on or before the last day authorized or denied for subsequent stay requests. If an extended stay is requested and the fifth day of the initial admission or the last date authorized or denied of the previous stay falls on a holiday or a weekend, the request for an extended stay is due by 5:00 p.m. of the next business day. The provider is notified of the decision in writing by the TMHP Prior Authorization Department.

- Extended stay requests for persons who are 11 years or age or younger require review by a psychiatrist.
- Extended stay requests for persons who are 12 through 20 years of age require review by a mental health professional. Any requests for extended stays that do not meet the medical necessity criteria for extended stays shall be referred to a psychiatrist for final determination.

3.4.4.1 Prior Authorization Appeals

All prior authorization requests not submitted or received by the TMHP Prior Authorization Department in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. The TMHP Prior Authorization Department must receive appeals within 15 days of receipt of the TMHP Prior Authorization Department denial notice.

- Appeals of a denial for an extended stay must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.
- Appeals of a denial for late submission of information must be accompanied by documentation which the provider believes supports the compliance with HHSC claims submission guidelines.

Appeals are reviewed first by an experienced psychiatric licensed clinical social worker, licensed professional counselor, or a registered nurse to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider will be notified of all denial determinations in writing by the TMHP Prior Authorization Department.

3.4.5 Reimbursement Guidelines

Revenue code 124 must be used for inpatient psychiatric services for persons birth through 20 years of age and 65 years of age and older in psychiatric facilities for FFS Medicaid.

Procedure codes 99238 (30 minutes or less) and 99239 (more than 30 minutes) must be used for a hospital discharge.

Professional services in an acute care hospital may be reimbursed to the professional who provides the service.

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Professional services in psychiatric facilities, i.e. IMDs, for persons 20 years of age and younger and 65 years of age and older may be reimbursed to the professional who provides the service.

- Services that are rendered in psychiatric facilities must be identified in the person-centered recovery plan of the person receiving services. Services that are not included in the person-centered recovery plan are subject to recoupment.
- Services that are rendered on the date of admission to and the date of discharge from a psychiatric facility may be reimbursed.
- If the person receiving services has not been discharged from a psychiatric facility, the facility is responsible for acute care services that are rendered to the person in an acute care facility. Claims that are submitted for these services will be denied as a duplicate service that has been paid to another provider.

Refer to: Subsection 9.2.60.6.1, "Inpatient or Observation Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) and Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Important: *Claims for professional services rendered during an inpatient stay in a psychiatric facility must include the psychiatric facility's ten-digit National Provider Identifier (NPI). Claims that do not include the psychiatric facility's NPI will be denied.*

Except for court-ordered services, admissions to acute care hospitals and psychiatric facilities are subject to the Texas Medicaid retrospective utilization review requirements.

3.4.5.1 Medicare Coinsurance and Deductible Reimbursement

Psychiatric facilities that are enrolled in Medicare may also receive Medicaid payment for the Medicare coinsurance or deductible according to current Medicaid guidelines.

Exception: *IMD services for clients who are 21 through 64 years of age are not eligible for fee-for-service reimbursement. If delivered through managed care and the managed care organization and client agree to an IMD as the setting for inpatient services, IMD services for clients who are 21 through 64 years of age are eligible for reimbursement for a total of 15 days per calendar month. The 15-day limitation is counted per calendar month, not per stay. As such, a stay of up to 15 days in a single month and a stay of up to 15 days in a following month may both be eligible for reimbursement. Medicaid will not reimburse coinsurance and deductible payments for psychiatric services that are rendered to these clients in an IMD beyond 15 days per calendar month.*

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) additional information about Medicaid guidelines for Medicare coinsurance and deductible payments.

3.4.6 Providing IMD Client Information to TMHP

IMD providers are requested to inform TMHP of the Medicaid clients who are residing in their facilities before submitting inpatient claims for those clients.

IMD providers can use the TMHP secure web page to enter client information and the admission and discharge dates by going to My Account and choosing the Manage IMD Clients Segment link in the Acute Care Online Portal field.

IMD providers can search for Medicaid client records that are associated with their NPIs.

Providers will be asked to submit the client's identification number and admission date. After the client is discharged, providers will be requested to enter the discharge date on the same Manage IMD Clients Segment screen.

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Providers will not be able to change previously reported client information except for the To Date of Service information.

Providers that submit inaccurate information can call the Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638 to have that client segment inactivated if the request is made within 24 hours of submission. After the erroneous client segment has been inactivated by TMHP, providers may submit a new client segment to replace it. After 24 hours have elapsed, providers must contact HHSC to request a correction to the information. This change must include the appropriate documentation of the client's patient control number (PCN) and the admission and discharge dates.

The change request and appropriate documentation must be submitted in writing to the following address:

Texas Health and Human Services Commission
Mail Code 91X PO Box 204077
Austin, Texas 78720-4077

3.5 Inpatient Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

The HHSC Office of Inspector General (OIG) UR Unit is responsible for retrospective review of inpatient DRG and TEFRA admissions. These reviews are accomplished through onsite visits, electronic access, or mail-in.

3.6 Utilization Review Process

The inpatient UR process for admissions reimbursed under the DRG prospective payment system consists of sampling medical records of paid Medicaid claims. The review process consists of three major components:

- *Admission review.* Determination of the medical necessity of the admission. For purposes of the Texas Medical Review Program (TMRP), TEFRA, and facility-specific per diem methodology reviews, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.
- *Quality review.* Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.
- *DRG validation.* Determination that the critical elements necessary to assign a DRG are present in the medical record and the diagnosis and procedures are sequenced correctly. The critical elements are age, sex, admission date, discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or comorbidities), and principal and secondary procedures.

The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, including the present on admission (POA) indicator, and quality of care. The medical record must reflect that any services reimbursed by Texas Medicaid were ordered by a physician or non-physician provider.

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When an admission denial or a denial of extended stay is issued, or when a technical denial becomes final, all money is recouped from the hospital for the admission or days of stay that are denied. When a DRG is reassigned as a result of UR, the payment to the hospital is adjusted.

Refer to: Subsection 3.6.3, "Technical Denials (DRG Prospective Payment)" in this handbook.

If an inpatient admission is denied, but a physician's order is present documenting the client originally was placed in observation, the UR unit may authorize the resubmission of services rendered during the first 48 hours on an outpatient claim.

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action, such as recoupment or referral to the HHSC OIG Medicaid Program Integrity (MPI) or Sanctions Unit.

3.6.1 Admission Review

All services, supplies, or items submitted as certified on the claim submission must be medically necessary for the client's diagnosis or treatment. Heath and Human Services Commission-Office of Inspector General-Utilization Review (HHSC-OIG-UR) personnel evaluate the medical necessity of an admission by comparing the medical record documentation to Change Healthcare InterQual® evidence-based guidelines. Non-physician reviewers use this criteria to determine medical necessity for initial approval of admission. If the case does not meet the initial approval criteria, the reviewer refers the case to a physician consultant who will determine the medical necessity of the inpatient admission. If the initial approval criteria are met but the medical necessity of the admission is still questionable, the non-physician reviewer refers the case to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, HHSC-OIG-UR will issue a denial.

3.6.1.1 Readmission Review

If a hospital admission or readmission occurs within 30 days of a discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity, quality, and DRG validation including POA indicators.

Transfers from one facility to another and readmissions are also subject to review.

3.6.1.2 Hospital-Based Ambulatory (HASC) Surgical Procedures

Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

3.6.1.3 Quality Review

Each Medicaid case is evaluated for quality of client care, adequacy of discharge planning, and medical stability of the client at discharge. Quality of care review includes the use of discharge screens and generic quality screens. Potential quality of care issues are identified by the physician. HHSC contracts with physician consultants to review medical records for quality of care. Physician consultants, of the specialty related to the care rendered, may make clinical recommendations or determine corrective actions when deemed appropriate. Child and adolescent psychiatrists may make recommendations based on review of inpatient psychiatric services provided to Medicaid clients younger than 21 years of age. Failure to verify completion of any corrective action recommendation within the specified time frame may result in referral of the case to the HHSC OIG MPI or Sanctions Unit.

3.6.1.4 Diagnosis-Related Group Validation

Each medical record is reviewed to validate the elements critical to the DRG assignment. These elements are the client's age, sex, admission date, patient discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or co-morbidities), POA indicators, and principal and secondary procedures. Documentation of these critical DRG elements in the medical record is evaluated for the correlation to the information provided on the claim form.

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The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The condition must be treated or evaluated during this admission to the hospital.

The secondary diagnoses are conditions that affect client care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and monitoring, or have clinically significant implications for future health-care needs.

The coding of diagnoses that have clinically significant implications for future health-care needs applies only to newborns and must be identified by the physician. Normal newborn conditions or routine procedures are not to be considered as complications or co-morbidities for DRG assignment.

Refer to: Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

The POA review will validate the POA indicator assigned to the principal and secondary diagnoses codes reported on claim forms. If it is determined that the principal and/or secondary diagnoses were not present at the time the order for inpatient admission occurs, the Commission will revise the POA indicator for the diagnosis code. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery are considered POA.

If the principal diagnosis, secondary diagnoses (complications or co-morbidities), or procedures are not substantiated in the medical record; sequenced correctly; have an incorrect POA indicator; or have been omitted, codes may be deleted, changed, or added. All diagnosis or procedure coding changes potentially resulting in a DRG change are referred to a physician consultant. When it is determined that the diagnoses and procedures are substantiated and sequenced correctly, the information will be entered into the applicable version of the Grouper software for a DRG determination. The CMS-approved DRG software considers each diagnosis and procedure and the combination of all codes and elements to make a determination of the final DRG assignment. When the DRG is reassigned, the payment to the provider is adjusted.

3.6.2 Recommendations to Enhance Compliance with Texas Medicaid Fee-for-Service Hospital Claims Submission

The following information highlights an area for physician and hospital providers where collaboration in client care delivery exists but can improve. Texas Medicaid, through its hospital UR activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims.

To enhance compliance with Texas Medicaid fee-for-service hospital claims submission and decrease the submission of inappropriate inpatient hospital claims, providers should adhere to the following:

- The hospital may admit clients in observation status if the physician has the reasonable expectation that the client will be discharged within 48 hours. If an inpatient claim was denied per retrospective UR, the hospital may resubmit the claim for the first 48 hours as an outpatient claim if the client was initially admitted in observation status (per physician order) and the stay was more than 48 hours.
- When a client is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This practice is acceptable when the physician makes changes to the admitting order before the hospital submits the claim for payment.
- The correction in admission status, when the above criteria are met avoids errors in claims submission and the potential need for a more lengthy appeal process.
- If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

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3.6.3 Technical Denials (DRG Prospective Payment)

3.6.3.1 On-Site Reviews

The following information describes on-site reviews:

- If the complete medical record is not made available during the on site review, a preliminary technical denial is issued on site. The hospital is allowed 60 calendar days from the date of the exit conference to provide the complete medical record to HHSC. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.
- If a complete medical record is made available on site, but a copy is required for further review, and the copy is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Note: *A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider failing to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: Subsection 1.7.4, "Retention of Records and Access to Records and Premises" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

3.6.3.2 Mail-In Reviews

If the complete medical record is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Hospital inpatient claim payments that have been recouped because of a technical denial may not be resubmitted on an outpatient claim.

Note: *A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider who fails to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: Subsection 1.7.4, "Retention of Records and Access to Records and Premises" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

3.6.4 Acknowledgment of Penalty Notice

Hospitals must have on file a signed acknowledgment from the physician stating that the physician received the following notice:

> "**Notice to Physicians:** Medicaid payment to hospitals is based, in part, on each client's principal and secondary diagnoses and the major procedures performed on the client, as attested to by the client's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws."

The acknowledgment of penalty notice must be specific to Texas Medicaid. Medicare penalty notices are not accepted.

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3.6.5 Sanctions

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG MPI or Sanctions Unit.

3.6.6 Utilization Review Appeals

Hospital providers may appeal adverse decisions by HHSC OIG UR Unit to the HHSC UR Medical Appeals Unit. A UR Medical Appeals decision is the final administrative decision of HHSC. Neither HHSC OIG UR Unit nor TMHP are responsible for Medical UR appeals.

Refer to: Subsection 7.3.3, "Utilization Review Appeals" in "Section 7: Appeals" (*Vol. 1, General Information*).

3.7 Claims Filing and Reimbursement

3.7.1 Medicaid Relationship to Medicare

Texas Medicaid may make deductible or coinsurance payments according to current Medicaid payment guidelines on valid, assigned Part A (hospital) and Part B (medical) Medicare claims.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about coinsurance and deductible payment guidelines.

Texas Medicaid provides reimbursement for 30 inpatient benefit days per spell of illness. When the 30 days coincide with the first 30 days of the Medicare benefit period and the client is eligible for both Medicare and Medicaid, Texas Medicaid pays the:

- Inpatient hospital deductible under Medicare Part A.
- Medicare Part A deductible for the first three pints of whole blood or packed red cells.

When the client only has Medicare Part B coverage, the hospital must follow these guidelines:

- Submit to Medicare the charges for certain inpatient ancillary services on a Medicare Claim Form 1483 for payment under the client's Part B coverage. The ancillary charges include the following:
  - Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests
  - X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
  - Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations
  - Prosthetic devices (other than dental) that replace all or part of an internal body organ or member (including contiguous tissue) or all or part of the function of a permanently inoperative or malfunctioning internal body organ or member including replacement or repairs of such devices (e.g., cardiac pacemakers, breast prostheses, maxillofacial devices, colostomy bags, and prosthetic lenses)
  - Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements and adjustments (if required) because of a change in the client's physical condition
  - Physical therapy (PT) services
  - Speech pathology services
  - Dialysis treatments

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- Submit to TMHP the remaining Part A charges on a UB-04 CMS-1450 paper claim form (or its electronic equivalent) indicating in Block 80 that the client is eligible for Medicare Part B benefits only. The client's Medicare number must appear on the Medicaid claim in Block 80. TMHP must receive these charges within 95 days of the last date of service on the claim.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

3.7.2 Inpatient Claims Information

Medicaid present on admission (POA) reporting is required for all inpatient hospital claims.

All hospital providers are required to submit a POA value for each diagnosis on the claim form, and no hospital is exempt from this POA requirement. Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values.

POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient visit, including emergency department, observation, or outpatient surgery, are considered POA.

The following table shows the POA values:

POA Value	Description	Payment
Y	Diagnosis was present at the time of admission	Payment will be made by Medicare when a hospital-acquired condition (HAC) is present
N	Diagnosis was not present at the time of admission	No payment will be made by Medicare when an HAC is present
U	Documentation was insufficient	No payment will be made by Medicaid when an HAC is present
W	Clinically undetermined	Payment will be made by Medicaid when an HAC is present:
(blank)	Exempt from POA reporting	Exempt from POA reporting
Note: Texas Medicaid follows Medicare guidelines for payments referenced in this table.		

Note: *If a diagnosis code is exempt from POA reporting, providers should leave the POA indicator field blank on the claim.*

TMHP will not recalculate the DRG based on POA indicator values for Medicare crossover claims or MCOs.

