Texas Medicaid

Provider Procedures Manual

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Provider Handbooks

Clinics and Other Outpatient Facility Services Handbook

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

CLINICS AND OTHER OUTPATIENT FACILITY SERVICES HANDBOOK

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1 General Information

This information is intended for birthing centers, Federally Qualified Health Centers (FQHCs), local health departments, maternity service clinics, renal dialysis facilities, Rural Health Clinics (RHCs) and tuberculosis (TB) clinics. This handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers. This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Texas Medicaid Managed Care Handbook*. Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook*.

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

1.1 National Drug Codes (NDC)

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

1.2 Revenue Codes for UB-04 Submissions

Claims that are submitted on the CMS-1450 UB-04 paper claim form or electronic equivalent by non-hospital facility or other non-hospital providers must be submitted with a revenue code for correct processing.

If the non-hospital provider is required to submit a procedure code for reimbursement, the provider must include the procedure code and an appropriate corresponding revenue code on the same detail, even if the chosen revenue code does not require a procedure code for claims processing.

Refer to: Subsection 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for a list of revenue codes that do and do not require procedure codes.

1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

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

These reimbursement guidelines do not apply in the following circumstances:

- The services were FQHC, RHC, THSteps, or some renal dialysis services.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.

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- The hospital is not the sole or 100-percent owner of the entity.

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

2 Birthing Center

2.1 Provider Enrollment

A birthing center is a place, facility, or institution where a woman is scheduled to give birth following a normal, uncomplicated (low-risk) pregnancy. This term does not include a hospital, an ambulatory surgical center, or the residence of the woman giving birth.

A birthing center must be licensed as a birthing center by the Department of State Health Services (DSHS) and meet the minimum standards as required by the Texas Health and Safety Code, Chapter 244.010. To enroll in Texas Medicaid, a birthing center must be licensed to provide a level of service commensurate with the professional services of a doctor of medicine (MD), doctor of osteopathy (DO), certified nurse-midwife (CNM), or licensed midwife (LM) who acts as birth attendant. Texas Medicaid may reimburse birthing center providers only for those services that the attending physician or CNM determines to be reasonable and necessary for the care of the mother or newborn child.

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

Birthing centers are encouraged to refer clients for Texas Health Steps (THSteps) services.

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

Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information on setting up referral procedures for family planning services.

The HHSC website a www.healthytexaswomen.org for information about family planning and the locations of family planning clinics receiving HHSC Family Planning Program funding from HHSC.

Subsection 7.2.1.3, "Laboratory Tests" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about required human immunodeficiency virus (HIV) testing for pregnant women.

2.2 Services, Benefits, Limitations, and Prior Authorization

Birthing centers may only be reimbursed by Texas Medicaid for their facility labor and delivery services using the following procedure codes:

Service	Procedure Code
Delivery	59409
Labor only	S4005

Note: *Deliveries at a facility licensed as a birthing center by DSHS must be billed with procedure code 59409.*

If the client is discharged prior to delivery, procedure code S4005 may be billed by the facility for labor services only.

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Refer to: Subsection 9.2.35, "Immunization Guidelines and Administration" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information about immunization administration.

2.2.1 Newborn Hearing Screening

The Texas Health and Safety Code, Chapter 47, requires birthing centers to offer all newborns a hearing screening as a part of the obstetrical care at delivery.

Refer to: Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the newborn hearing screening.

Subsection 2.2.2.3, "Abnormal Hearing Screening Results" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about abnormal hearing screens.

2.2.2 Newborn Eligibility Process

If the mother of the newborn is eligible for Medicaid, the newborn may be assigned his or her own Medicaid number. The birthing center must complete form GN.4, "Birthing Center Report (Newborn Child or Children) (Form 7484)" to provide information about each child born to a mother who is eligible for Medicaid.

Refer to: Hospital Report (Newborn Child or Children) (Form 7484) on the TMHP website at www.tmhp.com.

If the newborn's name is known, the name must be on the form. The use of "Baby Boy" or "Baby Girl" delays the assignment of a number.

The form must be completed by the birthing center no later than five days after the child's birth. Birthing centers that submit the birth certificate information using the HHSC, Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth software and the HHSC Form 7484 receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers that are involved in the care of the newborn.

Additional information about obtaining a newborn Medicaid identification number can be found on the agency website at www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs-services/medicaid-pregnant-women-chip-perinatal. Providers may also call 1-888-963-7111, Ext. 7368 or 1-512-458-7368 for additional information or comments about this process.

Upon receipt of a completed 7484 form, DSHS verifies the mother's eligibility and, within ten days of the receipt, sends notification letters to the hospital or birthing center, attending physician (if identified), mother, and caseworker. The notice includes the child's Medicaid identification number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification card (Your Texas Benefits Medicaid card) to the client.

The attending physician's notification letter is sent to the address on file (by license number) at the Texas Medical Board. This address must be kept current to ensure timely notification. Physicians must submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

2.2.3 Prior Authorization

Prior authorization is not required for services rendered in birthing centers.

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2.2.4 Services Rendered in the Birthing Center Setting

Maternity clinic, physician, CNM, LM, nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) providers who render prenatal or family planning services in the birthing center setting must submit separate claims.

Refer to: Section 4, "Obstetric Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about birthing center providers.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered.

Birthing center services are subject to retrospective review and recoupment if documentation does not support the service billed.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Claims for birthing center services must be submitted to Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, providers must include all required information on the claim, as TMHP does not key any information from attachments. Superbills or itemized statements are not accepted as claim supplements.

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

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

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement

Birthing centers are reimbursed in accordance with 1 TAC §355.8181. See the applicable fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. The Centers for Medicare & Medicaid Services (CMS) NCCI and medically unlikely edits (MUE) guidelines can be found in the NCCI Policy and Medicaid Claims Processing manuals, which are available on the CMS NCCI web page. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

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

3 Comprehensive Health Center (CHC)

CHCs or physician-operated clinics are funded by federal grants. To apply for participation in Texas Medicaid, they must be certified and participate as health centers under Medicare (Title XVIII).

CHC claims are paid according to each center's encounter rates as established by CMS. Medicaid payments to CHCs are limited to Medicare deductible or coinsurance according to current guidelines. CHC providers that supply laboratory services in an office setting must comply with the rules and regulations for the Clinical Laboratory Improvement Amendments (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

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

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

"Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Section 4, "Federally Qualified Health Center (FQHC)" in this handbook.

Section 8, "Rural Health Clinic" in this handbook.

4 Federally Qualified Health Center (FQHC)

4.1 Enrollment

To enroll in Texas Medicaid, an FQHC must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services (HHS) to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. The CMS has granted a waiver for the Medicare prerequisite at the time of initial enrollment of FQHC parents and satellites. FQHC look-alikes are *not* required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers.

Refer to: Subsection 4.3.2.1, "Medicare Crossover Claims Pricing" in this handbook.

A copy of the Public Health Service's Notice of Grant Award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to TMHP Provider Enrollment annually.

FQHCs are required to notify TMHP of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing Texas Medicaid for FQHC services must also be approved by the United States Department of Health and Human Services Health Resources and Services Administration (HRSA). For accounting purposes, centers may elect to enroll the HRSA-approved satellites using a Federally Qualified Satellite (FQS) provider identifier that ties back to the parent FQHC National Provider Identifier (NPI) and tax ID number (TIN). This procedure allows for the parent FQHC to have one provider agreement and one cost report that combines all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to submit claims to Texas Medicaid directly, the center must have a separate NPI from the parent FQHC and will be required to file a separate cost report.

All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care

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services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

FQHC providers do not need to apply for a separate physician or agency number to provide family planning services.

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

FQHCs must identify and attest to all contractual agreements for those medical services in which the FQHC is receiving Prospective Payment System (PPS) reimbursement. This is a mandate from the 2012 to 2013 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 78).

