Medical Nutrition Services

CSHCN Services Program Provider Manual

March 2021

TEXAS
Health and Human
Services

MEDICAL NUTRITION SERVICES

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26.1 Enrollment

To enroll in the CSHCN Services Program, providers of medical nutrition services (medical foods, medical nutritional counseling services, medical nutritional products, and total parenteral nutrition) must meet the conditions outlined in the enrollment sections provided in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical foods are in Section 26.3.1, "Enrollment" in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical nutritional counseling services are in Section 26.4.1, "Enrollment" in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical nutrition products are in Section 26.5.1, "Enrollment" in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of total parenteral nutrition are in Section 26.6.1, "Enrollment" in this chapter.

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 25 Texas Administrative Code *(TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.*

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. *Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 25 TAC §38.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.*

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

26.2 Vitamins and Minerals

26.2.1 Enrollment

Vitamins and minerals may be reimbursed to Durable Medical Equipment (DME) providers, home health providers, and Custom DME providers.

Refer to: Section 17.1, "Enrollment" in Chapter 17, "Durable Medical Equipment (DME)" for more detailed information about CSHCN Services Program provider enrollment procedures for DME and Custom DME providers and Section 21.1, "Enrollment" in Chapter 21, "Home Health Services" for more detailed information about CSHCN Services Program provider enrollment procedures for home health providers

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26.2.2 Benefits, Limitations, and Authorization Requirements

Vitamin and mineral supplements with a prescription are a benefit of the CSHCN Services Program. The client's diagnosis and a prescription for the requested vitamin(s) and mineral(s) is required to determine coverage.

The following procedure codes for vitamin and mineral products are manually priced, and are benefits when prior authorized and submitted with the corresponding procedure code and state modifier:

Vitamin or Mineral	Procedure Code	State Modifier
Beta-carotene	A9152	U1
Vitamin A (retinol)	A9152	
Biotin	A9152	U2
Boric acid	A9152	U3
Copper	A9152	
Iodine	A9152	
Phosphorous	A9152	
Zinc	A9152	
Calcium	A9152	U4
Chloride	A9152	U5
Iron	A9152	U6
Magnesium	A9152	U7
Vitamin B1 (thiamin)	A9152	U8
Vitamin B2 (riboflavin)	A9152	
Vitamin B3 (niacin)	A9152	
Vitamin B5 (panthothenic acid)	A9152	
Vitamin B6 (pyridoxine, pyridoxal 5-phosphate)	A9152	
Vitamin B9 (folic acid)	A9152	
Vitamin B12 (cyanocobalamin)	A9152	
Vitamin C (ascorbic acid)	A9152	U9
Vitamin D (ergocalciferol)	A9152	UA
Vitamin E (tocopherols)	A9152	UB
Vitamin K (phytonadione)	A9152	UC
Multi-minerals	A9153	U1
Multi-vitamins	A9153	U2
Trace elements	A9153	U3
Miscellaneous	A9152 or A9153	UD

Note: *Claims for multivitamins with any combination of additives must be submitted with modifier U2.*

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Vitamin and mineral products may be indicated for, but are not limited to, treatment of the following conditions:

Vitamin or Mineral	Condition
Beta-carotene	• Vitamin A deficiency • Cystic fibrosis • Disorders of porphyrin metabolism • Intestinal malabsorption
Biotin	• Biotin deficiency • Biotinidase deficiency • Carnitine deficiency • Cystic fibrosis
Boric acid	• Recalcitrant vulvovaginitis
Calcium	• Calcium deficiency • Disorders of calcium metabolism • Chronic renal disease • Pituitary dwarfism, isolated growth hormone deficiency • Cystic fibrosis • Intestinal disaccharidase deficiencies and disaccharide malabsorption • Allergic gastroenteritis and colitis
Chloride	• Hypochloremia • Hypercapnia with mixed acid-base disorder
Copper	• Disorders of copper metabolism
Iodine	• Iodine deficiency • Simple and unspecified goiter and nontoxic nodular goiter • Cystic fibrosis
Iron	• Disorders of iron metabolism • Iron deficiency anemia • Cystic fibrosis
Magnesium	• Magnesium deficiency • Hypoparathyroidism • Cystic fibrosis
Phosphorous	• Disorders of phosphorous metabolism
Vitamin A (retinol)	• Vitamin A deficiency • Intestinal malabsorption • Disorders of the biliary tract • Cystic fibrosis