Depending on the POA indicator value, the DRG may be recalculated, resulting in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a POA DRG recalculation, the lesser of the number of days will be reimbursed.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*).

"Section 6: Claims Filing" (*Vol. 1, General Information*).

A complete list of POA exempt diagnosis codes can be found on the CMS website.

Claims for inpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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In Block 44 of the UB-04 CMS-1450, enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim.

Hospitals may submit information only claims to TMHP when one of the following situations exists. Hospitals must use TOB 110 to file these claims:

- Inpatient 30-day spell of illness benefit is exhausted.
- Payment made by a third party resource or other insurance exceeds the Medicaid allowed amount.

Additional claims information can be found within individual topic areas in this section.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*).

"Section 6: Claims Filing" (*Vol. 1, General Information*).

The Claim Form Examples page on the TMHP website at www.tmhp.com.

3.7.3 Inpatient Claims Submission

Inpatient hospital claims for traditional Medicaid clients must be submitted to TMHP if the client is enrolled in traditional Medicaid at the time of service or during the time of the admission.

3.7.4 Inpatient Reimbursement

3.7.4.1 Prospective Payment Methodology

Inpatient hospital stays except state-owned teaching hospitals, and psychiatric facilities (CCP) are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to Texas Medicaid's UR requirements.

The DRG reimbursement includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. The technical services are not billable to Texas Medicaid clients.

Texas Medicaid does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all Medicaid inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, Texas Medicaid requires that only one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 paper claim form, to be considered for payment.

The number of days of care charged to a beneficiary for inpatient hospital or skilled nursing facility (SNF) care services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for reporting purposes even if the hospital or SNF uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a patient returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

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Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims may be subject to retrospective review, which may result in recoupment. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

A new provider is given a reimbursement inpatient interim rate of 50 percent until a cost audit has been performed. A default standard dollar amount (SDA) rate is assigned for newly enrolled providers or newly constructed facilities.

Payment is calculated by multiplying the SDA for the hospital's payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Hospital reimbursement is made in accordance with the following TAC rules:

- 1 TAC §355.761 - Reimbursement Methodology for Institutions of Mental Diseases (IMD)
- 1 TAC §355.8052 - Inpatient Hospital Reimbursement
- 1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology
- 1 TAC §355.8058 - Inpatient Direct Graduate Medical Education (GME) Reimbursement
- 1 TAC §355.8060 - Reimbursement Methodology for Freestanding Psychiatric Facilities
- 1 TAC §355.8061 - Outpatient Hospital Reimbursement
- 1 TAC §355.8065 - Disproportionate Share Hospital Reimbursement Methodology
- 1 TAC §355.8066 - Hospital-Specific Limit Methodology

Medicaid providers that are cost-reimbursed are subject to cost reporting, cost reconciliation, and cost settlement processes, as defined in the following TAC rules:

- 1 TAC §355.8061 (a)(2) - Outpatient Hospital Remibursement
- 1 TAC §355.8052 (i)(i) - Inpatient Hospital Reimbursement
- 1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology

3.7.4.2 Client Transfers

3.7.4.2.1 Admission Dates

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date on which the client was admitted into each facility in Block 12 on the UB-04 CMS-1450.

3.7.4.2.2 Continuous Stays – Client Transfers and Readmissions

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be submitted as one admission under the NPI and taxonomy code. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Admissions submitted inappropriately are identified and denied during the UR process and may result in intensified review.

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of either the mean length of stay for the DRG or the eligible days in the facility. The DRG modifier, PT, on the R&S Report indicated per diem pricing related to a client transfer. Services must be medically necessary and are subject to Texas Medicaid's UR requirements.

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HHSC performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date that the client was admitted into each facility in Block 12 on the UB-04 CMS-1450. Inpatient authorization requirements are based on the requirements that are specified by the program in which the client is enrolled on the date of the original admission. Providers must adhere to the authorization requirements for claims to be considered for reimbursement. Providers are reimbursed at the rate in effect on the date of discharge.

3.7.4.3 Observation Status to Inpatient Admission

The dates of the inpatient admission must be reported as follows:

- *Date of inpatient admission*: The date of admission must reflect the date that the client was admitted to the hospital as an inpatient.
- *Dates of service*: The from date of service (FDOS) must reflect the date that the client first presented at the hospital for services including, but not limited to, emergency room (ER), observation, labor and delivery, or inpatient services.

If services that are rendered before the inpatient admission must be submitted on the inpatient claim, the number of preadmission days that are related to the inpatient admission cannot exceed the days of allowed for the rendered services:

Services	Days Allowed	Units
Emergency room (ER) services	One day (24 hours) before the inpatient admission	Submitted per day
Observation services	Up to two days (48 hours) before the inpatient admission	Submitted in hours
Labor and Delivery	Up to three days before the inpatient admission	Submitted per day

Diagnosis-Related Group (DRG) hospital claims allow for a total of three days of pre-admit services. Non-DRG hospital claims are allowed one day of pre-admit services, and a second day if additional observation hours occurred.

> ***Note:*** *If the client is admitted as an inpatient more than 24 hours after presenting in the ER without being placed in observation status or more than 48 hours after being placed in observation status, the ER and observation services may be reimbursed separately as outpatient services and must not be included on the inpatient claim.*

3.7.4.4 Outliers

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients who are 20 years of age and younger as of the date of the inpatient admission. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Providers can view their day and cost outlier payment information for inpatient hospital claims on the Electronic Remittance and Status (ER&S) Report. The R&S Report reflects the outlier reimbursement payment and defines the type of outlier paid. To view the day and cost outlier payment information, providers, facilities, and third party vendors may need to update their 835 electronic file format. For information about how to update the 835 electronic file format, refer to the revised electronic data interchange (EDI) companion guide (ANSI ASC X12N 835 Healthcare Claim Payment/Advice-Acute Care Companion Guide) on the TMHP website at www.tmhp.com.

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3.7.4.4.1 Day Outliers

All of the following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the mean length of stay (MLOS) by more than two days.
- Inpatient days must exceed the DRG day threshold for the specific DRG.

Once the outlier payment criteria are met:

- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 60 percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

In compliance with 1 TAC §355.8052, all DRG inpatient hospital day outlier payments must not exceed the allowed cost for the service. All hospitals except in-state children's hospitals, both day and cost outlier payments have been reduced by 10 percent.

TMHP calculates payments as follows:

1) Calculate the day outlier.

   Calculate the allowed cost for the service (i.e., the cap amount) by taking the difference between the Tax Equity and Fiscal Responsibility Act (TEFRA) and DRG-payable amounts.

   Take the lesser of the day outlier or the cap amount.

   Reduce the day outlier by 10 percent for all hospitals except in-state children's hospitals.

2) Calculate the cost outlier:

   Reduce the cost outlier by 10 percent for all hospitals except in-state children's hospitals.

Reimbursement is made for day or cost outliers on claims that qualify. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Example

Calculations	Example amount
Day Outlier Calculation: ([SDA x DRG relative weight / Mean Length of Stay] x Outlier Days) x 0.6 = day outlier amount	$500.00
Apply Cap and Reduce by 10 Percent Calculate the allowed cost for the service (i.e., the cap amount) by taking the difference between the TEFRA and DRG payable amounts (in this example, $600.00). Take the lesser of the day outlier or the cap amount (in this example it would be the day outlier of $500.00). Reduce by 10 percent.	$450.00
Calculation1: Cost Threshold 11.14 x Universal Mean ($10,161.08) = <amount A> 11.14 x SDA = <amount B> 1.5 x DRG Relative Weight x SDA = <amount C> Cost threshold = The greater of <amount C> compared with (the lesser of <amount A> and <amount B>)	$550.00

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Calculations	Example amount
Calculation2: Cost Outlier Allowed amount x reimbursement rate = TEFRA amount TEFRA amount - cost threshold x 0.6 percent = cost outlier amount Reduce by 10 percent.	$495.00

The calculations in this example would result in one of the following payments:

- If the claim qualifies for the day outlier payment only, payment will be made up to $450.00.
- If the claim qualifies for the cost outlier payment only, payment will be made up to $495.00.
- If the claim qualifies for both the day outlier and cost outlier payment, the payment will be made up to $495.00, which is the greater of the day outlier or the cost outlier payment.

3.7.4.5 Maternal Level of Care Designation for Inpatient and Outpatient Services

Hospitals enrolled in Texas Medicaid may be reimbursed for inpatient and outpatient maternal services only if the hospitals have received a maternal level of care designation from the Department of State Health Services in accordance with 25 Texas Administrative Code §§133.201-133.210. The maternal level of care designation applies to Texas Medicaid and Texas Medicaid Managed Care Organizations.

Providers can refer to the DSHS website for more information for Maternal Level of Care Designation.

3.7.4.6 Hospitals That Do Not Meet Minimum Requirements for Maternal Level of Care Designation

A hospital that does not meet the minimum requirements for any level of care designation for maternal services will not be reimbursed for inpatient and outpatient maternal services rendered to Texas Medicaid and Medicaid MCO clients. Hospitals without a maternal level of care designation may be reimbursed for emergency services provided or reimbursed under state or federal law to stabilize the mother prior to transport to a facility capable of providing the appropriate level of care.

Note: *Maternal LOC Designation is not required for state-owned providers.*

Claims for inpatient and outpatient maternal services submitted by hospitals that do not have a maternal level of care designation on file will be denied. Providers can appeal the claim with documentation of the emergency services required.

If maternal inpatient and outpatient services are rendered by a facility which has applied for (but not yet received) a maternal designation, the facility must still adhere to existing claim filing deadlines (95 days from the date of discharge) and is also responsible for keeping their claim appeals active while awaiting maternal level of care designations to adhere to the 120-day claim appeal deadline.

Requirements to obtain a maternal level-of-care designation only apply to facilities located in Texas. Those entities physically located outside of Texas but enrolled in Texas Medicaid (i.e., out-of-state or border state facilities) are exempt from requiring a maternal level of care designation for inpatient and outpatient services rendered to maternal clients.

Note: *When submitting paper claims for inpatient and outpatient maternal services rendered at a facility with an address that is different from the provider's billing address, providers must enter the address of the facility where services were rendered in the remarks field.*

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3.7.4.7 Other Requirements

The submitted facility address on the claim must match the physical address of the location that has been issued a maternal level of care designation. If the facility address is not included on the claim, the submitted billing address must match the physical address of the location that was issued a maternal level of care designation.

Important: *Claims will be denied if the address submitted on the claim does not match the physical address of the location that was issued a maternal level of care designation. For example, numbers must be spelled out as words or left numeric on the claim to match the address on the maternal level of care designation on file. "Street" or "avenue" must either be spelled out or abbreviated, etc.*

3.7.4.7.1 Inpatient Hospital Claims for $10 Million or More

Providers should split fee-for-service inpatient claims for $10 million or more into separate interim claims. The interim claims should each total less than $10 million and be submitted with the following type of bill (TOB) for appropriate processing:

- First interim claim (TOB 112): Covers most of the inpatient stay
- Subsequent claims (TOB 113): Cover any subsequent inpatient stay charges, if applicable
- Final discharge claim (TOB 114): Covers the remaining days billed and charges

Providers should submit at least a first interim claim and the final discharge claim. Subsequent claims can include any additional charges.

3.7.4.8 Crossover Claims for Dual-eligible Clients

Maternal level of care designation requirements will also apply for maternal inpatient and outpatient crossover claims.

3.7.4.9 Neonatal Level of Care Designation for Inpatient Services

Hospitals enrolled in Texas Medicaid may be reimbursed for inpatient neonatal services only if the hospitals have received a neonatal level of care designation from DSHS in accordance with Title 25 Texas Administrative Code §§133.181-133.190.

A neonatal service is any inpatient hospital service rendered to a client who is 28 days of age or younger.

Refer to: The DSHS website for more information on Neonatal Level of Care Designation.

3.7.4.10 Hospitals that Do Not Meet Minimum Requirements for Neonatal Level of Care Designation

A hospital that does not meet the minimum requirements for any level of care designation for neonatal services will not be reimbursed for inpatient neonatal services rendered to Texas Medicaid and CSHCN Services Program clients. Hospitals without a neonatal level of care designation may be reimbursed for emergency services to stabilize an infant prior to transport to a facility capable of providing the appropriate level of care.

Claims for inpatient neonatal services submitted by hospitals that do not have a neonatal level of care designation on file will be denied. Providers can appeal claims by providing documentation that emergency services were required.

If neonatal inpatient services are rendered by a facility that has applied for (but not yet received) a neonatal designation, the facility must still adhere to existing claim filing deadlines (95 days from the date of discharge). While awaiting neonatal level of care designation the facility is responsible for maintaining active claims appeals to adhere to the 120-day claim appeal deadline.

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Requirements to obtain a neonatal level of care designation only apply to facilities located in Texas. Those entities that are physically located outside of Texas and enrolled in Texas Medicaid (i.e., out-of-state or border state facilities) are exempt from requiring a neonatal level of care designation for inpatient services rendered to neonatal clients.

Note: *When submitting paper claims for inpatient neonatal services rendered at a facility with an address that is different from the provider's physical address, providers must enter the address of the facility where services were rendered in the remarks field.*

Refer to: "Section 7: Appeals" (*Vol. 1, General Information*) for more information.

3.7.4.11 Other Requirements

The submitted facility address on the claim must match the physical address of the location that has been issued a neonatal level of care designation. If the facility address is not included on the claim, the submitted billing address must match the physical address of the location that was issued a neonatal level of care designation.

Important: *The hospital address on the health facilities license must match the address billed on the claim. Claims will be denied if the address submitted on the claim does not match the address on file. Providers should refer to the DSHS approval letter to verify the correct address.*

Refer to: The DSHS website for more information for more information on address updates.

3.7.4.12 Transfers

When Texas Medicaid or CSHCN Services Program clients are 28 days of age and younger on the date of admission and are subsequently transferred to another facility, neonatal level of care designation requirements will apply to all facilities involved in that client's continuous inpatient stay.

3.7.4.13 Crossover Claims for Dual Eligible Clients

Neonatal level of care designation requirements will also apply to services rendered to a client who is less than 28 days old and has dual Medicare and Medicaid eligibility on the date of admission.

3.7.4.14 Children's Hospitals

Children's hospitals are reimbursed using the prospective payment methodology based on APR-DRG methodology.

With the exception of designated children's hospitals, hospitals that are reimbursed by APR-DRG payment methodology receive one SDA rate.

Designated children's hospitals receive two SDA rates:

- One rate for obstetric delivery services rendered to clients who are 18 years of age and older.
- One rate for all other services rendered to clients who are 18 years of age and older and all services rendered to clients who are 17 years of age and younger, including obstetric delivery services.

3.7.4.15 Potentially Preventable Complications (PPC) and Potentially Preventable Readmissions (PPR)

Potentially Preventable Complications (PPCs)

By definition, potentially preventable complications (PPCs) are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from the natural progression of the underlying illness. A PPC is an inpatient hospital complication that was potentially preventable based on criteria such as hospital characteristics, reason for admission, procedures, and the interrelationships between underlying medical conditions.