The attestation shall be made using the Federally Qualified Health Center Affiliation Affidavit, which is available on the TMHP website at www.tmhp.com.

4.1.1 Initial Cost Reporting

New FQHCs must file a projected cost report within 90 days of their designation as an FQHC to establish an initial payment rate. The cost report will contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. The FQHC must file a cost report within five months of the end of the FQHC's initial fiscal year. The cost settlement must be completed within 11 months of the receipt of a cost report. The cost per visit rate established by the cost settlement process will be the base rate. Any subsequent increases will be calculated as provided herein.

FQHC providers are required to submit a copy of their Medicare-audited cost report for the provider's fiscal year within 30 days of receipt from Medicare to:

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

A new FQHC location established by an existing FQHC participating in Texas Medicaid will receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

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

4.1.2 Services, Benefits, Limitations, and Prior Authorization

The services listed in the following tables may be reimbursed using the FQHC's NPI. Any additional physician services must be submitted for reimbursement using the physician's NPI. Hospital services are not considered for reimbursement to FQHC providers, and cannot be billed using the facility provider number assigned to the FQHC.

General Medical Services									
T1015									
General medical services must be submitted using one of the appropriate modifiers AH, AJ, AM, SA, TD, TE, TH, U1, U2, or U7.									

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FQHC Encounter Services							
G0466	G0467	G0468	G0469	G0470			

Adult Preventative Care									
99385	99386	99387	99395	99396	99397				
Adult preventative care must be submitted with diagnosis codes Z0000, Z0001, Z01411, and Z01419.									

Case Management
G9012
Comprehensive visit must be submitted using modifiers U2 and U5. **Follow-up face-to-face visit must be submitted using modifiers TS and U5.** **Follow-up telephone visit must be submitted using modifier TS.**

Family Planning Services									
99202	99203	99204	99205	99211	99212	99213	99214	99215	J7296
J7297	J7298	J7300	J7301	J7307					
Annual family planning examination must be submitted with modifier FP.									

Mental Health Services									
90791	90792	90832	90833*	90834	90836*	90837	90838*	90846	90847
90853	90899	96116	96130	96132	96136				
*** Procedures cannot be performed by Psychologist. Mental health services must be submitted using one of the appropriate modifiers AH, AJ, AM, U1, or U2.**									

THSteps Dental Services									
D0120	D0140	D0145	D0150	D0160	D0170	D0180	D0330	D0340	D0350
D0367	D0470	D1110	D1120	D1208	D1351	D1510	D1516	D1517	D1520
D1526	D1527	D1551	D1552	D1553	D1575	D2140	D2150	D2160	D2161
D2330	D2331	D2332	D2335	D2390	D2391	D2392	D2393	D2394	D2750
D2751	D2791	D2792	D2930	D2931	D2932	D2933	D2934	D2940	D2950
D2954	D2971	D3220	D3230	D3240	D3310	D3320	D3330	D3346	D3347
D3348	D3351	D3352	D3353	D4277	D4278	D4283	D4285	D4341	D4355
D5211	D5212	D5630	D5640	D5650	D5660	D5670	D5671	D5720	D5721
D5740	D5741	D5760	D5761	D5992	D5993	D6049	D6549	D7140	D7210
D7220	D7230	D7250	D7270	D7286	D7510	D7550	D7910	D7961	D7962
D7970	D7971	D7997	D7999	D8010	D8020	D8070	D8080	D8210	D8220
D8660	D8670	D8680	D9110	D9211	D9212	D9223	D9224	D9225	D9230
D9243	D9244	D9245	D9246	D9247	D9930	D9944	D9974	D9994	D9995
D9999									
Procedure codes D8210, D8220, and D8080 must be submitted with Diagnostic Procedure Code (DPC) remarks codes for correct claims processing.									

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THSteps Medical Services									
99211	99381	99382	99383	99384	99385	99391	99392	99393	99394
99395	96160	96161							
THSteps medical services must be submitted using modifier EP in addition to one of the appropriate modifiers AM, SA, or U7.									

Note: *Procedure codes 96160 and 96161 are a benefit for Texas Medicaid clients who are 12 through 18 years of age and is limited to once per calendar year, any provider. Only one procedure code (96160 or 96161) may be reimbursed for the mental health screening per client per calendar year based on the description of the procedure code and the service rendered.*

Vision Care Services									
92002	92004	92012	92014	92015	92020	92025	92060	92065	92081
92082	92083	92100	92201	92202	92230	92235	92240	92242	92250
92260	92265	92270	92273	92274	92285	92286	92287	95060	95930
95933	S0620	S0621							

Copayments									
CP001	CP002	CP005	CP006						

Refer to: Subsection 6.3.5, "Modifiers" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for a definition of modifiers.

Section 3, "Texas Health Steps (THSteps) Dental" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 2, "Healthy Texas Women (HTW) Program Overview" in the *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "Vision Care Professionals" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

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

Subsection 9.2.60.4.2, "Preventive Care Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 8.8.2.2, "HMO Copayments" in "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for information about HMO copayments.

The *Health and Human Services Commission Family Planning Program Services Handbook* (*Vol. 2, Provider Handbooks*).

Medicaid coverage is limited to FQHC services that are covered by Texas Medicaid and are reasonable and medically necessary. When furnished to a client of the FQHC, medically necessary services include the following:

- CNM services
- Clinical psychologist services
- Licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), and other mental health services

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- Dental services
- NP services
- Other ambulatory services included in Medicaid such as family planning, THSteps, and maternity service clinic (MSC)
- PA services
- Physician services
- Services and supplies necessary for services that would be covered otherwise, if furnished by a physician or a physician service
- Vision care services
- Visiting nurse services to a homebound individual, in the case of those FQHCs located in areas with a shortage of home health agencies

Types of FQHC visits are defined in 1 TAC §355.8261. A visit is a face-to-face encounter between an FQHC client and a physician, PA, NP, CNM, visiting nurse, qualified clinical psychologist, LCSW, LMFT, LPC, other health-care professional for mental health services, dentist, dental hygienist, or optometrist. Encounters that take place on the same day at a single location with more than one health-care professional or multiple encounters with the same health-care professional constitute a single visit, except where one of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The FQHC client has a medical visit and an other health visit such as a qualified clinical psychologist, LCSW, LMFT, LPC, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a THSteps medical checkup.

All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. They are not billable as a separate encounter.

Registered nurses may not be the sole provider of a medical checkup in an FQHC. If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be used. These procedure codes are informational only, and are not payable.

To be reimbursed for Case Management for Children and Pregnant Women, an FQHC must be approved as a case management services provider by the DSHS Case Management Branch.

An annual family planning examination is allowed once per state fiscal year (September 1 through August 31), per client, per provider. An FQHC may be reimbursed for up to three family planning encounters per client, per year, regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters, an annual family planning examination, or intrauterine devices.

Family planning services must be submitted with the most appropriate evaluation and management (E/M) procedure code and one of the following family planning diagnosis codes:

Family Planning Diagnosis Codes							
Z30011	Z30013	Z30014	Z30018	Z3002	Z3009	Z302	Z3040
Z3041	Z3042	Z30430	Z30431	Z30432	Z30433	Z3049	Z308
Z309	Z9851	Z9852					

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Procedure code 58300 must be submitted on the same claim as J7296, J7297, J7298, J7300, and J7301. Procedure code 58300 will process as informational only. Only the annual family planning examination requires modifier FP. All other family planning visits do not require the FP modifier. Claims filed incorrectly may be denied.

Laboratory and radiology services or the services of a licensed vocational nurse (LVN), registered nurse (RN), nutritionist, or dietitian are *not* considered an encounter, because they are incidental to an encounter with one of the previously-mentioned payable health-care professionals. Providers should continue to include the cost associated with these services on their cost report (they are allowable but do not constitute an encounter).

