Section 1: Provider Enrollment and Responsibilities

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SECTION 1: PROVIDER ENROLLMENT AND RESPONSIBILITIES

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1.1 Provider Enrollment

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

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

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

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

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

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

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

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

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

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

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

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

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

1.1.1 Provider Enrollment Revalidation Requirements

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

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

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

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

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

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

1.1.2 NPI and Taxonomy Codes

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

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

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

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

1.1.3 Online Enrollment

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

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

Online enrollment has the following advantages:

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

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

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

1.1.4 Provider Enrollment Identification

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

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

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

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

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

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

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

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

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

1.1.4.1 Medicare-Only Providers

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

1.1.4.2 Ordering- or Referring-Only Providers

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

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

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

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

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

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

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

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

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

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

1.1.5 Affordable Care Act of 2010 (ACA) Enrollment Requirements

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

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

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

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

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

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1.1.5.1 Provider Screening Requirement

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

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

1.1.5.2 Provider Revalidation

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

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

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

1.1.5.3 Application Fee

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

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

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

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

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

1.1.6 Surety Bond Enrollment Requirement

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

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

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

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

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

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

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

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

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

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

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

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

1.1.6.1 Ambulance Providers

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

Providers can refer to the DSHS website for additional information.

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

1.1.7 * Provider Enrollment Application Determinations

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

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

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

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

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

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

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

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

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

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

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

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

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

1.1.8 Enrollment in Medicaid Managed Care Programs

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

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

1.1.9 Required Enrollment Forms

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

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

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

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

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

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

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

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

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1.1.9.1 Application Payment Form

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

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

1.1.9.2 HHSC Medicaid Provider Agreement

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

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

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

1.1.9.3 Owner/Creditor/Principal Entry

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

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

Principals of the provider include all of the following:

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

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

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A subcontractor of the provider is defined as follows:

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

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

1.1.9.4 Disclosure of Ownership and Control Interest Statement

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

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

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

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

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

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

1.1.9.5 Franchise Tax Account Status Page

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

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

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

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

The following certificates also apply for corporations:

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

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

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

1.1.9.7 Copy of License, Temporary License, or Certification

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

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

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

TMHP directly obtains licensure information from the following licensing boards:

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

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

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

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

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

1.1.9.8 Physician's Letter of Agreement

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

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

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

1.1.9.9 Licensure Renewal

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

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

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

1.1.9.10 Medicare Participation

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

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

1.1.9.10.1 Medicare-Enrolled Groups

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

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

1.1.9.10.2 * Providers Eligible for a Waiver

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

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

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

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

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

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

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

1.1.9.11 Group Information Changes

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

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

1.2 Payment Information

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

1.2.1 Using EFT

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

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1.2.2 Advantages of EFT

Advantages of EFT include:

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

1.2.3 EFT Enrollment Procedures

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

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

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

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

1.2.4 Receiving Paper Checks

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

1.2.5 Stale-Dated Checks

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

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

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

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

1.3 * Provider Disenrollment

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

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

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

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

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

1.3.1 Excluded Entities and Providers

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

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

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

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

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

1.4 Provider Reenrollment

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

1.4.1 Medicare Number

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

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

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

1.4.3 Physical Address

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

1.4.4 Change in Principal Information

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

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

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

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

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

1.5 Change of Ownership Requirements

The new owner must do the following:

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

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

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1.6 Claims Filing During Enrollment

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

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

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

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

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

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

1.7 Provider Responsibilities

1.7.1 Compliance with Texas Family Code

1.7.1.1 Child Support

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

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

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

1.7.1.2 Reporting Child Abuse or Neglect

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

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

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

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

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

1.7.1.3 Procedures for Reporting Abuse or Neglect

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

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

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

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

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

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

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

Reports can be made anonymously.

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

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

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1.7.1.4 Procedures for Reporting Suspected Sexual Abuse

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

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

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

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

1.7.1.5 Training

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

1.7.1.6 Reporting Abuse and Neglect of the Elderly or Disabled

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

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

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

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

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

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

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

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

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

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

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

1.7.2 Texas Medicaid and CHIP Hospital Data Collection and Reporting Requirements

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

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

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

1.7.3 Maintenance of Provider Information

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

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

Subsection 1.4.1, "Medicare Number" in this section.