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S.B. 7, Chapter 526, the 82nd Texas Legislature, 2011, establishes the authority of HHSC, and Texas Government code 543A.0151 requires HHSC to identify PPCs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. A statewide average PPC rate is calculated for all hospitals within Texas. Each hospital has an individual rate. Hospitals are able to compare their rate of PPC to the statewide average.

The PPC analysis is performed in accordance with TAC, §354.1446 Potentially Preventable Complications.

Potentially Preventable Readmission (PPRs)

By definition, potentially preventable readmissions (PPRs) are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up.

Texas Medicaid uses a 15 day readmission interval.

Section 531.913, House Bill (H.B.) 1218, 81st Legislature, 2009, Texas Government Code 543A.0151, requires the HHSC to identify PPRs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC delivers an annual, confidential report of the results to each hospital that is enrolled in Texas Medicaid, and each of those hospitals must distribute the information to their care providers. HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. Patients are never identified in the reports.

PPR Analysis

The PPR analysis is performed in accordance with TAC, §354.1445 Potentially Preventable Readmissions.

Refer to: The HHS website at www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events for more information on Potentially Preventable Events (PPE).

3.7.4.16 State-owned Teaching Hospitals

Inpatient hospital stays in designated state-owned teaching hospitals are reimbursed according to the TEFRA payment methodology.

State-owned teaching hospitals are defined specifically in 1 TAC §355.8052 as the following hospitals: University of Texas Medical Branch (UTMB); University of Texas Health Center Tyler; University of Texas Southwestern Medical Center (UTSW) and M.D. Anderson Hospital.

3.7.4.17 Payment Window Reimbursement Guidelines

3.7.4.17.1 Guidelines for Services Preceding an Inpatient Admission

The following payment window reimbursement guidelines apply to services that are rendered by the hospital or an entity that is wholly owned or operated by the hospital. The three-day (or one-day) payment window does not apply if:

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

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Texas Medicaid inpatient hospital providers must submit, as part of the client's inpatient hospital claim, all related professional and outpatient services that were rendered on the date of the client's inpatient admission or one of the following dates immediately before admission:

- Within three calendar days before the client's inpatient admission for hospitals that receive DRG reimbursement, with the exception of children's hospitals.
- Within one calendar day before the client's inpatient admission for hospitals that receive reimbursement other than DRG.
- Within one calendar day before the client's inpatient admission for children's hospitals.

Professional and outpatient services that must be submitted as part of the inpatient hospital claim include the following services if they are rendered by the hospital or an entity that is wholly owned or operated by the hospital:

- Diagnostic services. Diagnostic services include outpatient laboratory and radiology services that are related to the inpatient admission and submitted by physician and outpatient hospital providers. Affected services will include the total and technical components. The professional interpretation component will not be included in the payment windows identified above.
- Non-diagnostic services. Non-diagnostic services include surgeries and other non-diagnostic procedures and services that are related to the inpatient admission and submitted by physician, outpatient hospital, or other providers.

Important: *Related professional and outpatient services that were rendered within the specified time frames must be submitted on the inpatient hospital claim and not on an outpatient hospital claim. An outpatient hospital claim for these services will be denied as part of the payment for the inpatient hospital stay.*

3.7.4.17.2 Exceptions

The following services are excluded from the payment window and may be submitted and reimbursed separately from the inpatient admission:

- Services rendered by federally qualified health center (FQHC) providers
- Services rendered by rural health clinic (RHC) providers
- Professional services that are rendered in the inpatient hospital setting (place of service 3)
- Non-emergency and emergency ambulance services

The outpatient emergency and maintenance renal dialysis procedure codes in the tables below are also exceptions to the one-day payment window reimbursement guidelines:

Procedure Codes									
G0257									
ESRD Physician Services									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970
Physician Services for Hemodialysis or Other Dialysis Procedures									
71010	71020	78300	78305	78306	80069	81050	82040	82310	82374
82435	82565	83615	83735	84075	84100	84132	84155	84295	84450
84520	85004	85007	85008	85014	85018	85025	85027	85041	85345
85347	85610	87340	90935	90937	90945	90947	93005		

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Procedure Codes									
Equipment and Supplies									
A4216	A4217	A4651	A4652	A4657	A4660	A4663	A4670	A4680	A4690
A4706	A4707	A4708	A4709	A4714	A4719	A4720	A4721	A4722	A4723
A4724	A4725	A4726	A4730	A4736	A4737	A4740	A4750	A4755	A4760
A4765	A4766	A4772	A4773	A4774	A4802	A4860	A4911	A4913	A4918
A4927	A4928	A4929	A4930	A4931	A4932	E0424	E0431	E0434	E0439
E0441	E0442	E0443	E0444	E1510	E1520	E1530	E1540	E1550	E1560
E1570	E1575	E1580	E1590	E1592	E1594	E1600	E1620	E1630	E1632
E1635	E1637								

3.7.4.17.3 Professional and Outpatient Claims for Services Related to the Inpatient Admission

Professional and outpatient services that are rendered on the date of admission, or within one of the one-day or three-day timeframes indicated above by the hospital or an entity that is wholly owned or operated by the hospital, are considered part of the inpatient stay. Professional and outpatient claims submitted for services that are related to the inpatient admission will be denied or recouped if they are submitted with the specified payment window.

When modifier PD is appended to a professional or outpatient service, the modifier indicates that the service is related to the inpatient admission. The total and technical components for professional and outpatient services that are related to the inpatient admission will be denied when submitted with modifier PD.

Note: *The professional interpretation component for professional and outpatient services that are related to the inpatient stay may be reimbursed separately even if accompanied by PD modifier.*

3.7.4.17.4 Professional and Outpatient Claims for Services Unrelated to the Inpatient Admission

Professional and outpatient services that are rendered within the specified timeframe by the hospital or an entity that is wholly owned or operated by the hospital may be reimbursed if they are identified as unrelated to the inpatient admission as follows:

- Professional and outpatient claims for diagnostic services that are unrelated to the inpatient admission must be submitted with modifier U4, which indicates the service is unrelated to the inpatient admission.
- Professional claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the professional claim to the principal inpatient diagnosis. Professional services must be submitted with modifier U4 if the services are unrelated and up to six digits of the referenced professional diagnosis code match the principle inpatient diagnosis code.
- Outpatient claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the outpatient claim to the principal inpatient diagnosis. The outpatient services must be submitted with condition code 51 if the services are unrelated and up to six digits of the referenced outpatient diagnosis code match the principle inpatient diagnosis code.

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Unrelated services that are denied as part of the inpatient admission can be appealed with modifier U4 or condition code 51, which indicates that the service is unrelated to the inpatient admission.

Note: *Claims that are submitted with modifier U4 or condition code 51 will be subject to retrospective review and may be recouped if there is not sufficient documentation to indicate the service was unrelated to the inpatient admission.*

These benefit changes do not impact services rendered by providers that are not wholly owned or operated by the hospital.

3.7.4.18 Potentially Preventable Readmissions (PPR)

H.B. 1218, 81st Legislature, Regular Session 2009, requires that HHSC identify potentially preventable readmissions (PPRs) in the Medicaid population and report results confidentially to each hospital. The law also requires each hospital to distribute the information to its care providers.

3.7.5 Provider Cost and Reporting

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient and outpatient costs in the cost reports submitted annually. The provider must prepare one copy of the applicable CMS Cost Report Form along with the required PCCM supplemental worksheets. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet, available from CMS, and the Outpatient PCCM D, Part V worksheet. A sample of the Outpatient PCCM D, Part V is available on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2.2, "Cost Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

If a change of ownership or provider termination occurs, the cost report is due within five months after the date of the change in ownership or termination. Any request for an extension of time to file must be made on or before the cost report due date and sent to TMHP Medicaid Audit at the address indicated under "Written Communication With TMHP" in the "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*). For questions or assistance, call TMHP Medicaid Audit at 1-512-506-7630 or email audit.costreport@tmhp.com.

Annual cost reports must be filed as follows:

- Submit one copy of the cost report to TMHP Medicaid Audit within five months of the end of the hospital's fiscal year along with any amount due to Texas Medicaid.
- TMHP Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to Texas Medicaid or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.
- Field audits are conducted when necessary.
- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary. The provider must send TMHP a copy of one of the following:
  - Audited or settled without audit Medicare Cost Report
  - Medicare Notice of Amount of Program Reimbursement
  - Medicare Audit Adjustment Report, if applicable

Medicaid hospitals may request copies of their claim summaries for their cost reporting fiscal year. The summaries for tentative settlements include three additional months of claim payments for the fiscal year. The summaries for final settlements include ten months of claim payments for the fiscal year. TMHP Medicaid Audit uses this data to determine the tentative and final settlements and interim rates.

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The Medicaid claim summary data are only generated once each month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs are submitted within 30 days after the fiscal year-end. Final settlement log requests are submitted within nine months after the fiscal year-end.

The Medicaid logs can be requested through the provider's administrator account on the TMHP website at www.tmhp.com. Medicaid logs can also be requested by calling 1-512-506-7630, by emailing audit.costreport@tmhp.com, or by sending a written request to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Allow 45 days for receipt of these logs.

3.7.6 Third Party Liability

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

Other Insurance Form on the TMHP website at www.tmhp.com.

Tort Response Form on the TMHP website at www.tmhp.com.

4 Outpatient Hospital (Medical and Surgical Acute Care Outpatient Facility)

This section contains benefit, limitation, authorization, and claims filing information for outpatient hospital facility emergency, observation, and other services.

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more comprehensive information about claims filing and appeals.

"Section 7: Appeals" (*Vol. 1, General Information*) for more comprehensive information about claims filing and appeals.

Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.

4.1 General Information

Outpatient diagnostic, therapeutic, and surgical services that are rendered in an acute care hospital setting are services that are provided to clients by or under the direction of a physician.

Outpatient hospital services include those services that are rendered:

- In the emergency room (ER)
- As day surgery
- In the observation room
- By ancillary departments such as the laboratory, radiology, physical or occupational therapy, cardiac rehabilitation, hyperbaric chamber, infusion services, and other areas able to provide services in the outpatient setting.

4.1.1 Drugs and Supplies

4.1.1.1 Self-Administered Drugs

Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements.

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These drugs that are provided by the hospital during an outpatient hospital visit are included in the hospital reimbursement and are not reimbursed separately. The client cannot be billed for self-administered drugs that are provided by the hospital during an outpatient hospital stay.

4.1.1.2 Take-Home Drugs and Supplies

Benefits do not include drugs and biologicals provided by the hospital and taken home by the client. Supplies provided by a hospital for use in physicians' offices are not reimbursable.

Take-home drugs and supplies are a benefit for services rendered to clients in the outpatient setting when supplied by prescription through the VDP.

4.1.2 Outpatient Services Provided Without Charge

Texas Medicaid pays the clinic registration fee in lieu of other benefits when a hospital provides outpatient services without charge, and if the registration fee is less than the allowed Medicaid payment.

Refer to: TAC Rule §354.1073 for information about authorized outpatient hospital services.

Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about noncovered items or services.

4.1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

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

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in this handbook for additional information about the payment window reimbursement guidelines.

4.2 Services, Benefits, Limitations, and Prior Authorization

4.2.1 Prior Authorization Requirements

The hospital is responsible for requesting prior authorization for the non-emergency transport to the client's home or to a nursing home after a non-scheduled outpatient visit.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

4.2.2 Emergency Department Services

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week.

Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state.

All claims that are submitted by outpatient hospital providers must include a procedure code with each revenue code for services that are rendered to Texas Medicaid clients. This procedure code must be listed on the same claim detail line as the emergency department revenue code.

The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered in the hospital's emergency department.

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Emergency department reimbursement may include room charges and ancillary charges. Emergency department room charges may be submitted using the following revenue codes:

Revenue Code	Description
450	Emergency room
451	Emergency room-EMTALA emergency medical screening
456	Emergency room, urgent care
459	Emergency room, other

Emergency department ancillary services include, but are not limited to, the following:

- Laboratory services
- Radiology services
- Respiratory therapy services
- Diagnostic studies (including, but not limited to, ECGs, computed tomography (CT) scans, and supplies)

The administration of the injection will not be reimbursed to outpatient hospital providers. An injection or infusion administered by a nurse is included in the emergency room charge and is not reimbursed separately to the outpatient facility.

Ancillary services must be submitted on the UB-04 CMS-1450 paper claim form using the appropriate procedure codes or revenue codes for rendered services.

If a client visits the emergency room more than once in one day, the times must be given for each visit.

If the client ultimately is admitted as an inpatient within 48 hours of treatment in the ER or clinic, the ER or clinic charges must be submitted on the inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the ER or clinic.

According to the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986, if any individual presents at the hospital's emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination and stabilization services within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists.

EMTALA medical screening code (451) may be considered for reimbursement when submitted as a stand-alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement. Services beyond screening (451) can be submitted with the appropriate corresponding emergency services code (450).

Medicaid claims administrators are prohibited from requiring prior authorization or primary care provider notification for emergency services including those needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition.

Texas Medicaid provides that certain undocumented aliens and legalized aliens who require treatment of an emergency medical condition or emergency behavioral health condition are eligible to receive that treatment. After the emergency condition requiring care is stabilized and is no longer an emergency, the coverage ends. If the alien continues to receive ongoing treatment after the emergency ceases, the ongoing treatment is not a benefit.

Texas Medicaid provides for medical services for eligible clients while out-of-state. The attending physician or other provider must document that the client was treated for an emergency condition. Out-of-state emergency services are also a benefit when the client's health would be in danger if he or she were required to travel back to Texas.

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Emergency department services are subject to retrospective review.

In instances of sudden illness or injury, the client may receive treatment in the ER and be discharged, placed on observation status, or admitted as an inpatient.

4.2.2.1 Emergency Department Payment Reductions

Nonemergent and nonurgent evaluation and management (E/M) services rendered in the emergency room may be reimbursed at 125 percent of the adult, physician office visit fee for procedure code 99202. Reimbursement is based on the E/M procedure code submitted on the same line item as the emergency room revenue code.

Imaging services rendered by outpatient hospital providers are reimbursed at the flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code.

Note: *Evaluation and management services that are rendered in the emergency room for critically ill or critically injured Texas Medicaid clients of any age, are not subject to reduction in payment.*

Exception: *Rural hospitals, nonemergent and nonurgent E/M services rendered in the emergency room may be reimbursed at 55 percent of the allowed rate.*

4.2.3 Day Surgery

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

These procedures are for clients who are scheduled for a day surgery procedure and are not inpatient at the time the day surgery is performed.

4.2.3.1 Inpatient Admissions for Day Surgeries

If a client is admitted for a day surgery procedure—whether scheduled or emergency—one of the following classifications may be considered an inpatient procedure.