Per federal regulations, the provider cannot submit claims to Medicaid or bill the client for vaccines obtained from the Texas Vaccine for Children (TVFC) Program.

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

4.1.3 After-Hours Care

After-hours care for FQHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday. After-hours care provided by FQHCs does not require a referral.

4.1.4 Prior Authorization

Prior authorization or authorization may be required for FQHC services. Refer to the individual sections referenced in subsection 4.1.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

4.1.5 Referral Requirements

Texas Medicaid fee-for-service limited clients, are allowed to choose any enrolled family planning provider.

4.2 Documentation Requirements

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

4.3 Claims Filing and Reimbursement

4.3.1 Claims Information

All services (except for family planning, THSteps medical, THSteps dental, copayments, vision, mental health services, and case management for high-risk pregnant women and infants) provided during an encounter must be submitted for reimbursement using procedure code T1015. All services provided that are incidental to the encounter must be included in the total charge for the encounter and are not billable as a separate encounter. For example, if an office visit was provided at a charge of $30 and a lab test for $15, the center would submit a claim to TMHP for procedure code T1015 for $45 and would be reimbursed at the center's encounter rate.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA are not reimbursed for laboratory services.

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

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To obtain the encounter rate when submitting claims for family planning services that are provided under Title XIX or HTW, FQHCs must use the most appropriate E/M procedure code, or procedure code J7296, J7297, J7298, J7300, and J7301, or J7307 with a family planning diagnosis code. Providers must use procedure code J7296, J7297, J7298, J7300, J7301, or J7307 if the visit is for the insertion of an intrauterine device (IUD) or implantable contraceptive capsule. These procedure codes must be submitted in conjunction with the most appropriate informational procedure codes for services that were rendered. Procedure codes J7296, J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an IUD or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program. Providers must use modifier FP only to submit claims for the annual family planning examination.

If an employed physician of an FQHC provides a service in the hospital (e.g., a delivery), the service may be billed using the physician provider number if the terms of the FQHC and physician agreement indicate this occurrence. Physicians must be enrolled in Medicaid separately from the FQHC facility. Physicians are not allowed to bill through their FQHC group number for hospital services. The services will be reimbursed at the physician fee-for-service (FFS) fee schedule rate. The costs that are associated with these physician services must be excluded from the FQHC's cost report and will not be considered during the FQHC cost settlement or encounter rate setting process.

Services rendered in the (inpatient or outpatient) hospital setting are not considered a reimbursable FQHC encounter and are not payable to the FQHC. FQHC services for clients who have only Medicaid must be submitted to TMHP in approved electronic format or on a UB-04 CMS-1450, CMS-1500, or 2017 paper claim form. Providers may purchase UB-04 CMS-1450 or CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a UB-04 CMS-1450 or CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The ADA Dental Claim Form can be downloaded at www.ada.org.

The 2017 Claim Form can be found in the Forms section of this manual.

Refer to: 2017 Claim Form on the TMHP website at www.tmhp.com.

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

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

Section 12, "Forms" in this handbook.

Claims must be filed as follows:

Services	Claim Form
THSteps medical services	UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format
Family planning claims filed by FQHC providers who have contracted with HHSC	2017 Claim Form or approved electronic format
Family planning claims filed by FQHC providers not contracted with HHSC	UB-04 CMS-1450 or 2017 paper claim form or approved electronic format

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Services	Claim Form
THSteps dental services	American Dental Association (ADA) Dental Claim Form or approved electronic format
Case Management for Children and Pregnant Women services	UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format

When filing for a client who has Medicare and Medicaid coverage, providers must file on the same claim form that was filed with Medicare.

Services provided by a health-care professional require one of the following modifiers with procedure code T1015, to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, U1, U2, or U7.

- If more than one health-care professional is seen during the encounter, the modifier must indicate the primary contact. The primary contact is defined as the health-care professional who spends the greatest amount of time with the client during that encounter.
- If the encounter is for antepartum care or postpartum care, the modifier TH must be indicated on the claim in addition to any other appropriate modifier.
- If the antepartum or postpartum care is provided by a CNM, the modifier SA must be indicated on the claim in addition to any other appropriate modifiers.

Use modifier TD or TE for home health services provided in areas with a shortage of home health agencies.

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

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

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

The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

The *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*).

4.3.2 Reimbursement

FQHCs are reimbursed provider-specific prospective payment system encounter rates in accordance with 1 TAC §355.8261.

FQHCs are exempt from the mandated rate reductions except for HHSC Family Planning services.

Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

Subsection 2.3, "Reimbursement Reductions" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

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4.3.2.1 Medicare Crossover Claims Pricing

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

For FQHC Medicare crossover claims, Texas Medicaid will reimburse the lesser of the following:

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

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

The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.

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

4.3.2.2 NCCI and MUE Guidelines

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

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

5 Local Health Department

Local Health Department (LHD) providers may be reimbursed for Medicaid services within their scope of practice.

The types of services LHD providers may render include, but are not limited to, the following:

- Dental
- Family planning
- Immunizations
- Laboratory
- Radiology
- Screening and treatment for sexually transmitted infections and infectious diseases
- Vaccines

LHD providers can refer to the applicable static Fee Schedules on the TMHP website at www.tmhp.com for a complete list of services that may be reimbursed to LHD providers.

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6 Maternity Service Clinic (MSC)

MSCs are limited provider clinics that are unrelated to a hospital and that only provide maternity services. An MSC will be reimbursed for antepartum care and/or postpartum care visits only. Hemoglobin, hematocrit and urinalysis procedures are included in the charge for antepartum care and not separately reimbursed. Services other than antepartum and postpartum care visits will be denied.

Refer to: Section 7, "Maternity Service Clinics (MSC)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

7 Renal Dialysis Facility

7.1 Enrollment

To enroll in Texas Medicaid, a renal dialysis facility must be Medicare-certified in the state where it is located. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.

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

7.2 Services, Benefits, Limitations, and Prior Authorization

Renal dialysis is a benefit of Texas Medicaid for the following acute kidney injury (AKI) or end stage renal disease (ESRD) diagnosis codes:

Diagnosis Codes							
N170	N171	N172	N178	N179	N181	N182	N1830
N1831	N1832	N184	N185	N186	N189	N990	T795XXA
T795XXD	T795XXS						

All of the services, except for ultrafiltration (revenue code B-881), are diagnosis-restricted to the diagnoses in the above table.

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

Subsection 3.2.5, "Organ and Tissue Transplant Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for information on organ transplant and facility services.

Dialysis treatments are a benefit for clients in an inpatient or outpatient hospital or a renal dialysis facility according to the guidelines for outpatient maintenance dialysis approved through CMS. Dialysis treatments may also be a benefit in the client's home. Outpatient dialysis includes:

- Staff-assisted dialysis performed by the staff of the center or facility.
- Self-dialysis performed by a client with or without professional assistance (the client must have completed an appropriate course of training).
- Home dialysis performed by an appropriately trained client (and the client's caregiver) at home.
- Dialysis furnished in a facility on an outpatient basis at an approved renal dialysis facility.

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7.2.1 Physician Supervision

Physician reimbursement for supervision of ESRD clients on dialysis is based on a monthly capitation payment (MCP) that is calculated by Medicare. The MCP is a comprehensive payment that covers all of the physician services that are associated with the continuing medical management of a maintenance dialysis client for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all places of service except inpatient hospital.

Physician supervision of outpatient ESRD dialysis includes services that are rendered by the attending physician during the course of an office visit which any of the following occur:

- Routine monitoring of dialysis
- Treatment or follow-up of complications of dialysis, including:
  - Evaluation of related diagnostic tests and procedures
  - Services that are involved in the prescription of therapy for illnesses that are unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts

The following physician services are a benefit for physician supervision of outpatient ESRD dialysis services:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970

Physician services (procedure codes 90935, 90937, 90945, and 90947) are a benefit for hemodialysis or other dialysis procedures and are restricted to diagnosis codes T795XXA, T795XXD, and T795XXS.