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

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

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

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

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

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

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

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

1.7.3.1 Contracted Provider Groups

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

1.7.3.2 NPI Verification

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

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

1.7.3.3 Online Provider Lookup (OPL)

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

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

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

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

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

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

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

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

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

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

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

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

1.7.3.4 Updating NPI and Taxonomy Codes

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

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

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

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

1.7.3.5 Updating Provider Specialty

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

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

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

1.7.4 Retention of Records and Access to Records and Premises

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

The documentation includes the following, without limitation:

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

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

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

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

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

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

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

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

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

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

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

1.7.4.1 Payment Error Rate Measurement (PERM) Process

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

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

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

1.7.5 Medicare Overpayment

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

1.7.6 Credit Balance and Recovery Vendor

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

1.7.7 Release of Confidential Information

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

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

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

1.7.8 Compliance with Federal Legislation

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

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

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

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

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

1.7.9 Tamper-Resistant Prescription Pads

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

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

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

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

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

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

1.7.10 Utilization Control — General Provisions

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

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

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

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

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

1.7.11 Provider Certification/Assignment

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

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

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

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

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

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

1.7.11.1 Delegation of Signature Authority

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

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

1.7.12 Billing Clients

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

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

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

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

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

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

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

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

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

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

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

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

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1.7.12.1 Client Acknowledgment Statement

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

The provider may bill the client only if:

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

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

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

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

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

1.7.13 General Medical Record Documentation Requirements

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

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

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

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

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

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

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

1.7.14 Informing Pregnant Clients About CHIP Benefits

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

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

To qualify for CHIP, a child must be:

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

CHIP benefits include:

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

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- Vision services
- Chiropractic services

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

1.7.15 Home Health Providers

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

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

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

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

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

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

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

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

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

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

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

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

1.7.16 Private Duty Nursing (PDN) Providers

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

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Home health agencies must do all of the following:

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

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

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

Independently enrolled RNs and LVNs must also:

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

Independently enrolled RNs must:

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

Independently enrolled LVNs must:

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

1.7.17 Certified Respiratory Care Practitioner (CRCP) Services

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

1.7.18 Physical, Occupational, and Speech Therapy Providers

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

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

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

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

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

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

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

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

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

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

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

1.7.19 Children's Services Comprehensive Care Program (CCP)

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

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

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

1.7.20 Nondiscrimination for Vaccine Status

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

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1.8 Computer-Based Training Courses for Providers

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

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

1.9 Enrollment Criteria for Out-of-State Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.10 Medicaid Fraud, Waste, and Abuse Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Administrative sanctions include, without limitation:

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

Administrative actions include:

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

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

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

1) Claims and Billing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2) Records and Documentation.

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

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

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

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

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

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

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

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

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

3) Program-Related Convictions.

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

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

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

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

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

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

4) Provider Eligibility.

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

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

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

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

e) Loss or forfeiture of corporate charter.

5) Program Compliance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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6) Delivery of Health-Care Services.

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

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

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

7) Improper Collection and Misuse of Funds.

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

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

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

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

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

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

8) Licensure Actions.

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

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

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

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

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

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

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

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

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

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

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

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

10) Cost-Report Violations.

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

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

c) Including unallowable cost items on a cost report;

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

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

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

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

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11) Kickbacks and Referrals.

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

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

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

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

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

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

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

1.10.1 Reporting Fraud, Waste, and Abuse

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

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

1.10.2 Suspected Cases of Provider Fraud, Waste, and Abuse

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

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1.10.3 Employee Education on False Claims Recovery

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

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

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

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

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

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

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

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

The MCO and SIU will do the following:

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

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

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

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

1.11 Texas Medicaid Limitations and Exclusions

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

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

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

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

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

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

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

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

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- Procedures and services considered experimental or investigational

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

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

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

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

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

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

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

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

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

Services that are not covered benefits of Texas Medicaid include:

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

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

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

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

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

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

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

1.13 Forms

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

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

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