- ASA Classification of Physical Status of III (P3), IV (P4), or V (P5)
- Classification of Heart Disease IV

The day surgery services must be submitted on an inpatient claim (TOB 111) using the hospital's NPI and taxonomy code. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the procedure must be included on one inpatient claim.

Refer to: The Anesthesia standards at www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system for a description of the ASA classes of physical status.

The descriptions for ASA classes of physical status are as follows:

- *Class I.* A normal healthy patient, without organic, physiological, or psychiatric disturbance.

  Example: *Healthy patient with good exercise tolerance.*

- *Class II.* A patient with mild systemic disease, controlled medical conditions without significant systemic effects.

  Example: *Controlled hypertension or diabetes mellitus without system effects, cigarette smoking without evidence of chronic obstructive pulmonary disease (COPD), anemia, mild obesity, age less than 1 or greater than 70 years, or pregnancy.*

- *Class III.* A patient exhibiting severe systemic disturbance that may or may not be associated with the surgical complaint and that seriously interferes with the patient's activities.

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Example: *Severely limiting organic heart disease, severe diabetes with vascular complications; moderate to severe degrees of pulmonary insufficiency; angina pectoris or healed myocardial infarction.*

- *Class IV*. A patient exhibiting extreme systemic disturbance that may or may not be associated with the surgical complaint, that interferes with the patient's regular activities, and that has already become life-threatening.

  Example: *Organic heart disease with marked signs of cardiac insufficiency present (for example, cardiac decompensation); persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency present.*

- *Class V*. The rare person who is moribund (in a dying state) before operation, whose pre-operative condition is such that he or she is expected to die within 24 hours even if not subjected to the additional strain of operation.

  Example: *Burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure; massive embolus.*

The Classification of Heart Disease consists of four classes:

- *Class I.* No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
- *Class II.* Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
- *Class III.* Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.
- *Class IV*. Unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, may be present even at rest. If any physical activity is undertaken, discomfort occurs.

4.2.3.2 Complications Following Elective or Scheduled Day Surgeries

If a condition of the scheduled day surgery requires additional care beyond the recovery period, the client may be placed in outpatient observation (stay less than 48 hours). The observation period must be submitted on an outpatient claim (TOB 131) using the hospital's NPI and taxonomy code. If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement (excluding the surgical procedure) must be included on the inpatient claim (TOB 111) using the hospital's NPI and taxonomy code. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must still be submitted as an outpatient procedure under the HASC NPI and taxonomy code.

4.2.3.3 Inpatient Admissions After Day Surgery

If a complication occurs for which the client requires inpatient admission immediately following the day surgery (no observation period), the day surgery must be submitted as an outpatient procedure (TOB 131), using the appropriate hospital or HASC NPI and taxonomy code. The inpatient admission is to be submitted as an inpatient claim (TOB 111), using the hospital's NPI and taxonomy code. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must not be included on the inpatient claim. The inpatient admission must be medically necessary and is subject to retrospective review.

4.2.3.4 Emergency or Unscheduled Day Surgeries

These procedures are for clients who require an unscheduled (emergency) day surgery procedure and are not inpatient at the time the day surgery is performed.

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If a client is first treated in the ER and then requires emergency surgery as an outpatient, claims for emergency, unscheduled outpatient surgical procedures must be filed itemizing each service, such as room charge, laboratory, radiology, anesthesia, and supplies. Providers must submit claims for unscheduled day surgery procedures and emergency services as outpatient procedures using the hospital NPI and taxonomy code. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status. The observation period must be submitted on the same outpatient claim.

Providers must submit claims for the unscheduled day surgery procedures and emergency services as outpatient procedures (TOB 131) using the hospital's NPI and taxonomy code. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status (stay less than 48 hours). The observation period must be submitted on the same outpatient claim (TOB 131) using the hospital's NPI and taxonomy code.

4.2.3.5 Complications Following Emergency or Unscheduled Day Surgery

If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation status (excluding surgical procedures and emergency services) must be included on the inpatient claim (TOB 111) using the hospital's NPI and taxonomy code. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery and emergency services must not be included on the inpatient claim since they are to be submitted using TOB 131 as outpatient procedures under the hospital's NPI and taxonomy code.

4.2.3.6 Incomplete Day Surgeries

Facilities must use either diagnosis codes Z5309, Z5329, Z538, or modifiers 73 (Discontinued outpatient procedure prior to anesthesia administration) or 74 (Discontinued outpatient procedure after anesthesia administration) to indicate that a surgical procedure, type of service (TOS) "F," was not completed. Claims billed with Z5309, Z5329, Z538, or modifiers 73 or 74 will be suspended for review of the medical documentation submitted with the claim.

Providers must submit the following documentation with the claim:

- The operative report
- The anesthesia report
- The reason that the operation was not complete

Reimbursement to HASC facilities for canceled or incomplete surgeries because of patient complications, is made according to the following criteria, depending on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of HASC payment for a procedure that is terminated for nonmedical or medical reasons before the facility has expended substantial resources.
- Reimburse at 33 percent of HASC payment up to the administration of anesthesia.
- Reimburse at 67 percent of HASC payment after the administration of anesthesia but before incision.
- Reimburse at 100 percent of HASC payment after incision.

Surgeries canceled because of incomplete pre-operative procedures are not reimbursed.

4.2.4 Outpatient Observation Room Services

Observation care is defined by the CMS as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

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Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital's nursing or other ancillary staff to evaluate the client's condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services (revenue codes 760, 761, 762, and 769) are a benefit only when medically necessary and when provided under a practitioner's order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
  - Laboratory, radiology, or other testing is necessary to assess the client's need for an inpatient admission.
  - The treatment plan is not established or, based on the client's condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.
- The medical necessity for inpatient treatment is unclear, that is:
  - The client's medical condition requires careful monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary
  - There is a delayed or slow progression of the client's signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.
  - The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.
- The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours.

Medically necessary services that do not meet the definition of observation care should be submitted separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay. Claims for observation services may be denied in their entirety if the services should have initially been inpatient admissions or if a reason for an inpatient admission developed, but the observation stay was not converted to inpatient.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner's expectation of the care that the client will require.

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4.2.4.1 Direct Outpatient Observation Admission

A client may be directly admitted to outpatient observation from the evaluating practitioner's office without being seen in the emergency room by a hospital-based practitioner. The practitioner's order should clearly specify that the practitioner wants the client to be admitted to outpatient observation status. An order for "direct admission" will be considered an inpatient admission unless otherwise specified by the practitioner's orders.

Brief observation periods following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., a breathing treatment) would be more appropriately coded as a treatment room visit.

4.2.4.2 Observation Following Emergency Room

A client may be admitted to outpatient observation through the emergency room if the client presents to the facility with an unstable medical condition and the evaluating practitioner determines that outpatient observation is medically necessary to determine a definitive treatment plan. An unstable medical condition is defined as one of the following:

- A variance in laboratory values from what is considered the generally accepted, safe values for the individual client.
- Clinical signs and symptoms that are above or below those of normal range and that require extended monitoring and further evaluation.
- Changes in the client's medical condition are anticipated, and further evaluation is necessary.

If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be submitted on a separate detail on the same claim as the observation room charges.

Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit.

4.2.4.3 Observation Following Outpatient Day Surgery

If a medical condition or complication of a scheduled day surgery requires additional care beyond the routine recovery period, the client may be placed in outpatient observation. The observation period should be submitted as an outpatient claim.

Reimbursement for outpatient observation after a scheduled day surgery is limited to situations in which the client exhibits an unusual reaction to the surgical procedure and requires monitoring or treatment beyond what is normally provided in the immediate post-operative period. Examples include, but are not limited to:

- Difficulty in awakening from anesthesia.
- A drug reaction.
- Other post-surgical complications.

4.2.4.4 Observation Following Outpatient Diagnostic Testing or Therapeutic Services

A client may be admitted to outpatient observation if the client develops a significant adverse reaction to a scheduled outpatient diagnostic test or to a therapeutic service, such as chemotherapy, that requires further monitoring. Observation services begin when the reaction occurred and end when the practitioner determines that the client is stable for discharge, or that an inpatient admission is appropriate.

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4.2.4.5 Documentation Requirements for Outpatient Observation

Documentation that supports the medical necessity of the outpatient observation services must be maintained by the facility in the client's medical record. Documentation must include:

- The order of the ordering practitioner for admission to observation care, which must be dated and timed.
- The practitioner's admission and progress notes, which must be dated and timed, confirm the need for observation care, and outline the client's condition, treatment, and response to treatment.
- Nurse's notes, which must be dated and timed, reflect the time at which the client was admitted to the observation bed, and the reason for the observation stay.
- All supporting diagnostic and ancillary testing reports, including orders for the testing or any pread-mission testing.
- Procedure notes and operative notes that address any complication that would support admission to observation status and must be dated and timed.
- Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must be dated and timed and detail orders and any complications that require admission to observation status.
- Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.
- All of the client education that was provided during the observation stay.
- The order for discharge from observation care, which must be signed, dated, and timed.
- The discharge notes, including nurse's notes that reflect the date and time at which the client was discharged from observation.

The client must be in the care of a practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are dated, timed, written, and signed by the practitioner.

Claims submitted for outpatient procedures in which the original intention was to keep the client for an extended period of time, such as overnight or for a 48-hour period, will be denied unless significant medical necessity is documented.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the outpatient observation services. Medical records will be evaluated to determine whether the practitioner's order (practitioner intent) and the services that were actually provided were consistent.

The medical records must clearly support the medical necessity of the outpatient observation services and must include a timed order for observation services that will support the number of hours that the client was under observation care and the hours that were submitted for payment.

4.2.4.6 Reporting Hours of Observation

Providers must submit the number of observation hours the client was under observation care.

Observation time begins at the clock time documented in the client's medical record. This time should coincide with the time that the client is placed in a bed for the purpose of initiating observation care in accordance with the practitioner's order.

Observation time ends when all medically necessary services related to observation care are completed. The end time of observation services may coincide with the time the client is actually discharged from the hospital or is admitted as an inpatient.

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Hospitals should round clock times for the beginning and end of observation to the nearest hour and submit the total number of hours for the observation stay on the claim. For the purposes of submitting claims for observation services, one unit equals one hour. Partial units or hours should be rounded up or down to the nearest hour. Claims submitted with observation room units exceeding 48 hours will be denied.

Any service that was ordered within the observation period may be included on the outpatient claim if a practitioner's order for the service was made within the observation period time frame but hospital scheduling limitations prevented the service from being performed before the 48 hours expired. Any services ordered after 48 hours must not be included on the outpatient claim nor billed to the client. If a period of observation spans more than one calendar day (i.e., extends past midnight), all of the hours for the entire period of observation must be included on a single line, and the date of service for that line is the date on which the observation care began.

Observation time may include medically necessary services and follow-up care that is provided after the time the practitioner writes the discharge order, but before the client is discharged. Reported observation time does not include the time the client remains in the observation area after treatment is completed for reasons such as waiting for transportation home.

Observation services must not be submitted concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure. In situations where a diagnostic or therapeutic procedure interrupts the observation stay, hospitals should record for each period of observation services the beginning and ending times of the observation period and add the lengths of time for the periods of observation services together to reach the total number of units reported on the claim.

Recovery room hours that are associated with an outpatient procedure must not be submitted simultaneously with hours of observation time.

Revenue code 761 will be denied if it is submitted for the same date of service by the same provider as revenue code 760, 762, or 769.

4.2.4.7 Client Status Change

When a client's status changes from outpatient observation to inpatient admission within the allowed 48-hour observation period, both the outpatient observation service and the inpatient admission must be submitted as separate details on the same inpatient claim.

The inpatient claim must include:

- The provider must submit the correct FDOS and Date of Admission (DOA) on the claim header.
- Charges for the observation room on the inpatient claim may be coded using the appropriate revenue code (760, 761, 762, or 769).
- The observation services are considered part of the facility's DRG payment, and are not separately reimbursed.

The practitioner's order for a change in client status from outpatient observation to inpatient admission must be written, dated, and timed before the outpatient observation claim is submitted for reimbursement.

4.2.4.8 Inpatient Admission to Outpatient Observation

When a client is admitted to the hospital as an inpatient and a subsequent internal utilization review (UR) determines that the services did not meet inpatient criteria, the hospital may change the client's status from inpatient to outpatient observation. The order to change from an inpatient to outpatient observation admission is effective for the same date and time as the inpatient order. This practice is acceptable under Texas Medicaid if all of the following conditions are met:

- The change in client status is made before the claim is submitted.

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- The hospital has not submitted a claim for the inpatient admission.
- The practitioner responsible for the care of the client concurs with the hospital UR determination to change to outpatient status.
- The practitioner's concurrence with the UR decision is documented in the client's medical record.

Note: *When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care.*

Reimbursement for emergency room (ER) and observation services are considered part of the inpatient DRG payment and must be submitted as separate details on the inpatient claim when the client is admitted as an inpatient under one or both of the following circumstances:

- The client has spent fewer than 24 hours after presenting in the ER without being placed in observation status.
- The client has spent fewer than 48 hours in observation status after presenting in the ER.

The date of admission on the inpatient claim must reflect the date the client presents at the hospital.

If the client is admitted as an inpatient more than 24 hours after presenting in the ER without being placed in observation status or more than 48 hours after being placed in observation status, the ER and observation services may be reimbursed separately as outpatient services.

Examples

The following examples indicate the appropriate dates of admission and claim submissions for different scenarios:

Scenario 1

In scenario 1, the ER and outpatient observation services must be submitted on the inpatient hospital claim, because the ER services are within 24 hours of the observation services, and the observation services are within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (12:30 a.m.)	40 minutes later, patient is placed in observation status
5/3/12 (12:00 a.m.)	23.5 hours later, after placement is in observation status, patient is admitted as an inpatient

Claims submissions are as follows:

- *ER visit:* Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- *Observation services:* Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- *Date of inpatient admission:* May 1, 2012

Scenario 2

In scenario 2, the ER service was more than 24 hours before the observation period began and must be submitted on an outpatient hospital claim. The observation service must be billed on the inpatient hospital claim because the service was within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

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The inpatient admission date reflects the date the patient was placed in observation status.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (11:55 p.m.)	24 + hours later, patient is placed in observation status
5/3/12 (4:00 a.m.)	4 hours later, patient admitted as an inpatient

Claims submissions are as follows:

- *ER visit:* Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services
- *Observation services:* Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- *Date of inpatient admission:* May 2, 2012

Scenario 3

In scenario 3, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the observation service was more than 48 hours before the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (12:30 a.m.)	40 minutes later, patient placed in observation status
5/4/12 (12:45 a.m.)	48 + hours later patient admitted as an inpatient

Claims submissions are as follows:

- *ER visit:* Submitted on an outpatient claim and reimbursed as part of the outpatient observation services
- *Observation services:* Submitted on the outpatient claim and reimbursed separately from the inpatient services
- *Date of inpatient admission:* May 4, 2012

Scenario 4

In scenario 4, the ER service may be reimbursed separately because it was more than 24 hours before the client was placed in observation status. The observation service may be reimbursed separately because it was more than 48 hours before the client was admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (11:55 p.m.)	24 + hours later, patient is placed in observation status
5/4/12 (12:00 p.m.)	48 + hours later, patient admitted as an inpatient

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Claims submissions are as follows:

- *ER visit:* Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services.
- *Observation services:* Submitted on an outpatient claim and reimbursed separately from the inpatient services.
- *Date of inpatient admission:* May 4, 2012

Scenario 5

In scenario 5, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the client was discharged and sent home without being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER after being discharged and sent home 14 hours earlier.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (12:30 a.m.)	40 minutes later, patient is placed in observation status.
5/2/12 (10:00 a.m.)	9.5 hours later, patient is discharged and sent home
5/3/12 (12:05 a.m.)	14 hours later, patient presents at the ER again and is admitted as an inpatient

Claims submissions are as follows:

- *ER visit:* Submitted on an outpatient claim and reimbursed as part of the observation services
- *Observation services:* Submitted on the outpatient claim and reimbursed separately from the inpatient services
- *Date of inpatient admission:* May 3, 2012

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be submitted as an outpatient episode of care.