Procedure codes 90935, 90937, 90945, and 90947 are a benefit for:

- ESRD or non-ESRD services in the inpatient setting when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of dialysis procedure. These codes are not payable for a cursory visit by the physician. Hospital visit procedure codes must be used for a cursory visit.
- Non-ESRD services when provided by a physician, nurse practitioner, clinical nurse specialist, or physician assistant in an office or outpatient setting.

Only one of the following procedure codes 90935, 90937, 90945, or 90947 may be reimbursed per day by any provider.

If the physician sees the client only when the client is not dialyzing, the physician must submit the appropriate hospital visit procedure code. The inpatient dialysis procedure code must not be submitted for payment.

Providers must use one of the following procedure codes to submit claims for services when the client:

- Is not on home dialysis.
- Has had a complete assessment visit during the calendar month.
- Has received a full month of ESRD related services

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962								

When a full calendar month of ESRD-related services are submitted for clients on home dialysis, providers must use procedure code 90963, 90964, 90965, or 90966.

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Providers must submit claims with procedure code 90967, 90968, 90969, or 90970 if ESRD-related services are provided for less than a full month, per day, under the following conditions:

- Partial month during which a client who is not on home dialysis received one or more face-to-face visits but did not receive a complete assessment.
- A client who is on home dialysis received less than a full month of services.
- Transient client.
- Client was hospitalized during a month of services before a complete assessment could be performed.
- Dialysis was stopped due to recovery or death of a client.
- Client received a kidney transplant.

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When submitting claims for these procedure codes, providers must indicate the dates of service on which supervision was provided.

Procedure codes 90967, 90968, 90969, and 90970 will be denied if they are submitted with dates of service in the same calendar month by any provider as the following procedure codes:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966				

Only one of the procedure codes in the previous table will be reimbursed per calendar month by any provider.

The following services may be provided in conjunction with physician supervision of outpatient ESRD dialysis but are considered nonroutine and may be submitted for reimbursement separately.

- Declotting of shunts when performed by the physician.
- Physician services to inpatients.

If one of the following occurs:

- A client is hospitalized during a calendar month of ESRD-related services before a complete assessment is performed.
- The client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment.

Then the physician must submit both of the following:

- Procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision.
- The appropriate hospital evaluation and management code for individual services provided on the days during which the client was hospitalized.

If a client has a complete assessment in the month during which the client is hospitalized, one of the following procedure codes must be submitted for the month of supervision:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962								

The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.

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- Dialysis at an outpatient facility other than the usual dialysis setting for a client of a physician who bills the MCP. The physician must submit procedure code 90967, 90968, 90969, or 90970 for each date on which supervision is provided. The physician may not submit claims for days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the client's renal condition that cause the number of physician-client contacts to increase. Physicians may submit claims on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

Inpatient services that are provided to a hospitalized client for whom the physician has agreed to submit monthly claims, may be reimbursed in one of the following ways:

- The physician may elect to continue monthly billing, in which case the physician may not bill for individual services that were provided to the hospitalized client.
- The physician may reduce the monthly amount submitted by 1/30th for each day of hospitalization and may charge fees for individual services that were provided on the hospitalized days.
- The physician may submit a claim for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the client during the course of the dialysis.

Clients may receive dialysis at an outpatient facility other than the client's usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly amount submitted for reimbursement by 1/30th for each day the client is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client's renal condition may be reimbursed on a fee-for-service basis. The physician must provide medical documentation with the claim that identifies how the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the MCP for physician supervision rendered to maintenance facility clients.

7.2.1.1 Unscheduled or Emergency Dialysis in a Non-Certified ESRD Facility

For some medical situations in which ESRD clients cannot obtain their regularly scheduled dialysis treatment at a certified ESRD facility, Texas Medicaid will allow for non-routine dialysis treatments furnished in the outpatient department of a hospital that does not have a certified dialysis facility.

Unscheduled dialysis for clients may be a benefit for one of the following reasons:

- Dialysis was performed following, or in connection with, a vascular access procedure.
- Dialysis was performed following treatment for an unrelated medical emergency (e.g., a client goes to the emergency room and, as a result, misses a regularly scheduled dialysis treatment that cannot be rescheduled).
- Emergency dialysis was performed for clients who would otherwise have to be admitted as inpatient in order for the hospital to receive payment.

Providers must submit claims using procedure code G0257 with revenue code 880 in order to receive payment for unscheduled outpatient dialysis.

Procedure code G0257 will be limited to once per week, same procedure, any provider. Procedure code G0527 will be denied if not submitted with revenue code 880, same day, same claim, same provider.

Procedure code G0257 is limited to diagnosis codes N185 and N186.

Texas Medicaid will provide a single payment to reimburse unscheduled or emergency dialysis treatments furnished to ESRD clients in the outpatient department of a hospital that does not have a certified ESRD facility.

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Reimbursement for procedure code G0257 is limited to the same services included in consolidated billing. Providers will not be reimbursed for individual services related to dialysis.

Repeated billing of this service by the same provider for the same clients may indicate routine dialysis treatments are being performed and providers will be subject to recoupment upon medical record review.

Other outpatient hospital services are only reimbursed if they are not related to the dialysis services and are determined to be medically necessary with supporting documentation.

7.2.2 Renal Dialysis Facilities - Consolidated Billing

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. The facility's charge must not include the charge for the physician's routine supervision.

One of the following revenue codes must be billed for the dialysis facility to receive the composite rate payment:

Revenue Code – Renal Dialysis Composite	Limitations
821	3 per week
831	3 per week
841	Hemodialysis (HD) – equivalent sessions
851	HD – equivalent sessions

The composite rate includes all of the following necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in the facility:

Procedure Codes – Durable Medical Equipment ESRD Supply							
36000	36430	36591	36593	49421	71045	71046	71047
71048	93005	93040	93041	A4215	A4216	A4217	A4218
A4244	A4245	A4246	A4247	A4248	A4450	A4452	A4651
A4652	A4653	A4657	A4660	A4663	A4670	A4671	A4672
A4673	A4674	A4680	A4690	A4706	A4707	A4708	A4709
A4714	A4719	A4720	A4721	A4722	A4723	A4724	A4725
A4726	A4728	A4730	A4736	A4737	A4740	A4750	A4755
A4760	A4765	A4766	A4770	A4771	A4772	A4773	A4774
A4802	A4860	A4870	A4890	A4911	A4913	A4918	A4927
A4928	A4929	A4930	A4931	A4932	A6204	A6215	A6216
A6250	A6260	A6402	E0210	E0424	E0431	E0434	E0439
E0441	E0442	E0443	E0444	E0447	E1500	E1510	E1520
E1530	E1540	E1550	1560	E1570	E1575	E1580	E1590
E1592	E1594	E1600	E1610	E1615	E1620	E1625	E1630
E1632	E1634	E1635	E1636	E1637	E1639	E1699	

DME ESRD supply (procedure code E1629) for necessary equipment, supplies, and services for the client receiving dialysis in the home are excluded from the composite rate and will be paid separately.

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Laboratory testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for the following routine laboratory tests are included in the facility's composite rate billed to Medicaid regardless of where tests were processed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by the renal dialysis facility unless they are an inclusive test.