4.2.4.9 Observation Services that are not a benefit

Outpatient observation services that are not medically necessary or appropriate are not benefits of Texas Medicaid, including, but not limited to, services provided under the following circumstances:

- As a substitute for an inpatient admission.
- Without a practitioner's order, including services ordered as inpatient services by the ordering practitioner, but submitted as outpatient by the billing office.
- For clients awaiting transfer to another facility, such as for nursing home placement.
- For clients with lack of or delay in transportation.
- As a convenience to the client, client's family, the practitioner, hospital, or hospital staff.
- For routine preparation before, or recovery after, outpatient diagnostic or surgical services.
- When an overnight stay is planned before diagnostic testing.
- To medically stable clients who need diagnostic testing or outpatient procedures that are routinely provided in an outpatient setting.
- Following an uncomplicated treatment or procedure.

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- As standing orders for observation following outpatient surgery.
- For postoperative monitoring during a standard recovery period of four to six hours, which is considered part of the recovery room service.
- For outpatient blood or chemotherapy administration and concurrent services.
- For services that would normally require an inpatient admission.
- Beyond 48 hours from the time of the observation admission.
- For a medical examination for clients who do not require skilled support.

4.2.5 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate. One of the following modifiers must be submitted for general medical services: AH, AJ, AM, SA, TD, TE, or U7.

The services listed below must be submitted using the RHC NPI and the appropriate benefit code:

- THSteps medical checkups
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations provided in hospital-based RHCs

These services must be submitted with an AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the Prospective Payment System (PPS) reimbursement methodology.

When submitting a claim on the CMS-1500 paper claim form, providers must use the appropriate national POS (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be submitted using the individual or group physician NPI and taxonomy code.

Hospital-based RHCs must submit claims for pneumococcal and influenza vaccines as non- RHC services, under their hospital NPI and taxonomy code.

> ***Note:*** *A visit is a face-to-face encounter between an RHC client and a physician, PA, nurse practitioner (NP), certified nurse-midwife (CNM), visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:*

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The RHC client has a medical visit and an other health visit.

An other health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

4.2.6 Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Outpatient cardiac rehabilitation is considered reasonable and necessary for clients who have had one of the following within 12 months of beginning the cardiac rehabilitation program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)

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- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

Note: *A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms to a remote site is not covered by Texas Medicaid.*

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (i.e. oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use. If no clinically significant arrhythmia is documented during the first three weeks of the program, the provider may have the client complete the remaining portion without telemetry monitoring by the physician's order.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program conducted by non-physician personnel who are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease, and provide the services under the direct supervision of a physician.

Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs. Outpatient cardiac rehabilitation begins after the client has been discharged from the hospital. A physician's prescription is required after the acute convalescent period and after it has been determined that the client's clinical status and capacity will allow for safe participation in an individualized progressive exercise program. Outpatient cardiac rehabilitation requires close monitoring and direct supervision by a physician and includes:

- Medical evaluation performed by the physician responsible for prescribing the client's rehabilitation program and includes a clinical examination, a medical history, and an initial plan or goal.
- An education and counseling program to modify risk factors (nutritional counseling, stress reduction, smoking cessation, weight loss, etc.).
- Prescribed exercise concurrent with and without electrocardiogram (ECG) monitoring.
- Services performed in an approved facility by trained professionals.

Note: *Direct supervision is met when the services are performed on hospital premises or within 250 yards of the hospital.*

Cardiac rehabilitation will be limited to a maximum of 2 one-hour sessions per day and 36 sessions over 18 weeks per rolling year.

Providers must obtain prior authorization for additional cardiac rehabilitation sessions, which will be limited to a maximum of 36 sessions in an extended period of time in a 52-week period from the date of authorization of additional sessions.

To confirm that a continuation of cardiac rehabilitation is at the request of, and coordinated with the attending physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and either the medical director or the referring physician. If the physician responsible for such follow-up is the medical director, then his or her notes must be evident in each client's medical record.

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Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the medical record contains documentation that the client has had another cardiac event, or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Medical necessity documentation must include the following:

- Progress made from the beginning of the cardiac rehabilitation period to the current service request date, including progress towards previous goals
- Information that supports the client's capability of continued measurable progress
- A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs

Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department. Providers must send prior authorization requests, along with documentation to support medical necessity, to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be submitted with modifier 25 appended to the E/M code when supporting documentation in the medical record demonstrates a separately identifiable E/M service was provided on the same day by the same provider who renders the cardiac rehabilitation.

Physical and occupational therapy will not be reimbursed separately when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition requiring such therapy.

Example: *If a client is recuperating from an acute phase of heart disease and has had a stroke that requires physical or occupational therapy, the physical or occupational therapy for the stroke may be reimbursed separately from the cardiac rehabilitation services for the acute phase of heart disease.*

When provided as part of the cardiac rehabilitation program, client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity to assist the client in adjusting living habits because of the cardiac condition, will not be separately reimbursed.

Procedure code S9472 (cardiac rehabilitation program nonphysician provider per diem) is used for hospitals submitting claims for cardiac rehabilitation, and it must be submitted with revenue code 943 (other therapeutic services-cardiac rehabilitation) and one of the following diagnosis codes:

Diagnosis Codes							
I110	I160	I161	I169	I201	I202	I208	I209
I2101	I2102	I2109	I2111	I2119	I2121	I2129	I213
I214	I219	I21A1	I21A9	I220	I221	I222	I228
I229	I2720	I2721	I2722	I2723	I2724	I2729	I2783
I501	I5020	I5021	I5022	I5023	I5030	I5031	I5032
I5033	I5040	I5041	I5042	I5043	I50810	I50811	I50812

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Diagnosis Codes							
I50813	I50814	I5082	I5083	I5084	I5089	I509	I5A
Z941	Z943	Z951	Z952	Z953	Z954	Z955	Z9861
Z98890							

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for clients who have documentation of acute myocardial infarction, coronary artery bypass surgery (CABG), percutaneous transluminal coronary angioplasty or coronary stenting heart valve repair/replacement, major pulmonary surgery, sustained ventrical tachycardia or fibrillation, class III or class IV congestive heart failure, or chronic stable angina within the past twelve (12) months prior to the beginning of the program.

4.2.7 Chemotherapy Administration

Hospitals must submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy.

Revenue code 636 may be reimbursed for the technical component of prolonged infusion of chemotherapeutic agents. The most appropriate chemotherapy procedure code must be billed with revenue code 636.

4.2.8 Colorectal Cancer Screening

Fecal occult blood tests, multi-targareted stool DNA (mt-sDNA) tests, screening colonoscopies, and sigmoidoscopies evidence-based methods of colorectal cancer screening.

4.2.8.1 Fecal Occult Blood Tests

Procedure codes G0328 (with modifier QW) and 82270 may be reimbursed one service per rolling year for clients who are 45 years of age and older.

4.2.8.2 MT-sDNA Tests

Procedure code 81528 may be reimbursed once every 3 years for clients who are 45 years of age and older for services rendered in the laboratory setting.

4.2.8.3 Sigmoidoscopies

Procedure code G0104 may be reimbursed once every 5 years and is limited to one of the following diagnosis codes:

Diagnosis Codes							
Z0000*	Z0001*	Z1210	Z1211	Z1213	Z859	Z86002	Z86003
Z86004	Z86006	Z86007	Z860100	Z860102	Z860109		
***Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the U.S. Preventive Services Task Force (USPSTF).**							

4.2.8.4 Colonoscopies

Procedure code G0105 may be reimbursed once every two years for clients who meet the definition of high-risk. Procedure code G0105 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5120	K51211	K51212	K51213	K51214	K51218	K5130

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Diagnosis Codes							
K51311	K51312	K51313	K51314	K51318	K5180	K51811	K51812
K51813	K51814	K51818	K5190	K51911	K51912	K51913	K51914
K51918	K51919	K523	K5281	K5282	K52831	K52832	K52838
K52839	K5289	K529	Z800	Z83710	Z83711	Z83718	Z83719
Z8372	Z85038	Z85048	Z859	Z86002	Z86003	Z86004	Z86006
Z86007	Z860101						

Refer to: Subsection 9.2.15.1.1, "Colorectal Cancer Screening" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.8.5 Exclusions

Barium enemas for colorectal cancer screening are not a benefit of Texas Medicaid.

4.2.9 Computed Tomography and Magnetic Resonance Imaging

Prior authorization is required for all outpatient nonemergent (i.e., those that are scheduled) CT, computed tomography angiography (CTA), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) studies before services are rendered. Authorization is not required for the emergency department or inpatient hospital radiology services. Retroactive authorization may be required for some outpatient emergent studies.

Reimbursement for procedures with descriptions that specify "with contrast" include payment for contrast materials. Some diagnostic radiopharmaceuticals are benefits of Texas Medicaid. Outpatient hospitals may submit the total component of the following procedure codes:

Procedure Codes									
77371	77372	77373	77422	77423	77520	77525	G0339		

Procedure code 77399 may be submitted as either the total component or the technical component.

Providers can refer to the OFL or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid. OFL and static fee schedules available on the TMHP website display fees after applicable rate reductions have been applied. Previously, the OFL and static fee schedules did not reflect all rate reductions, and providers were required to calculate the 1- and 2-percent reductions implemented.

Refer to: Subsection 4.2.9, "Computed Tomography and Magnetic Resonance Imaging" in this handbook for additional information about prior authorization requirements.

Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about emergency outpatient imaging services.

4.2.10 Electrodiagnostic (EDX) Testing

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as EDX testing, must be medically indicated and may be reimbursed to outpatient hospitals. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

NCS and EMG studies are diagnosis restricted and may require prior authorization.

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Refer to: Subsection 9.2.26.7, "Esophageal pH Probe Monitoring" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.11 Fluocinolone Acetonide

The fluocinolone acetonide intravitreal implant may be reimbursed for services rendered to clients who are 12 years of age and older. Procedure code J7311 is only payable with a posterior uveitis diagnosis of more than six months duration and the condition has been unresponsive to oral or systemic medication treatment.

4.2.11.1 Prior Authorization for Fluocinolone Acetonide

To request prior authorization, providers must submit requests by fax or mail to the SMPA Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

4.2.12 Fetal Nonstress Testing and Contraction Stress Test

Claims for nonstress and contraction stress testing conducted in the outpatient setting must be submitted with revenue code 729. Services during an inpatient hospital stay are reimbursed under the hospital's DRG.

Refer to: Section 4.1.1, "Antepartum and Fetal Invasive Procedures" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.13 Hyperbaric Oxygen Therapy (HBOT)

HBOT is a type of therapy that increases the environmental oxygen pressure to promote the movement of oxygen from the environment into the client's body tissues. Such treatment may be a benefit of Texas Medicaid when it is performed in specially constructed hyperbaric chambers, pressurized to 1.4 atmosphere absolute (atm abs) or higher, which may hold one or more clients (sea-level pressure is equal to 1 atm.abs). Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, this use of oxygen is not considered hyperbaric oxygen treatment in itself.

HBOT procedure codes 99183 and G0277 require prior authorization before the date that service is initiated.

The number of billable units of procedure code G0277 is based upon the time that the client receives treatment with hyperbaric oxygen.

In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, air breaks, and ascent, (in minutes), as follows:

- The first unit is for the time spent in the chamber receiving hyperbaric oxygen and must be for a minimum of 16 minutes.
- To bill for a second (or subsequent unit), all previous units of time must have been for the full thirty minutes, and the last unit must be fore 16-30 minutes.

Procedure code 99183 equates to one total treatment (one professional session).

Procedure code G0277 must be billed with revenue code B-413 on the same claim. If procedure code G0277 is not on the same claim as revenue code B-413, the claim will be denied.

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Refer to: Subsection 9.2.33, "Hyperbaric Oxygen Therapy (HBOT)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

4.2.14 Laboratory Services

Routine laboratory services, directly related to the surgical procedure being performed, are not reimbursed separately. Claims for nonroutine laboratory services provided with emergency conditions may be submitted separately with documentation that the complicating condition arose after the initiation of the surgery. Outpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory.

Exception: Hospital laboratories may submit claims for all the tests performed on a specimen if some but not all the tests are done by another laboratory on referral from the hospital submitting the claim.

The billing hospital must enter the name and NPI and taxonomy code of the performing laboratory in Block 80 of the UB-04 CMS-1450 paper claim form and must enter the performing laboratory's NPI and taxonomy code next to the service provided by the performing laboratory.

Hospitals may submit claims for a handling fee (procedure code 99001) for collecting and forwarding a specimen to a referral laboratory when the laboratory handling fee is not being billed through other methods. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

Refer to: The *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.14.1 Clinical Laboratory Improvement Amendments (CLIA)

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

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

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

4.2.15 Lung Volume Reduction Surgery (LVRS)

LVRS surgery must be performed in a facility that meets at least one of the following requirements:

- Certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission on Accreditation of Health Care Organization (JCAHO)
- Approved by Medicare as a lung or heart-lung transplant facility

The surgery must be both preceded and followed by a program of diagnostic and therapeutic services that are consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the client's potential to successfully undergo and recover from surgery. The program must meet all of the following requirements:

- Include a 6-to 10-week series of at least 16, and no more than 20, pre-operative sessions, each lasting a minimum of 2 hours
- Include at least 6, and no more than 10, post-operative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks after the LVRS
- Be consistent with the care plan that was developed by the treating physician following the performance of a comprehensive evaluation of the client's medical, psychosocial, and nutritional needs

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- Be arranged, monitored, and performed under the coordination of the facility where the surgery takes place. Prior authorization is required for the LVRS procedure. However; prior authorization is not required for the pre-operative and post-discharge pulmonary services

LVRS must be prior authorized and is limited to clients who have severe emphysema, disabling dyspnea, and evidence of severe air trapping. Prior authorization is not required for the associated preoperative pulmonary surgery services for preparation of LVRS (procedure codes G0302, G0303, and G0304) or the associated postdischarge pulmonary surgery services after LVRS (procedure code G0305).

LVRS and post-discharge LVRS are restricted to the following eemphysema diagnosis codes:

Diagnosis Codes				
J430	J431	J432	J438	J983

Procedure codes 32491, G0302, G0303, G0304 and G0305 are limited to one per rolling year per client any provider.

Procedure code G0305 may be reimbursed only if a claim for LVRS (procedure code 32491) has been submitted within the past 12 months.

Refer to: Subsection 9.2.44, "Lung Volume Reduction Surgery (LVRS)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.16 Magnetoencephalography (MEG) Services

Inpatient and outpatient hospitals must use revenue code 860 or 861 for reimbursement of magnetoencephalography (MEG) services. The appropriate MEG procedure code must be listed on the claim.

Note: *Reimbursement to an outpatient hospital will be based on the submitted procedure code.*

Refer to: Subsection 9.2.66, "Magnetoencephalography (MEG)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.17 Neurostimulators

Neurostimulators may be a benefit in the outpatient hospital setting when medically necessary. All procedures require prior authorizations.

Refer to: Subsection 9.2.46, "Neurostimulators" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.2.17.1, "Prior Authorization for Neurostimulators" in this handbook.

4.2.17.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator device require prior authorization. Requests for prior authorization must be submitted to the SMPA Department.

Refer to: Subsection 9.2.46.15, "Prior Authorization of Neurostimulator Devices Procedure Codes" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.18 Occupational and Physical Therapy Services

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

4.2.19 Radiation Therapy Services

Take-home drugs given during the course of therapy can be reimbursed separately through the VDP.

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Hospitals use revenue code 333, Radiation therapy, on the UB-04 CMS-1450 paper claim form when submitting charges for these services.

The following radiation therapy services provided in an outpatient setting are allowed only once per day unless documentation of medical necessity supports the need for repeated services:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavity radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization, and radioisotope therapy

4.2.19.1 Radiopharmaceuticals

Radiopharmaceuticals may be considered for separate reimbursement when used for therapeutic treatment.

The following procedure codes are payable to outpatient hospitals:

Procedure Codes									
79403*	A9513	A9542	A9543	A9563	A9564	A9600	A9699		
***Total or technical component**									

Strontium-89 chloride may be billed using procedure code A9600 and will be limited to a total of 10 mci intravenously injected every 90 days, any provider.

Strontium-89 chloride is reimbursed as one service per 90 days for any provider.

Strontium-89 chloride will be considered when submitted with diagnosis code C7951 or C7952.

Sodium phosphate p-32, therapeutic, will be considered when submitted with one of the following diagnoses:

Diagnosis Codes							
C7951	C7952	C9110	C9112	C9192	C91Z2	C9292	C92Z2
C9512	C9592	D45					

Chromic phosphate p-32 suspension will considered when submitted with diagnosis code C782 (secondary malignant neoplasm of the pleura) and diagnosis code C786 (secondary malignant neoplasm of the retroperitoneum and peritoneum).

Refer to: Subsection 9.2.64, "Radiation Therapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

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Prior Authorization for Therapeutic Radiopharmaceuticals

Procedure codes A9542 and A9543 require prior authorization. Ibritumomab tiuxetan will be considered when submitted with one of the following diagnosis codes:

Diagnosis Codes							
C8259	C8399	C8499	C84A9	C84Z9	C8519	C8529	C8589
C8599							

Prior authorization is required for procedure codes A9542 and A9543, which will be considered with documentation of all of the following:

- A diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy.
- Marrow involvement is less than 26 percent.
- Platelet count is 100,000 cell/mm3 or greater.
- Neutrophil count is 1,500 cells/mm3 or greater.
- Client has failed a trial of rituximab.

Lutetium lu 177 dotatate (Lutathera) intravenous injection (procedure code A9513) is indicated for the treatment of clients who are 18 years of age or older with a diagnosis of gastroenteropancreatic-neuroendocrine tumors. For all other indications, Lutetium lu 177 dotatate (Lutathera) injection for intravenous use is not proven to be medically effective and is considered experimental.

Lutetium lu 177 dotatate (Lutathera) procedure code A9513 must be administered under the control of an oncologist or a nuclear medicine specialist who is licensed and authorized to administer radiopharmaceuticals in an outpatient setting. Prior authorization requests must be submitted to the Special Medical Prior Authorization (SMPA) department at TMHP using the Special Medical Prior Authorization (SMPA) Request Form.

An SMPA Request Form must be completed, signed, and dated by the prescribing provider. The SMPA form will not be accepted after 90 days from the date of the prescribing provider's signature.

The completed SMPA Request Form must be maintained by the prescribing provider in the client's medical record and is subject to retrospective review.

Section C of the SMPA Request Form under the Statement of Medical Necessity must contain the following:

- Documentation of the client's dosage
- The administration schedule
- The number of injections to be administered during the prior authorization period
- The requested units and millicuries per injection
- The dosage calculation

Prior authorization must be requested through the SMPA department with appropriate documentation. Requests can be mailed or faxed to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

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Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

Refer to: Subsection 9.2.78.2, "Other Limitations on Therapeutic Radiopharmaceuticals" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

4.2.20 Respiratory Services

4.2.20.1 Aerosol Treatment

Nebulized aerosol treatments with short-acting beta-agonists provided in the outpatient setting are considered medically necessary for certain acute medical problems when breathing is compromised. Authorization is not required for aerosol treatments.

Outpatient facilities must submit claims for aerosol treatments using revenue code 412 and the appropriate beta-agonist procedure code.

4.2.20.2 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement provided in the physician's office or outpatient hospital setting is considered medically necessary as an adjunct to the established clinical and laboratory assessments for diagnosing and assessing asthma, predicting exacerbations, and evaluating the response of a patient with asthma to anti-inflammatory therapy.

Claims for nitric oxide treatments may be submitted using procedure code 95012. Hospital providers must include the following when submitting claims for procedure code 95012:

- Revenue code 419 must appear on the same line as procedure code 95012.
- The claim must have a line item for either procedure code 94010 or 94060. This line item must also indicate revenue code 419.

Note: *Procedure code 94010 or 94060, when submitted in conjunction with procedure code 95012, may only be reimbursed in an office or outpatient hospital setting, and is not reimbursed for critical care, emergency care, or anesthesiology.*

4.2.20.3 Pulmonary Function Studies

Pulmonary function studies considered for reimbursement to outpatient hospitals include, but are not limited to, the following procedures when submitted with the total component (TOS 5):

Procedure Codes									
94010	94060	94070	94150	94200	94375	94450	94452	94453	94617
94618	94619	94621	94726	94727	94728	94729	95012		

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High Altitude Simulation Test (HAST) procedure codes 94452 and 94453 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
E840*	E8411	E8419*	E848*	E849*	I270*	I271*	I2720
I2721	I2722	I2723	I2724	I2729	I2781*	I2783	I27840
I27841	I27848	I27849	I2789*	I279*	J410*	J411*	J418*
J42*	J430*	J431*	J432*	J438*	J439*	J440*	J441*
J4489*	J449*	J471*	J479*	J60*	J700*	J701	J708*
J709*	J8281	J8282	J8283	J8289	J8401	J8402	J8403
J8409	J8410	J84170	J84178	J849	J9610	J9611	J9612
J982	P270*	P271*	P278*	Q332*	Q334	Q336	

Note: *When billing for HAST (procedure code 94452 or 94453) with one of the diagnosis codes indicated in the table with an asterisk (*), evidence of hypoxemia must be documented in the client's medical record.*

When multiple procedure codes are submitted, the most inclusive code of the related codes will be reimbursed and all other related codes will be denied.

When unrelated pulmonary function studies are submitted together, each will be considered for reimbursement.

4.2.21 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Refer to: Subsection 9, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including hospital services. Hospital services are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

4.4 Outpatient Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

TMHP is responsible for a comprehensive integrated review process to identify misuse and inappropriate claim submission patterns by outpatient hospitals and HASCs. All providers are subject to TMHP's UR monitoring. Providers are selected for review based on a comparison of their individual resource utilization with a peer group of similar specialty and geographic locality. The main goal of the required utilization control is to identify those providers whose practice patterns are aberrant from their peers and provide the necessary educational actions to help the provider achieve Texas Medicaid compliance. An analysis of UR data is completed by a registered nurse analyst for review by the medical director and staff. If the analyst substantiates that a provider's practice and claim submission patterns are inconsistent with the federal requirements and Texas Medicaid's scope of benefits, a TMHP repre-

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sentative contacts the provider. The purpose of the contact is to discuss appropriate claim submission guidelines and to assist the provider in resolving the inappropriate claim submission patterns identified in the review.

TMHP uses the following criteria when reviewing all hospital outpatient medical records. Services must be:

- Medically necessary.
- Ordered by a physician, signed, and dated. Signature stamps are valid if initialed and dated by the physician.
- Submitted in the quantities ordered and documented as provided.
- Program benefits.
- Specifically identified on the charge tickets or itemized statement submitted with the claim or by the HCPCS procedure code on the claim.
- Indicated by the documentation in the medical record.
- Submitted to Texas Medicaid only after other medical insurance resources have been exhausted.

Refer to: Subsection 4.1.1, "Your Texas Benefits Medicaid Card" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

The determination of the TMHP UR process may result in the following:

- Educational letters and visits
- Mail-in of medical records for review
- On-site medical record review (outpatient, HASC, or inpatient records not reviewed)
- Referral of questionable claims to HHSC or HHSC OIG
- Recoupment
- Prepayment review

The intent of these actions is to ensure the most effective and appropriate use of available services and facilities and provide appropriate, cost-effective care to clients with Medicaid coverage.

4.5 Claims Filing and Reimbursement

4.5.1 Outpatient Claims Information

Claims for scheduled procedures that are performed in a HASC must be submitted using the HASC NPI and taxonomy codewith type of bill (TOB) 131. Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital NPI and taxonomy code and appropriate revenue and HCPCS code (if required) with TOB 131.

Claims for outpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form.

Freestanding ambulatory surgical centers must submit claims on the CMS-1500 claim form. The performing surgeon or referring physician name and number must be identified in Block 17. Identification of outpatient charges must be in Block 44 if submitting by HCPCS code. If appropriate, the revenue code must be indicated in Block 42. Texas Medicaid recommends the use of specific procedure codes for claim submission. Do not use the revenue code description in Block 43; the HCPCS narrative description must be identified in this block. For example, when submitting charges for physical therapy, do not use the description associated with revenue code 420. To receive reimbursement for physical therapy services, providers must identify the specific modality used (e.g., gait training).

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Examples:

- *Emergency Room.* Submit as "Emergency room" or "Emergency room charge per use." If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 13, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. Claims for emergency CT, CTA, MRI, or MRA studies provided in the emergency department must have the appropriate corresponding emergency services revenue code (450, 451, 456, or 459) to be considered for payment.
- *Observation Room.* Submit as "observation room." (Revenue code 762).
- *Operating Room.* Submit as "Operating Room." (Revenue code 360, 361, or 369).
- *Recovery Room.* Submit as "Recovery Room" or "Cast Room" as appropriate. (Revenue code 710 or 719).
- *Injections.* Must have "Inj.-name of drug; route of administration; the dosage and quantity" or the injection code.
- *Drugs and Supplies.* The drug description must include the name, strength, and quantity. Take-home drugs and supplies are not a benefit of Texas Medicaid:
  - Take-home drugs must be submitted with revenue code 253.
  - Take-home supplies must be submitted with revenue code 273.
  - Self-administered drugs must be submitted with revenue code 637.
- *Radiology.* Facilities must submit claims using the most appropriate revenue and HCPCS code. The physician must submit claims for professional services by a physician separately. The license number of the ordering physician must be in Block 83. If the client receives the same radiology procedure more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 13, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.
- *Laboratory.* Provide a complete description or use the procedure codes for the laboratory procedures. The physician must submit claims for professional services by a physician separately. Blocks 78–79 must have the license number of the ordering physician. If laboratory work is sent out, enter the name of the test and name and address or Medicaid number of the laboratory where the work was forwarded. If the client receives the same laboratory procedure more than once in one day, give the time for each visit. The time of the first visit must be identified in Block 13, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.
- *Nuclear Medicine.* Provide a complete description.
- *Day Surgery.* Day surgery must be submitted as an inclusive charge using TOS F. Providers must not submit claims for separate services that were provided in conjunction with the surgery (e.g., lab, radiology, and anesthesia). File claims for unscheduled emergency outpatient surgical procedures with separate charges (e.g., lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital's NPI and taxonomy code.

Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital NPI and taxonomy code and appropriate revenue and HCPCS code (if required) with TOB 131.

Refer to the ambulatory surgical center/hospital-based ambulatory surgical center (ASC/HASC) section for information on scheduled procedures.Additional claims information can be found within individual topic areas within this section.

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Charges on claims must be itemized on the face of the UB-04 CMS-1450 paper claim form instead of submitting attachments or charge details. TMHP uses information attached to the claim for clarification purposes only.

If a claim contains more than 28 details, continue the claim on additional UB-04 CMS-1450 paper claim forms or electronic equivalent. Total each claim form as a stand-alone claim. If you do not total each page, your claim may be denied for being over the limitation, and must be resubmitted with 28 or less details.

Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Outpatient hospital services must be itemized by date of service. Procedures repeated over a period of time must be submitted for each separate date of service. Do not combine multiple dates of service on the same line detail.

4.5.2 Outpatient Reimbursement

Outpatient services are reimbursed on a reasonable cost based on a percentage of the hospital's most recent tentative Medicaid cost report settlement.

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

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

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

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

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High-volume providers are eligible for additional payments on Texas Medicaid fee-for-service claims. A high-volume outpatient hospital provider is defined as one that was paid at least $200,000 during calendar year 2004.

All clinical laboratory services are reimbursed at a percentage of the prevailing charge. Hospitals that are identified by Medicare as sole community hospitals are reimbursed at a higher percentage of the prevailing charges for services that are provided to clients in the outpatient setting.

Clinical pathology consultations are also allowed for reimbursement.

Refer to: The HHSC Rate Analysis web page at pfd.hhs.texas.gov/hospitals-clinic-services for additional information about hospital reimbursement.

Subsection 3.7.5, "Provider Cost and Reporting" in this handbook for more information about the calculation of the interim rate.

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

4.5.3 Provider Cost and Reporting

Refer to: Subsection 3.7.5, "Provider Cost and Reporting" in this handbook.