Procedure Codes – Labs Subject to ESRD Consolidated Billing							
80047^	80048^	80051^	80053^	80069^	80076	82040^	82108
82306	82310^	82330^	82374^	82379	82435^	82565^	82570^
82575	82607	82610	82652	82668	82728	82746	83540
83550	83735	83970	84075^	84100	84132^	84134	84155^
84157	84295^	84466	84520^	84540	84545	85014^	85018^
85025^	85027	85041	85044	85045	85046	85048	86704
86705	86706	87040	87070	87071	87073	87075	87076
87077	87081	87340	87341	87467	G0306	G0307	G0499
QW^ Modifier							

All drugs and biologicals used for the treatment of ESRD or AKI (unless specified otherwise) are included in the composite rate payment and are not paid separately, the following drugs are included:

Procedure Codes									
A4216	A4217	A4802	J0360	J0604	J0612	J0613	J0616	J0618	J0620
J0630	J0670	J0878	J0884	J0892	J0895	J0899	J0945	J1160	J1200
J1205	J1240	J1265	J1270	J1643	J1644	J1720	J1740	J1750	J1800
J1938	J1955	J2151	J2360	J2430	J2501	J2720	J2795	J2993	J2997
J3265	J3373	J3410	J3420	J3480	J3489	J7030	J7040	J7042	J7050
J7060	J7070	J7120	J7131	Q0163					

The following drugs used for the treatment of ESRD are excluded from the composite rate and will be paid separately:

Procedure Codes – Drugs Not Subject to ESRD Consolidated Billing									
J0879	J0882	J1439	J1756	J2916	Q4081	Q5105			

In addition to the diagnosis codes listed in the table of section 6.2, "Services, Benefits, Limitations, and Prior Authorization," procedure code J0879 is restricted to diagnosis code L2989, and procedure code Q5105 is restricted to diagnosis code D631.

Other drugs and biologicals furnished by an ESRD facility that are not used for the treatment of ESRD may be billed separately.

The ordering physician must maintain documentation in the client's medical record to support medical necessity.

Maintenance for Hemodialysis, IPD, CAPD, and CCPD

End Stage Renal Disease facilities furnishing dialysis treatments in-facility are paid for up to three treatments per week. ESRD facilities treating patients at home, regardless of modality, receive payment for three hemodialysis equivalent treatments per week.

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Maintenance intermittent peritoneal dialysis (IPD) is usually performed in sessions of 10 to 12 hours duration, three times per week. However, it is sometimes performed in fewer sessions of longer duration. If more than three sessions occur in one week, the provider must supply documentation of medical necessity with the claim.

For clients undergoing CAPD or CCPD in the home, the number of days of peritoneal dialysis, regardless of dialysate exchanges performed each day, is converted to hemodialysis-equivalent sessions. This is accomplished by dividing the number of days of peritoneal dialysis by 7 and multiplying the result by 3.

For clients undergoing CAPD or CCPD in the home, the number of days of peritoneal dialysis regardless of dialysate exchange performed each day will be 14 per 31 days.

A combination of HD, IPD, CAPD, and CCPD dialysis treatments are limited to 14 sessions within 31 days for any provider. If more than 14 sessions are needed, the provider must supply documentation of medical necessity with the claim. Documentation can include but is not limited to medical records, physicians' notes, and lab results. Records must clearly show why extra sessions are medically required.

The ordering physician must maintain documentation supporting medical necessity in the client's medical record.

7.2.3 Ultrafiltration

A separate ultrafiltration treatment to remove the excess fluid may be covered.

Ultrafiltration is performed on a day other than the day of a dialysis treatment. The dialysis facility must document in the medical record why the ultrafiltration could not have been performed at the time of dialysis treatment. Ultrafiltration performed on the same day as the dialysis treatment, is not separately reimbursed.

Ultrafiltration may be reimbursed using revenue code 881 up to a maximum of 3 times per week.

7.2.4 Home Dialysis Items and Services

Texas Medicaid utilizes Medicare's composite rate reimbursement system, consolidated billing. Under this reimbursement system, the dialysis facility must assume responsibility for providing all home dialysis equipment, supplies, and home support services.

One of the following revenue codes must be billed for the dialysis facility to receive the composite rate payment for clients that are treated in the home:

Revenue Code	Limitations
821	3 per week
831	3 per week
841	Hemodialysis (HD) – equivalent sessions
851	HD – equivalent sessions

Support services are included in the composite rate. Support services specifically applicable to home clients include, but are not limited to:

- Periodic monitoring of a client's adaptation to home dialysis and performance of dialysis, including provisions for visits to the home or the facility.
- Visits by trained personnel for the client with a qualified social worker and a qualified dietitian, made in accordance with a plan prepared and periodically reviewed by a professional team, which includes the physician.
- Individual unscheduled visits to a facility made on an as-needed basis; (e.g., assistance with difficult access situations).

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- ESRD-related laboratory tests covered under the composite rate.
- Providing, installing, repairing, testing, and maintaining home dialysis equipment, including appropriate water testing and treatment.
- Ordering of supplies on an ongoing basis.
- A record keeping system that assures continuity of care.
- Support services specifically applicable to chronic ambulatory peritoneal dialysis (CAPD) also include, but are not limited to:
  - Changing the connecting tube and administration set.
  - Monitoring the client's performance of CAPD, assuring that it is done correctly, and reviewing proper techniques with the client or informing the client of modifications to apparatus or technique.
  - Documenting whether the client has or has had peritonitis that requires physician intervention or hospitalization (unless there is evidence of peritonitis, a culture for peritonitis is not necessary).
  - Inspecting the catheter site.

Routine laboratory services listed in the table of section 6.2.2, Renal Dialysis - Consolidated Billing are included in the composite rate and are not reimbursed separately.

Equipment and supplies are listed in the table of section 6.2.2, Renal Dialysis - Consolidated Billing are included in the composite rate and are not reimbursed separately.

Installation and repair of home hemodialysis machines are not a benefit of Texas Medicaid. Home modifications for use of medical equipment are not a benefit of Texas Medicaid.

Clients may have a one month reserve of supplies available for use. Renal dialysis services beyond these limitations may be considered for clients who are 20 years of age and younger through the Comprehensive Care Program (CCP) with prior authorization.

7.2.5 Facility Revenue Codes

Under consolidated billing, the following services are a benefit for renal dialysis centers:

Service	Revenue Code	Description
Maintenance	821	Hemodialysis (outpatient/home)–composite or other rate
	831	Peritoneal Dialysis (outpatient/home)–composite or other rate
	841	CAPD (outpatient/home)–composite or other rate
	851	CCPD (outpatient/home)–composite or other rate
Training	829	Hemodialysis (outpatient/home)–other
	839	Peritoneal Dialysis (outpatient/home)–other
	849	CAPD (outpatient/home)–other
	859	CCPD (outpatient/home)–other
Miscellaneous	881	Miscellaneous dialysis–ultrafiltration

Renal dialysis facilities should not use a HCPCS/CPT code when submitting a claim with a revenue code.

The facility charge must not include the charge for the physician's routine supervision.

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7.2.6 Training for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycle Peritoneal Dialysis (CCPD), and Chronic Ambulatory Peritoneal Dialysis (CAPD)

Most self-dialysis training for hemodialysis, IPD, CCPD, and CAPD is provided in an outpatient setting. Dialysis training provided in an inpatient setting will be reimbursed at the same rate as the facility's outpatient training rate.

Reimbursement for hemodialysis, IPD, CCPD, and CAPD training services and supplies provided by the dialysis facility includes personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine dialysis laboratory tests.

It may be necessary to supplement the patient's dialysis during CAPD training with intermittent peritoneal dialysis or hemodialysis because the client has not mastered the CAPD technique.

Training is limited to once per day. The composite rate will be denied as part of dialysis training when submitted for the same date of service.

The following revenue codes may be reimbursed for dialysis training:

Revenue Code	Limitations
829	18 sessions per lifetime
839	18 sessions per lifetime
849	18 sessions per lifetime
859	18 sessions per lifetime

Revenue codes 829, 839, 849, and 859 are limited to one per day, any procedure, any provider.

7.2.7 Laboratory and Radiology Services

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

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

Laboratory and radiology testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for routine laboratory and radiology tests in tables of section 6.2.2 Renal Dialysis - Consolidated Billing are included in the facility's composite rate submitted to Texas Medicaid regardless of where tests were processed.

7.2.7.1 Hematopoietic Injections

Medicaid reimbursement is allowed for hematopoietic injections that are administered to clients who have anemia that is associated with chronic renal failure.

Providers must submit the client's most recent dated hemoglobin or hematocrit levels in the comments section of the claim form when billing with procedure code Q4081. Frequency and quantity limitations apply.

Refer to: The *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about benefit and limitation criteria.

7.2.7.2 Blood Transfusions

Whole blood (procedure codes P9010 and P9011) for transfusions may be reimbursed separately to dialysis facilities when medically indicated for a Medicaid eligible client.

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7.2.8 Telemedicine and Telehealth Services

Certain telemedicine and telehealth services may be provided for ESRD clients if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interactions, such as an in-person visit.

Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided.

The following ESRD dialysis services are authorized for telemedicine and telehealth delivery using synchronous audiovisual technology:

Procedure Codes							
90951	90952	90954	90955	90957	90958	90960	90961

Services provided by synchronous audio-visual technology must be billed using modifier 95.

During a Declaration of State of Disaster, the Texas Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

7.2.9 Vaccine Services for Renal Dialysis Facilities

The following procedure codes may be reimbursed to renal dialysis facility providers:

Category	Procedure Codes
COVID-19 vaccine	91320, 91322
Hepatitis B immune globulin	90371, J1571, J1573
Hepatitis B vaccine for immunocompromised/ dialysis patients	90740, 90747
Influenza vaccine	90653, 90655, 90656, 90657, 90658, 90661, 90662, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90756
Pneumococcal vaccine	90670, 90671, 90677, 90684, 90732
Vaccine administration	90460, 90471, 90472, 90480
Vaccine counseling	G0315

7.2.10 Prior Authorization

Prior authorization is not required for renal dialysis services. Prior authorization must be obtained for transplant-related services provided to clients who are not eligible for Medicare and are eligible only for Medicaid.

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7.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including renal dialysis services. Renal dialysis services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement. All physicians', renal dialysis centers', and medical suppliers' supporting documentation is subject to retrospective review.

7.4 Claims Filing and Reimbursement

7.4.1 Claims Information

Renal dialysis facility services must be submitted to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

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

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

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

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

Reminder: *The original onset date must be included on the claim form to prevent claim denial. The original onset date must be the same date entered on Form CMS-2728 sent to the Social Security office.*

7.4.2 Reimbursement

Renal dialysis facilities are reimbursed according to composite rates, which are based on the CMS-specified calculations and the Texas Medicaid Reimbursement Methodology (TMRM). Texas Medicaid may reimburse for dialysis services by consolidated billing as defined by CMS.

All required items and services included under the composite rate must be made available by the facility, either directly or under arrangements, for each client.

Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Refer to: Section 2.2, "Fee-for-Service Reimbursement Methodology" for more information about reimbursement.

7.4.2.1 NCCI and MUE Guidelines

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

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

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7.5 Medicare and Medicaid

Medicaid coverage of a renal dialysis client who may be eligible for Medicare coverage begins with the original onset date of the dialysis treatments and may continue for a period of three months. During this period, Medicare eligibility is reviewed through the Health and Human Services Commission (HHSC). If HHSC determines that the client is Medicare-eligible, Medicaid coverage begins with the original onset date and continues until Medicare coverage begins.

If HHSC determines that the client is not eligible for Medicare, Medicaid coverage of eligible clients begins with the original onset date and continues as long as the dialysis treatments are medically necessary and the client is eligible for Medicaid. The date of onset is the date of the first dialysis treatment and does not change even if the client sees another provider.

Medicare eligibility usually begins after a three-month waiting period has been served. Medicare eligibility begins before the waiting period has expired if the individual receives a transplant or participates in a self-dialysis training program during the waiting period.

7.5.1 Facility Providers

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

Texas Medicaid processes ESRD Medicare claims using the Part B Immunosuppressive Drug (Part B-ID) benefit for the reimbursement of immunosuppressive drugs for ESRD Medicare clients who have lost Part A and Part B Medicare coverage.

7.5.2 Physician Providers

The five percent reduction does not apply to physician-billed services. Nephrologists that are enrolled in Texas Medicaid as physician providers may be reimbursed according to the current payment guidelines.

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

8 Rural Health Clinic

8.1 Enrollment

To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. An NPI is issued to the RHC after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation. An RHC can also apply for enrollment as a family planning agency.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA are not reimbursed for laboratory services.

8.1.1 Initial Cost Reporting

New RHCs must file a projected cost report within 90 days of their designation as an RHC to establish an initial payment rate. The cost report will contain the RHC's reasonable costs anticipated to be incurred during the RHC's first full fiscal year. The projected cost report must contain a minimum of six months of information. The RHC must file a cost report within five months of the end of the RHC's initial fiscal year. The cost settlement must be completed within six months of the receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases or decreases shall be calculated as provided herein. A new RHC location established by an

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existing RHC participating in Texas Medicaid will receive the same effective rate as the RHC establishing the new location. An RHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

Providers must submit initial cost reports to the following address:

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

Providers can refer to 1 TAC §355.8101 for more information about reimbursement.

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

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

8.2 Services, Benefits, Limitations, and Prior Authorization

8.2.1 Services Rendered by the RHC Facility Provider

General services and copayments are billed using the RHC's NPI. All other services billed using the RHC's NPI are processed as informational only.

Important: *If an RHC facility provider submits a claim for THSteps and Family Planning services, the services will process as informational only and will not be reimbursed.*

The following services are benefits of Texas Medicaid when provided in an RHC:

- Physician services
- Services and supplies furnished as incidental to physician services
- Services provided by an NP, CNM, LCSW, LMFT, LPC, or a PA's services
- Services and supplies furnished as incidental to the NP's or PA's services
- Visiting nurse services on a part-time or intermittent basis to homebound clients in areas determined to have a shortage of home health agencies (A homebound client is someone who is permanently or temporarily confined to his place of residence, not including a hospital or skilled nursing facility (SNF), because of a medical condition.)

When an RHC bills for visiting nurse services, the written plan of treatment to be used for the visiting nurse must be developed by the RHC supervising physician. It must be approved and ordered by the client's treating physician if different from the supervising physician. The plan of treatment must be reviewed and approved by the supervising physician of the clinic at least every 60 days.

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

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

An *other* health visit includes, but is not limited to, a face-to-face encounter between an RHC client and an LCSW, LMFT, or LPC.

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For freestanding RHCs, all laboratory services provided in the RHC's laboratory are included in the encounter. This includes the basic laboratory tests as well as any other laboratory tests provided in the RHC laboratory. Consequently, there is no separate billing for laboratory services. However, if the RHC laboratory becomes a certified Medicare laboratory with its own supplier number, and enrolls in Medicaid as an independent laboratory, all laboratory tests (except the basic laboratory tests) performed for RHC and non-RHC clients can be billed to Medicaid. The claim must be filed under their independent laboratory NPI and using the appropriate HCPCS codes.

Refer to: The Medicare website at www.cms.gov for more information about Medicare RHC laboratory requirements.

8.2.1.1 Encounter Rates

An encounter rate may be reimbursed to the RHC facility only for the following services:

General Medical Services (encounter may be reimbursed to the RHC facility only)
T1015
General medical services must be submitted using one of the appropriate modifiers AJ, AM, SA, TD, TE, U1, U2, or U7. Adult preventative care must be submitted with diagnosis codes Z0000, Z0001, Z01411, and Z01419.

Note: *If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to clarify the service that was performed.*

8.2.1.2 Medicaid Fee-for-Service Reimbursement Rates

The following copayments may be reimbursed to RHC providers billing under their own NPI, and are reimbursed at the Medicaid fee-for-service rate.