4.5.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4.5.5 Outpatient Hospital Revenue Codes

UB-04 CMS-1450 revenue codes must be used to submit claims for outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing:

Revenue Code	Description	Comments
Special Charges – Canceled Surgery		
220	Special Charges	Procedure code required
Pharmacy		
250	General classification	
251	Generic drugs	
252	Nongeneric drugs	
253	Take-home drugs	Not a benefit
254	Drugs incident to other diagnostic services	
255	Drugs incident to radiology	
256	Experimental drugs	Not a benefit
257	Nonprescription drugs	
258	IV solutions	
259	Other pharmacy	
260	General classification	

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Revenue Code	Description	Comments
261	Infusion pump	
262	IV therapy/pharmacy services	
263	IV therapy/drug/supply delivery	
264	IV therapy/supplies	
269	Other IV therapy	
Medical/Surgical Supplies and Devices		
270	General classification	
271	Nonsterile supply	
272	Sterile supply	
273	Take-home supplies	Not a benefit
274	Prosthetic/orthotic devices	Not a benefit
275	Pacemaker	
276	Intraocular lens	
277	Oxygen take-home	Not a benefit
278	Medical/surgical supplies and devices- other implants	Procedure code required
279	Medical/surgical supplies and devices- other	Procedure code required
280	General Classification	
289	Other oncology	
300	Laboratory	Procedure code required
301	Laboratory- chemistry	Procedure code required
302	Laboratory- immunology	Procedure code required
303	Laboratory- renal patient (home)	Procedure code required
304	Laboratory- non-routine dialysis	Procedure code required
305	Laboratory- hematology	Procedure code required
306	Laboratory- bacteriology/microbiology	Procedure code required
307	Laboratory- urology	Procedure code required
309	Laboratory- other	Procedure code required
Laboratory – Pathological		
310	Laboratory- pathological	Procedure code required
311	Laboratory- pathological cytology	Procedure code required
312	Laboratory- pathological histology	Procedure code required
314	Laboratory- pathological biopsy	Procedure code required
319	Laboratory- pathological other	Procedure code required
Radiology – Diagnostic		
320	Radiology- diagnostic	Procedure code required
321	Radiology- diagnostic angiocardiography	Procedure code required
322	Radiology- diagnostic, arthrography	Procedure code required
323	Diagnostic, arteriography	Procedure code required
324	Chest X-ray	Procedure code required

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Revenue Code	Description	Comments
329	Other diagnostic radiology	Procedure code required
Radiology – Therapeutic		
330	General classification	Procedure code required
331	Chemotherapy-injected	Procedure code required
332	Chemotherapy-oral	Procedure code required
333	Chemotherapy-radiation therapy	Procedure code required
335	Chemotherapy-IV	Procedure code required
339	Other therapeutic radiology	Procedure code required
Nuclear Medicine		
340	General classification	Procedure code required
341	Nuclear medicine- diagnostic	Procedure code required
342	Nuclear medicine- therapeutic	Procedure code required
349	Nuclear medicine- other	Procedure code required
Computed Tomography (CT) Scan		
350	General classification	Procedure code required
351	CT scan- head scan	Procedure code required
352	CT scan- body scan	Procedure code required
359	CT scan- other CT scans	Procedure code required
Operating Room Services		
360	Operating room services	
361	Minor surgery	
369	Other operating room services	
Anesthesia		
370	Anesthesia	
371	Anesthesia incident to radiology	
372	Anesthesia incident to other diagnostic services	
374	Acupuncture	Not a benefit
379	Other anesthesia	
380	Blood	Procedure code required
381	Blood- packed red cells	Procedure code required
382	Blood- whole blood	Procedure code required
383	Blood- plasma	Procedure code required
384	Blood- platelets	Procedure code required
385	Blood- leucocytes	Procedure code required
386	Blood- other components	Procedure code required
387	Blood- other derivatives (cryoprecipitates)	Procedure code required
389	Other blood	Procedure code required
Blood Storage and Processing		
390	Blood storage and processing	
391	Blood administration	Not a benefit

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Revenue Code	Description	Comments
399	Other blood storage and processing	Not a benefit
Other Imaging Services		
400	Other imaging services	Procedure code required
401	Other imaging services- diagnostic mammography	Procedure code required
402	Other imaging services- ultrasound	Procedure code required
403	Other imaging services- screening mammography	Procedure code required
404	Other imaging services- positron emission tomography	Procedure code required
409	Other imaging services- other	Procedure code required
Respiratory Services		
410	Respiratory services	
412	Inhalation services	
413	Hyperbaric oxygen therapy	
419	Other respiratory services	Procedure code required
Physical Therapy		
420	Physical therapy	Procedure code required
421	Physical therapy- visit charge	Procedure code required
422	Physical therapy- hourly charge	Procedure code required
423	Physical therapy- group rate	Procedure code required
424	Physical therapy- evaluation/reevaluation	Procedure code required
429	Physical therapy- other	Procedure code required
Occupational Therapy		
430	Occupational therapy	Procedure code required
431	Occupational therapy- visit charge	Procedure code required
432	Occupational therapy- hourly	Procedure code required
433	Occupational therapy- group rate	Procedure code required
434	Occupational therapy- evaluation/reevaluation	Procedure code required
439	Occupational therapy- other	Procedure code required
Speech-Language Pathology		
440	Speech-language pathology	
441	Speech-language pathology- visit charge	Procedure code required
442	Speech-language pathology- hourly charge	Procedure code required
443	Speech-language pathology- group rate	Procedure code required
444	Speech-language pathology- evaluation/ reevaluation	Procedure code required
449	Speech-language pathology- other	Procedure code required
Emergency Room		
450	Emergency room	Procedure code required
451	EMTALA emergency medical screening services	
456	Urgent care	Procedure code required
459	Other	Procedure code required

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Revenue Code	Description	Comments
Pulmonary Function		
460	Pulmonary function	Procedure code required
469	Pulmonary function- other	Procedure code required
Audiology		
470	Audiology	Procedure code required
471	Audiology- diagnostic	Procedure code required
472	Audiology- treatment	Procedure code required
479	Audiology- other	Procedure code required
Cardiology		
480	Cardiology	Procedure code required
481	Cardiology- cardiac cath lab	Procedure code required
482	Cardiology- stress test	Procedure code required
483	Unassigned procedure code	Procedure code required
489	Cardiology- other	Procedure code required
Clinic		
510	Clinic	
511	Chronic pain center	
512	Dental clinic	
513	Psychiatric clinic	
514	Obstetrics-Gynecology (OB/GYN) clinic	
515	Pediatric clinic	
516	Urgent care clinic	
517	Family practice clinic	
519	Other clinic	
Freestanding Clinic		
520	Freestanding clinic	
523	Family practice clinic	
526	Urgent care clinic	
529	Other freestanding clinic	
Skilled Nursing (Home Health)		
550	Skilled nursing	Procedure code required
551	Skilled nursing- visit charge	Procedure code required
552	Skilled nursing- hourly charge	Procedure code required
559	Skilled nursing- other	Procedure code required
Medical Social Services (Home Health)		
560	Medical social services	Procedure code required
561	Medical social services- visit charge	Procedure code required
562	Medical social services- hourly charge	Procedure code required
569	Medical social services- other	Procedure code required
Home Health Aide (Home Health)		

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Revenue Code	Description	Comments
570	Home health aide	Procedure code required
571	Home health aide- visit charge	Procedure code required
572	Home health aide- hourly charge	Procedure code required
579	Home health aide- other	Procedure code required
Other Visits (Home Health)		
580	Other visits (home health)	Procedure code required
581	Other visits (home health)- visit charge	Procedure code required
582	Other visits (home health)- hourly charge	Procedure code required
589	Other visits (home health)- other	Procedure code required
Magnetic Resonance Technology (MRT)		
610	Magnetic resonance imaging- general classification	Procedure code required
611	Magnetic resonance imaging- brain (incl brain stem)	Procedure code required
612	Magnetic resonance imaging- spinal cord (incl spine)	Procedure code required
619	Magnetic resonance imaging- other MRI	Procedure code required
Drugs Requiring Specific Identification		
630	Drugs requiring specific identification	
631	Drugs requiring specific identification, single source drug	
632	Drugs requiring specific identification, multiple source drug	
633	Drugs requiring specific identification, restrictive prescription	
634	Drugs requiring specific identification, erythro-poietin (EPO) less than 10,000 units	
635	Drugs requiring specific identification, erythro-poietin (EPO) 10,000 or more units	
636	Drugs requiring specific identification, drugs requiring detailed coding	
Hospice Service		
650	Hospice services	
651	Routine home care	
652	Continuous home care - 1/2 (at least 8 but less than 16 hrs care)	
655	Inpatient respite care	
656	General inpatient care/non-respite	
657	Physician	
659	Hospice services - other	
Cast Room		
700	General classification	
709	Other cast room	

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Revenue Code	Description	Comments
Recovery Room		
710	General classification	
719	Other recovery room	
Labor Room/Delivery		
720	General classification	
721	Labor	
722	Delivery	
723	Circumcision	
724	Birthing center	
729	Other labor room/delivery	
Electrocardiogram (EKG/ECG)		
730	General classification	Procedure code required
731	Holter monitor	Procedure code required
732	Telemetry	Procedure code required
739	Other EKG/ECG	Procedure code required
Electroencephalogram (EEG)		
740	General classification	Procedure code required
741	Other EEG	Procedure code required
Gastrointestinal Services		
750	General classification	
759	Other gastrointestinal	
Treatment or Observation Room		
760	General classification	
761	Treatment room	
762	Observation room	
769	Other treatment/observation room	
Preventive Care Services		
770	General classification	Procedure code required
771	Vaccine administration	Procedure code required
779	Other preventive care services	Procedure code required
Lithotripsy		
790	General classification	Not a benefit
799	Other lithotripsy	Not a benefit
Miscellaneous Dialysis		
880	Miscellaneous dialysis	Procedure code required
881	Ultrafiltration	
Other Diagnostic Services		
920	General classification	Procedure code required
921	Peripheral vascular lab	Procedure code required
922	Electromyelogram	Procedure code required

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Revenue Code	Description	Comments
923	Pap smear	Procedure code required
924	Allergy test	Procedure code required
925	Pregnancy test	Procedure code required
929	Other diagnostic service	Procedure code required
943	Cardiac rehabilitation	Procedure code required

Refer to: The National Uniform Billing Committee (NUBC) website at www.nubc.org for additional information.

4.5.6 Third Party Liability

Refer to: Subsection 3.7.1, "Medicaid Relationship to Medicare" in this handbook.

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

Other Insurance Form on the TMHP website at www.tmhp.com.

Tort Response Form on the TMHP website at www.tmhp.com.

5 Lung Cancer Screening

5.1 Services, Benefits, and Limitations

Lung Cancer Screening is a benefit of Texas Medicaid and include the preventive service of lung cancer screening utilizing annual Low Dose Computed Tomography (LDCT) screening.

Preventive lung cancer screening that uses low dose computed tomography (LDCT) (procedure code 71271) is a benefit of Texas Medicaid once per year for asymptomatic high-risk clients meeting screening criteria. Screening may be initiated by a referral from a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). Physicians, PAs, NPs, and CNSs can order radiological procedures appropriate to their licensure.

Procedure code 71271 is a radiological procedure that provides high-resolution three-dimensional images of the lungs to detect lung nodules, which may indicate lung cancer in an asymptomatic high-risk client.

Lung cancer is commonly diagnosed in most clients when the disease is in an advanced stage and when the chances of curative therapy can be lower. Screening for early lung cancer detection can decrease mortality in high-risk clients. When used as a component of routine preventive screening, this might result in a more favorable treatment outcome.

Lung cancer commonly develops because of smoking for a greater number of years and many packs per day. A calculation derived from these numbers is referred to as pack years. A pack year of smoking history is defined as twenty cigarettes smoked daily for one year.

Potential risks that may be associated with LDCT lung cancer screening are false-positives and over-diagnosis that could result in further testing follow-ups. Additional risks include low dose cumulative exposure to low dose ionizing radiation over multiple years.

5.1.1 Client Eligibility

High-risk clients should be informed of tobacco smoking cessation counseling and that the annual lung cancer screening is not a substitute for smoking cessation.

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The United States Preventive Services Task Force (USPSTF) has determined LDCT lung cancer screening to be a component of an annual routine health screening for clients who meet the high-risk category. Before the first annual LDCT lung cancer screening, the client should complete a counseling and shared decision-making visit with the provider, per the USPSTF Guidelines.

A high-risk client must meet all the following eligibility criteria for LDCT lung cancer screening, per the USPSTF:

- Be 50 through 80 years of age
- Have at least a 20-pack year smoking history
- Be a current smoker or have quit smoking within the previous 15 years
- Be asymptomatic (no signs or symptoms of lung cancer)
- Be engaged in shared decision-making about screening with their provider, including discussion of its potential health benefits, limitations, and harms
- Receive a referral for LDCT lung cancer screening, preferably to a facility with experience and expertise in lung cancer screening

A client that does not meet the USPSTF criteria for LDCT lung cancer screening but presents with chronic obstructive pulmonary disorder and associated symptoms (such as cough and shortness of breath), may also qualify for LDCT lung cancer screening.

A client is no longer eligible to receive annual LDCT lung cancer screening after meeting one or more of the following criteria, per the USPSTF:

- Non-smoker for 15 years
- Life expectancy is substantially limited
- The client is not willing or able to have curative lung surgery

Clients with signs or symptoms of lung cancer are not eligible to receive LDCT lung cancer screening. Symptomatic clients should undergo a diagnostic work up that is appropriate to their clinical presentation. Presumptive lung cancer signs or symptoms that are not attributable to other causes may include the following:

- An unexplained cough
- A cough producing blood (hemoptysis)
- Unexplained weight loss of greater than 15 pounds in the last 12 months
- Abnormal chest x-ray, presence of bony or soft tissue masses in combination with abnormally enlarged or changed consistency of the lymph nodes (lymphadenopathy)

5.1.2 Prior Authorization and Documentation Requirements

Prior authorization must be obtained before performing LDCT lung cancer screening (procedure code 71271). Approved prior authorization requests will be valid for up to 90 days.

The client's ordering provider must submit a prior authorization request on the Radiology Prior Authorization Request Form, which must include all the following documentation:

- The client's diagnosis
- A statement confirming that the patient meets all the eligibility criteria for LDCT lung cancer screening
- Client's current smoking status — current smoker or non-smoker with less than 15 years since their quit date

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Prior authorization requests for procedure code 71271 may only be approved for clients with one of the following diagnosis codes, which must be included on the Radiology Prior Authorization Request Form:

Diagnosis Codes						
F17210	F17211	F17213	F17218	F17219	F17290	F17291
F17293	F17298	F17299	Z720	Z87891		

Prior authorization for LDCT lung cancer screening is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the service and must be maintained in the client's medical record, both by the ordering physician and the performing facility.

Refer to: Subsection 4.2.6.2, "Request Form and Documentation" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) and Subsection 4.2.6.3, "Methods of Submission" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about submitting prior authorization requests for CT services.

5.1.3 Exclusions

Annual LDCT lung cancer screening is not covered for any indications other than the possibility of lung cancer.