Copayments									
CP001	CP002	CP005	CP006						

8.2.1.3 Freestanding Rural Health Clinic Services

The following services cannot be reimbursed to freestanding RHCs using only the RHC NPI. Use of the RHC NPI for billing these services causes claims to be processed as informational only. Services in any of these categories must be billed using the professional (non-RHC) NPI and the appropriate benefit code:

- THSteps medical checkups, which includes immunizations
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)

These services must be billed with an AM, SA, or U7 modifier.

Physician supplies are not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits. Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician NPI.

Exception: *If later in the same day the client suffers an additional illness or injury requiring diagnosis or treatment, the clinic may submit a claim for a second visit.*

Freestanding RHCs submit an all-inclusive encounter for services provided. All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. A claim for these services may not be submitted as a separate encounter.

If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be identified on the claim. These procedure codes are informational only, and are not payable.

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All services provided during a freestanding RHC encounter must be submitted using procedure code T1015. The total submitted amount should be the combined charges for all services provided during that encounter.

One of the following modifiers must be reported with procedure code T1015 to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, U1, U2, or U7. If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to designate the health-care professional providing the service.

Reminder: *The primary initial contact is defined as "the health-care professional who spends the greatest amount of time with the client during that encounter."*

If more than one health-care professional is seen during the encounter, the modifier (if appropriate) must indicate the primary contact. For example, if an NP or a PA performs an antepartum exam, modifiers SA or U7, and TH, must be entered. A maximum of two modifiers may be reported with each encounter.

Providers who render services in an RHC setting for THSteps Medical services or Family Planning services may be reimbursed an encounter rate.

THSteps Medical Services

RHC facility providers may be reimbursed for THSteps medical services using their RHC NPI with the appropriate benefit code.

If the appropriate benefit code is not included, the service will process as informational only and will not be reimbursed.

THSteps Medical Services									
99381	99382	99383	99384	99385	99391	99392	99393	99394	99395
THSteps medical services must be billed using one of the following modifiers: AM, SA, or U7.									

8.2.1.4 Family Planning Services

RHC facility providers may be reimbursed for family planning services using their RHC NPI with the appropriate benefit code.

If the appropriate benefit code is not included, the service will process as informational only and will not be reimbursed.

Family planning services must be submitted with the most appropriate evaluation and management (E/M) procedure code and the most appropriate family planning diagnosis code:

Family Planning Services*									
99202	99203	99204	99205	99211	99212	99213	99214	99215	J7296
J7297	J7298	J7300	J7301	J7307					
*** Family planning services performed in the RHC setting must be billed with the appropriate modifier: AM, SA, or U7.**									

RHC providers may receive an encounter rate when submitting claims with procedure code T1015, in addition to a flat "add on" fee for the Long-Acting Reversible Contraception (LARC) procedure codes listed above.

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Refer to: Subsection 4.1.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

Subsection 6.3.5, "Modifiers" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for a definition of modifiers.

Section 9, "Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

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

Subsection 8.8.2.2, "HMO Copayments" in "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for information about HMO copayments.

Subsection 9.2.60.4.2, "Preventive Care Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

8.2.2 Services Rendered by Non-RHC Providers In An RHC Setting

Non-RHC providers (i.e., physicians and non-physician practitioners) submitting claims for THSteps and Family Planning services in the RHC setting must use their own NPI and the appropriate benefit code.

The following services, when rendered in an RHC setting by a non-RHC provider, will process as an encounter and will be reimbursed to the non-RHC provider as an encounter rate equivalent to the host facility:

- THSteps medical services
- Family planning services

Non-RHC providers rendering services in an RHC setting must use the appropriate national place of service (72) in order for claims to process as encounters.

8.2.3 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate. One of the following modifiers must be submitted for general medical services: AH, AJ, AM, SA, TD, TE, U1, U2, or U7.

The following services must be submitted using the National Provider Identifier (NPI) and the appropriate benefit code:

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

Note: *Refer to the tables in the above sections for procedure codes.*

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

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be submitted using the individual or group physician NPI. Hospital-based RHCs must submit claims for pneumococcal and influenza vaccines as non-RHC services, under their hospital NPI.

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8.2.3.1 After-Hours Care

After-hours care for RHCs is defined as care provided on weekends, federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday.

8.3 Prior Authorization

Prior authorization or authorization is not required for RHC services.

8.4 Documentation Requirements

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

8.4.1 Record Retention

Freestanding RHCs must retain their records for a minimum of six years. Hospital-based RHCs must retain their records for a minimum of ten years.

8.5 Claims Filing and Reimbursement

8.5.1 Claims Information

General services and copayments are billed using the RHC's NPI. For all other services, providers must submit claims using their NPI and the appropriate benefit code.

Refer to: Subsection 9.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

Place of service 72 must be used on all claims when billing for services other than general medical. Benefit code EP1 must be used on claims for THSteps medical services.

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

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

8.5.2 Reimbursement

Freestanding and hospital-based RHCs are reimbursed provider-specific per visit rates calculated in accordance with 1 TAC §355.8101. Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

8.5.2.1 Medicare Crossover Claims Pricing

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

For RHC Medicare crossover claims, Texas Medicaid will reimburse the lesser of the following:

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

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

The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.

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

8.5.2.2 NCCI and MUE Guidelines

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

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

9 Tuberculosis Services

TB clinics must be enrolled in Texas Medicaid and provide services in accordance with 1 TAC, §354.1371.

9.1 Enrollment

To enroll in Texas Medicaid as a tuberculosis (TB) clinic, the applicant must:

- Be a facility that is not an administrative, organizational, or financial part of a hospital.
- Be organizationally structured and operated to provide outpatient clinical care TB services and perform public health response TB activities.
- Have a letter verifying their TB services from the Texas Department of Health Services (DSHS) Tuberculosis and Hansen's Disease Section (TB Section). Examples of eligible TB clinics include local health departments funded by DSHS as a provider of TB clinic services.
- Employ or have a formal arrangement with a licensed physician (MD or DO) who assumes professional responsibility for the services provided to the clinic's clients.

Providers of TB-related clinic services must complete a provider application from the Texas Department of State Health Services (TX DSHS) Tuberculosis (TB) and Hansen's Disease Unit (TB Unit). Per Texas DSHS policy, TB clinics must develop and operate under a set of written policies and procedures that specify the criteria for licensed and non-licensed staff to provide services. The policies and procedures must include the following:

- The personnel file requirements for staff who provide directly observed therapy (DOT).
- The training and supervision that are required for outreach workers to be considered qualified to perform the assigned services.
- The written delegation protocol for services that are not performed by a physician, advanced practice registered nurse (APRN), or PA.
- The documentation that is required for all client encounters.

Once approved by DSHS, providers of TB-related clinic services are eligible to enroll using the Provider Enrollment and Management System (PEMS).

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Providers must obtain a group or individual NPI through the National Plan and Provider Enumeration System (NPPES). Providers that list additional (satellite) clinics in the DSHS TB Unit provider application will receive a different NPI for each location from NPPES. Enrollment as a Medicaid provider is not complete until enrollment has been finalized through PEMS.

The effective date for participation is the date an approved provider application with the TB Unit is established.

To receive a TB Unit provider application form or provider supplement, send a request to the following email address: tb.feedback@dshs.texas.gov

Providers can access the TB application online through the following link: TBMedicaidApplication.pdf

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

9.1.1 Managed Care Program Enrollment

TB clinics do not need to enroll with the Medicaid managed care health plans. All services provided by TB clinics are submitted to TMHP for all Medicaid clients, including Medicaid managed care clients.

9.2 Services, Benefits, Limitations, and Prior Authorization

The level of service provided varies depending on whether the services are delivered by a nonphysician or physician and if medications are prescribed.

9.2.1 TB-Related Clinic Services

The following services may be performed by a physician, APRN, or PA in the TB clinic:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

A physician's presence is not required to perform procedure code 99211; however, the physician must provide direct supervision by being present in the clinic and immediately available to furnish assistance and direction at the time service is provided.

Before TB treatment can be initiated, an initial screening (procedure code T1023) by an RN, LPN, or LVN, or a new patient physician E/M visit (procedure code 99202, 99203, 99204, or 99205) must be performed. If the treatment is initiated by a nursing screening, a new patient physician E/M visit must be completed within 90 days, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

Following the initial new patient physician E/M visit, an established patient physician E/M visit (procedure code 99212, 99213, 99214, or 99215) must be billed every 90 days throughout the course of treatment, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

Clients with latent TB infection, including those in a high-risk group (children who are 4 years of age and younger, those who are immunocompromised, and clients who are HIV-positive), and those with active TB disease, must be seen by a physician every 90 days throughout the course of treatment.

A physician must evaluate each client with active TB disease or LTBI prior to discharge from TB treatment.

Procedure codes H0033, T1002, T1003, and T1023 may be provided under established clinic protocols.

The initial TB screening (procedure code T1023), performed by an RN, LPN, or LVN includes, but is not limited to the following:

- Brief mental and physical assessment

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- Exposure history
- Referral for lab or X-ray per protocol
- Referral for social or other medical services
- Other assessment

Procedure code T1023 may be reimbursed prior to the client being seen by a physician, and no more often than once per 12 months. One RN or LVN/LPN (procedure codes T1023, T1002, and T1003) service may be reimbursed per day, per client, when physician services are not performed.

Subsequent nursing services (Procedure code T1002 and T1003) may be a benefit when not provided the same day as a physician E/M visit.

Reimbursement for DOT services (procedure code H0033) provided in the clinic or other places of service, excluding inpatient hospitals, SNFs, intermediate care facilities (ICFs), outpatient hospitals, independent laboratories, birthing centers, and extended care facilities will be limited to one per day, and a maximum of five per week, per client, throughout the course of treatment.

Procedure codes T1002 and T1003 are limited to a maximum of eight 15-minute units per day, per client.

- Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day.
- If the total number of minutes of nursing services per procedure code is less than 8 minutes for a calendar day, then no unit of service can be billed for that day. The minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.
- If more than 1 unit of service is billed, every unit except the last must be for the complete 15 minutes, with the last unit being no less than 8 minutes of nursing service.
- Time spent in contact investigations in not reimbursable.

Reimbursement for new client examinations (procedure code 99202, 99203, 99204, and 99205) are limited to new clients who have not received services in the same clinic for a period of three years.

One established E/M service may be reimbursed per day, per client, same provider.

Refer to: Subsection 9.2.60.1.1, "New and Established Patient Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about established patient E/M services.

9.2.2 Ancillary Services

The following ancillary TB services are a benefit of Texas Medicaid:

Procedure Codes									
71045	71046	71047	71048	81025*	86580	86701^	86703	89220	96365
96366	96367	96368	96374	96375	99000	99001	J0278	J1834	J1956
J2020**	J2280**	J3000**							
*** CLIA waived test** **^ Must be billed with QW modifier** **** Must be billed with KX modifier when oral formulation is not appropriate for the client**									

Procedure code 99000 is limited to specimens transported from the office setting.

Procedure code 99001 is limited to specimens transported from any setting except the office.

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Certain injectable TB medications (procedure codes J2020, J2280, and J3000), which also have an oral formulation, must be billed with modifier KX to indicate that the oral formulation is not appropriate for the client.

All drugs for which Medicaid is billed must have been purchased by the TB clinic. In the event that the clinic received the drug at no cost through DSHS or another source, it cannot be billed to Texas Medicaid. All medication claims are subject to retrospective review.

Lab-handling charges (procedure codes 99000 and 99001) is limited to one per day for each client unless specimens are sent to two or more different laboratories. If specimens are sent to two or more different laboratories, the information must be documented on the claim.

Handling or conveyance of a specimen from the patient in the clinic to a laboratory (procedure code 99000) will be reimbursed only when submitted with one of the following professional or nursing services performed on the same date of service. Prior authorization is not required for procedure code 99000 or 99001.

Procedure Codes									
99202	99203	99204	99205	99211	99212	99213	99214	99215	T1002
T1003*	T1023								
* Reimbursed for individual or group TB clinics for services rendered in the home or other setting.									

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

Refer to: The TMHP website Required CLIA Lab Certifications web page at www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

9.2.3 Prior Authorization

Prior authorization is not required for TB-related services.

9.3 Documentation Requirements

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

9.4 Provider Responsibilities

If approved to submit claims as a TB clinic under Texas Medicaid, the provider must adhere to the following requirements:

- Be a facility that is not an administrative, organizational, or financial part of a hospital, but is organized and operated to provide medical care to outpatients.
- Comply with all applicable federal, state, and local laws and regulations.
- Employ or have a contract or formal arrangement with a licensed physician (M.D. or D.O.) who is responsible for providing medical direction and supervision over all services provided to the clinic's clients. To meet this requirement, a physician must see the client at least once every 90 days to prescribe the type of care provided and, if the services are not limited by the prescription, periodically review the need for continued care.
- Adhere to the guidelines issued by HHSC, under the authority of the Texas Health and Safety Code, and ensure that services are consistent with the recommendations of the American Thoracic Society and the Centers for Disease Control and Prevention (CDC). For more information, visit the website at www.cdc.gov/tb/index.html.

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- Maintain complete and accurate medical records of each recipient's care and treatment and accurately document all services provided and the medical necessity for the services.
- Ensure that services provided to each client are commensurate with the client's medical needs based on the client's assessment or evaluation, diagnostic studies, plan of care, and physician direction. These services must be documented in the client's medical records.
- Be enrolled and approved for participation in Texas Medicaid.
- Sign a written provider agreement with HHSC or its designee. By signing the agreement, the provider of TB-related clinic services agrees to comply with the terms of the agreement and all requirements of Texas Medicaid including regulations, rules, handbooks, standards, and guidelines published by HHSC or its designee.
- Submit claims for services covered by Texas Medicaid in the manner and format prescribed by HHSC or its designee.
- Be organized and operated to provide TB-related services, which include, but are not limited to, the covered services as indicated in subsection 9.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.
- Not provide services within an SNF, ICF, or intermediate care facility for persons with intellectual disability (ICF-ID)

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

9.5 Claims Filing and Reimbursement

9.5.1 Claims Information

TB-related clinic services must use benefit code TB1 on all claims and authorization requests. All TB-related clinic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply them. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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

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

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

9.5.1.1 Managed Care Clients

TB-related services are carved out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients, but are administered by TMHP and not the client's MCO.

9.5.2 Reimbursement

The Medicaid reimbursement rates for TB clinics are calculated in accordance with 1 TAC §355.8085.

X-ray services are reimbursed in accordance with 1 TAC §355.8085 and are listed in the current physician fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules

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include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

9.5.2.1 NCCI and MUE Guidelines

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

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

10 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
American Dental Association (ADA) Dental Claim Filing Instructions	Subsection 6.7, "American Dental Association (ADA) Dental Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
Tuberculosis Screening and Guidelines	Subsection A.5, "Tuberculosis Screening and Guidelines" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

11 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

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12 Forms

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

Forms
Federally Qualified Health Center Affiliation Affidavit
Hospital Report (Newborn Child or Children) (Form 7484)

13 Claim Form Examples

Claim Form Examples
Birthing Center
2017 Claim Form
Family Planning Services for Hospitals, FQHCs
FQHC Encounter (T1015)
FQHC Follow-Up
Renal Dialysis Facility CAPD Training
Renal Dialysis Facility CAPD/CCPD
Renal Dialysis CMS-1500 Example
Rural Health Clinic Freestanding
Rural Health Clinic Freestanding (Immunization)
Rural Health Clinic Hospital-Based
Tuberculosis

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