The following services are not a benefit of Texas Medicaid:

- Screening for clients who do not meet the high-risk criteria
- Positron emission tomography (PET), which is considered investigational and experimental for lung cancer screening and is therefore excluded as a lung cancer screening benefit since the effectiveness of PET for lung cancer screening has not been established
- Chest radiography and sputum cytology, which are not valid methods for lung cancer screening and are not covered benefits for lung cancer screening
- LDCT lung cancer screening using the following methods of testing:
  - Computer-aided detection with physician review and interpretation of digital film or radiographic images of chest
  - Computed tomography of thorax without contrast
- LDCT lung cancer screening for the following diagnosis codes: F17200, F17201, F17203, F17208, F17209, F17220, F17221, F17223, F17228, F17229, or Z77090

6 Ambulatory Surgical Center and Hospital Ambulatory Surgical Center

6.1 Enrollment

To enroll in Texas Medicaid, an ASC must:

- Meet and comply with applicable state and federal laws, rules, regulations, and provisions of the state plan under Title XIX of the Social Security Act.
- Be enrolled in Medicare.
- Meet and comply with state licensure requirements for ASCs.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

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All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an HASC provider number at the time of enrollment.

An out-of-state provider may enroll in Texas Medicaid if it is the customary or general practice for clients in a particular locality to use medical resources in another state. An out-of-state provider located within 50 miles of the Texas border is automatically considered to meet this criterion.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

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

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

6.2 Services, Benefits, Limitations, and Prior Authorization

ASCs, both freestanding and hospital-based, provide same day elective surgery for clients who do not require a hospital admission and who are not expected to require extensive postoperative care.

6.2.1 Drugs and Supplies

Outpatient prescribed medications are a benefit to eligible clients when obtained through a pharmacy contracted with the Texas Vendor Drug Program. Prescribed take-home supplies are a benefit to eligible clients when obtained through Medicaid durable medical equipment (DME).

Refer to: Section 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*)) for information about this program.

Subsection 2.2.4, "Medical Supplies" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*).

6.2.2 Incomplete Surgical Procedures

Refer to: Subsection 4.2.3.6, "Incomplete Day Surgeries" in this handbook for information about incomplete surgical procedures.

6.2.3 Complications Following Day Surgery Requiring Outpatient Observation or Inpatient Admission

If the client is placed in outpatient observation or inpatient status following an HASC day surgery, the day surgery procedure must still be submitted as an outpatient procedure under the HASC NPI and taxonomy code.

Refer to: Subsection 4.2.3.2, "Complications Following Elective or Scheduled Day Surgeries" in this handbook.

Subsection 4.2.3.4, "Emergency or Unscheduled Day Surgeries" in this handbook in this handbook.

6.2.4 Planned Admission for Day Surgery

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

6.2.5 Cochlear Implants

A cochlear implant is a benefit of Texas Medicaid when medically indicated. ASC and HASC providers may be reimbursed for the implantation procedure using procedure code 69930, and for the cochlear implant devices using procedure code L8614. L8614 will process as part of another service for ASC and HASC providers since payment will be applied to the procedure code 69930 for the global rate.

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Refer to: Subsection 9.2.22, "Cochlear Implants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.6 Colorectal Cancer Screening

Procedure codes G0104, G0105, and G0121 are a benefit of Texas Medicaid in the ASC or HASC setting.

6.2.6.1 Sigmoidoscopies

Procedure code G0104 may be reimbursed once every 5 years and is limited to one of the following diagnosis codes:

Diagnosis Codes							
Z0000*	Z0001*	Z1210	Z1211	Z1213	Z859	Z86002	Z86003
Z86004	Z86006	Z86007	Z860100	Z860102	Z860109		

***Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.**

6.2.6.2 Colonoscopies

Procedure code G0121 may be reimbursed once every ten rolling years for clients who are 45 years of age and older. Procedure code G0121 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
Z0000*	Z0001*	Z1210	Z1211	Z1213			

***Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.**

Procedure code G0105 may be reimbursed once every two years for clients who meet the definition of high-risk. Procedure code G0105 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5120	K51211	K51212	K51213	K51214	K51218	K5130
K51311	K51312	K51313	K51314	K51318	K5180	K51811	K51812
K51813	K51814	K51818	K5190	K51911	K51912	K51913	K51914
K51918	K51919	K523	K5281	K5282	K52831	K52832	K52838
K52839	K5289	K529	Z800	Z8371	Z83710	Z83711	Z83718
Z83719	Z8372	Z85038	Z85048	Z859	Z86002	Z86003	Z86004
Z86006	Z86007	Z860101					

Refer to: Subsection 9.2.15.1.1, "Colorectal Cancer Screening" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.7 Dental Therapy Under General Anesthesia

Facilities must use procedure code G0330 to submit claims for dental therapy under general anesthesia. Prior authorization is not required for ASCs and HASCs unless the client is enrolled in a Medicaid managed care organization.

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Refer to: Subsection 3.2.29.2.1, "Dental Therapy Under General Anesthesia" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.2.24, "Hospitalization and ASC/HASC" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

6.2.8 Fluocinolone Acetonide

Procedure code 67027 for implantation may be reimbursed to HASCs. This benefit is limited to clients who are 12 years of age and older and requires prior authorization.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

Subsection 4.2.11, "Fluocinolone Acetonide" in this handbook.

6.2.9 Implantable Infusion Pumps

Implantable infusion pumps are a benefit of Texas Medicaid. Implantable infusion pumps may be medically necessary in the following circumstances:

- Administration of intrathecal or epidural antispasmodic drugs to treat refractory intractable spasticity
- Administration of intrathecal, epidural, or central venous analgesic (opioid or non-opioid) drugs for treatment of severe chronic intractable pain
- Administration of intrahepatic chemotherapy for primary liver cancer or metastatic cancer with metastases limited to the liver

An IIP is not a benefit for the following uses:

- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

Providers may be reimbursed for implantable infusion pumps using procedure codes E0782, E0783, and E0786.

If procedure codes E0782 and E0783 are billed with the same date of service, only one may be reimbursed.

Refer to: Subsection 9.2.40, "Implantable Infusion Pumps" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.9.1 Prior Authorization for Implantable Infusion Pump

Implantable infusion pumps (procedure codes E0782, E0783, and E0786) require prior authorization.

Prior authorization is not required for the physician services associated with the insertion, revision, removal, refilling, or maintenance of the IIP.

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Providers must request prior authorization for the implantable infusion pump through the SMPA department with the supporting documentation for medical necessity. Send authorization requests to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Note: *ASCs are paid based on a global fee, with the exception that certain pieces of equipment may be reimbursed separately from the ASC or HASC global rate.*

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

Refer to: Subsection 9.2.40.0.1, "Prior Authorization for Implantable Infusion Pumps" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.10 Brachytherapy

The following procedure codes are payable to ASC and HASC facilities:

Procedure Codes								
19296	19297	19298	31643	55860	55874	55875	57155	58346

Prior authorization is not required for brachytherapy services.

Refer to: Subsection 9.2.64, "Radiation Therapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.2.11 Neurostimulators

Neurostimulators are a benefit of Texas Medicaid when medically necessary. All procedures require prior authorization.

Refer to: Subsection 9.2.46, "Neurostimulators" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Neurostimulator devices may be reimbursed separately from the global fee.

Refer to: The Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for procedure codes that may be reimbursed to ASC providers.

6.2.12 Prior Authorization

Some procedures require the performing provider to obtain prior authorization. When prior authorization is required, providers can mail or fax the request to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

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6.2.13 Gynecological and Reproductive Health and Family Planning Services

The following gynecological and reproductive health services and family planning services procedure codes may be reimbursed to ASC and HASC providers:

Procedure Codes									
11976	11981	11982	11983	55250	56620	56805	57335	57410	58260
58262	58353	58356	58541	58545	58546	58550	58552	58555	58558
58559	58560	58561	58562	58563	58565	58600	58615	58670	58671
58673	58674	59150	59151	59840	59841				

Refer to: The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about these procedure codes.

The Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for additional information about procedure codes that may be reimbursed to ASC providers.

The online fee lookup (OFL) or the static fee schedules for on the TMHP website at www.tmhp.com for additional information about rate information for individual procedure codes.

6.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including ASC and HASC services. ASC and HASC services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement.

6.4 Claims Filing and Reimbursement

6.4.1 Claims Information

Freestanding ASC claims must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Hospital-based ASCs must submit claims to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form.

Claims must contain the billing provider's complete name, address, and a NPI and taxonomy code. When completing a UB-04 CMS-1450 or a CMS-1500 paper claim form, providers must include all required information on the claim; TMHP does not key any information from claim attachments. Providers must purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

Scheduled procedures performed in a HASC must be submitted for reimbursement using the HASC NPI and taxonomy code with TOB 131. Emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted for reimbursement using the hospital NPI and taxonomy code with TOB 131.

To submit claims for services performed by certified registered nurse anesthetists (CRNAs), an ASC must enroll as a CRNA group provider and indicate the CRNA performing NPI and taxonomy code on claims for those services.

Refer to: Section 4, "Certified Registered Nurse Anesthetist (CRNA)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for specific billing instructions for CRNA services.

"Section 6: Claims Filing" (*Vol. 1, General Information*).

Section 11, "Claim Form Examples" in this handbook.

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6.4.2 Reimbursement

Reimbursement is limited to the lesser of the amount reimbursed to an ASC for similar services, the hospital's actual charge, or the allowable cost determined by HHSC. When multiple surgical procedures are performed on the same day, only the procedure with the highest reimbursement rate on the fee schedule will be reimbursed.

Claims for physician and CRNA services performed in an ASC or HASC must be submitted under the physician or CRNA NPI and taxonomy code and are reimbursed separately.

6.4.2.1 ASC and HASC Global Services

The ASC or HASC payment represents a global payment and includes room charges and supplies. Covered services provided are submitted as one inclusive charge. All facility services provided in conjunction with the surgery (e.g., laboratory, radiology, anesthesia supplies, medical supplies) are considered part of the global payment and cannot be itemized or submitted separately.

Routine X-ray and laboratory services directly related to the surgical procedure being performed are not reimbursed separately. All nonroutine laboratory and X-ray services provided with emergency conditions may be submitted separately with documentation that the complicating condition arose after the initiation of the surgery.

Medical and prosthetic devices such as intraocular lenses may be supplied by the ASC or HASC and implanted, inserted, or otherwise applied during a covered surgical procedure and is considered part of the global surgical fee.

Exception: *Certain pieces of equipment may be reimbursed separately from the ASC or HASC global rate.*

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

Subsection 4.2.3, "Day Surgery" in this handbook for information about HASCs.

6.4.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

7 Military Hospitals

7.1 Military Hospital Enrollment

To enroll in Texas Medicaid, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veterans Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.

Military hospital providers must comply with CLIA rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

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7.2 Services, Benefits, Limitations and Prior Authorization

7.2.1 Military Hospital Inpatient Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to the Medicaid "spell of illness." The spell of illness is defined as "30 days of inpatient hospital care, which may accrue intermittently or consecutively."

After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. Exceptions are made in the following instances:

- THSteps-eligible clients do not have a 30-day spell of illness limitation, if medically necessary conditions exist (covered under THSteps-CCP).

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.1.2, "Spell of Illness" in this handbook.

Hospitals may submit information only claims to TMHP when one of the following situations exists:

- The inpatient 30-day spell of illness benefit is exhausted.
- Payment that was made by a third party resource or other insurance exceeds the Medicaid allowed amount.

For clients who are 21 years of age and older, there is an inpatient expenditure cap of $200,000 per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments exceeding $200,000 will be recouped.

It is appropriate to submit information only claims using TOB 110.

The following hospital services must be medically necessary and are subject to the utilization review requirements of Texas Medicaid. Medicaid reimbursement for services cannot exceed the limitations of Texas Medicaid.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons, as certified by the physician. Additionally, the hospital must document the medical necessity for a private room, such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information is included in Block 80 or attached to the claim.
- Whole blood and packed red cells that are reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary services or supplies ordered by a physician.

Medicaid benefits are not available for take-home or self-administered drugs or personal comfort items except when received by prescription through the VDP.

Only inpatient claims that have an emergency diagnosis on the claim are considered for reimbursement.

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7.2.2 Military Hospital Outpatient and Physician Services

Although Medicare reimburses for emergency outpatient and inpatient services, Medicaid does not reimburse for either outpatient or physician services. Military hospitals are not reimbursed for outpatient day surgery.

7.2.3 Prior Authorization

Prior authorization is not required for services rendered in military hospitals.

7.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including military hospital services. Military hospital services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement.

7.3.1 Documentation for Nursing Facility Admissions

The admission Minimum Data Set (MDS) must be used for admissions to a nursing facility. There are instances in which hospital social workers and discharge nurses might also complete the admission MDS, such as:

- If the client is in a long-term care acute center.
- If the potential receiving nursing facility wants a better clinical picture of the client, a paper copy of the admission MDS is completed by the hospital staff before the client is accepted for admission into the nursing facility.

Refer to: The Long Term Care Program page on the TMHP website at www.tmhp.com for additional information, including instructions for all forms and assessments.

7.4 Claims Filing and Reimbursement

7.4.1 Military Hospital Claims Information

If TOB 110 is used to submit a claim, all charges must be noncovered and the claim will finalize with EOB 217, "Payment reduced through hospital action."

It is appropriate to submit information only claims using TOB 110.

Military hospitals may submit total charges in one line with appropriate accommodation revenue codes. Emergency hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Providers may purchase claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claims supplements.

Refer to: Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Military Hospital (Emergency Inpatient) on the TMHP website at www.tmhp.com for a claim form example.

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7.4.2 Military Hospital Reimbursement

Reimbursement is limited to claims submitted for emergency inpatient care only.

Allowed inpatient hospital stays are reimbursed according to a prospective payment methodology based on DRGs. The reimbursement method itself does not affect inpatient benefits and limitations. Texas Medicaid requires that one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. Providers must submit only one claim per inpatient stay to Medicaid, regardless of the diagnosis, to ensure accurate payment. The DRG reimbursement includes all facility services provided to the client while registered as an inpatient.

Reimbursement to hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). This limitation does not apply to services related to certain organ transplants or services to clients who are 20 years of age and younger and covered by the CCP.

Military hospitals should keep a Medicaid client as an inpatient for only the length of time necessary to stabilize the client. The Medicaid client, once stabilized, should be transferred to the nearest Medicaid acute care hospital facility for further treatment.

When more than one hospital provides care for the same client, the hospital that furnishes the most significant amount of care receives consideration for a full DRG payment.

The other hospital is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility.

Client transfers within the same facility or readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are considered one continuous stay. These readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be included in one submission under the NPI and taxonomy code. Admissions that were submitted inappropriately are identified and denied during the utilization review process and may result in an intensified review.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine if the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

The inpatient DRG reimbursement includes payment for all radiology and laboratory services, including those sent to referral laboratories.

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

8 Claims Resources

Refer to the following sections and forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)

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Resource	Location
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

9 Contact TMHP

Note: *The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.*

10 Forms

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

Forms
Hospital Report (Newborn Child or Children) (Form 7484)
Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information
Non-emergency Ambulance Prior Authorization Request
Psychiatric Inpatient Extended Stay Request Form
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)

11 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Ambulatory Surgical Center
Hospital-Based ASC
Hospital Inpatient
Military Hospital (Emergency Inpatient)

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