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Vitamin or Mineral	Condition
Vitamin B1 (thiamin)	• Vitamin B1 deficiency • Disturbances of branched-chain amino-acid metabolism (e.g. maple syrup urine disease) • Disorders of mitochondrial metabolism • Wernicke-Korsakoff syndrome • Cystic fibrosis
Vitamin B2 (riboflavin)	• Vitamin B2 deficiency • Disorders of fatty acid oxidation • Riboflavin deficiency, ariboflavinosis • Disorders of mitochondrial metabolism • Cystic fibrosis
Vitamin B3 (niacin)	• Vitamin B3 deficiency • Disorders of lipid metabolism (e.g. pure hypercholesterolemia) • Cystic fibrosis
Vitamin B5 (pantothenic acid)	• Vitamin B5 deficiency
Vitamin B6 (pyridoxine, pyridoxal 5 phosphate)	• Vitamin B6 deficiency • Sideroblastic anemia • Cystic fibrosis
Vitamin B9 (folic acid)	• Vitamin B9 deficiency • Folate-deficiency anemia • Combined B12 and folate-deficiency anemia • Disorders of mitochondrial metabolism • Sickle-cell disease • Pernicious anemia • Cystic fibrosis
Vitamin B12 (cyanocobalamin)	• Vitamin B12 deficiency • Disturbances of sulphur-bearing amino-acid metabolism (e.g., homocystinuria and disturbances of metabolism of methionine) • Pernicious anemia • Combined B12 and folate-deficiency anemia • Cystic fibrosis
Vitamin C (asorbic acid)	• Vitamin C deficiency • Anemia due to disorders of glutathione metabolism • Disorders of mitochondrial metabolism • Cystic fibrosis

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Vitamin or Mineral	Condition
Vitamin D (ergocalciferol)	• Vitamin D deficiency • Galactosemia • Glycogenosis • Disorders of magnesium metabolism • Intestinal malabsorption • Chronic renal disease • Cystic fibrosis • Disorders of phosphorous metabolism • Hypocalcemia • Disorders of the biliary tract • Hypoparathyroidism • Intestinal disaccharidase deficiencies and disaccharide malabsorption • Allergic gastroenteritis and colitis
Vitamin E (tocopherols)	• Vitamin E deficiency • Inflammatory bowel disease (e.g. Crohn's disease and ulcerative colitis) • Disorders of mitochondrial metabolism • Chronic liver disease • Intestinal malabsorption • Disorders of the biliary tract • Cystic fibrosis
Vitamin K (phytonadione)	• Vitamin K deficiency • Congenital deficiency of other clotting factors • Intestinal malabsorption • Acquired coagulation factor deficiency • Cystic fibrosis • Disorders of the biliary tract • Chronic liver disease
Zinc	• Zinc deficiency • Wilson's disease • Acrodermatitis enteropathica • Cystic fibrosis
Multimineral	• Other and unspecified protein-calorie malnutrition
Multivitamins	• Cystic fibrosis • Other and unspecified protein-calorie malnutrition
Trace elements	• Mineral deficiency

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26.2.3 Prior Authorization Requirements

Prior authorization for vitamin and mineral products must be requested using the CSHCN Services Program Authorization and Prior Authorization Request Form and be submitted on or before the date that the products are dispensed. Vitamin and mineral products that are dispensed before the date that the prior authorization request is received, or before the date of the physician's order, will not be approved.

- A physician's prescription with the name of the vitamin or mineral product, dosage, frequency, duration, and route of administration.
- The manufacturer's suggested retail price (MSRP) or average wholesale price (AWP) (whichever is applicable) with the calculated price per dose or the providers' documented invoice price.

Requests for additional vitamin and mineral products must be submitted before the current authorized period expires, but no more than 30 days before the expiration. Prior authorization of vitamin and mineral products may be considered for up to 6 months and for a quantity up to a 30-day supply.

> ***Note:*** *Liquid formulations of vitamin and mineral products may be considered for quantities that exceed the 30-day supply to allow for variance in container sizes.*

If a client's eligibility expires, all prior authorizations for the client become invalid and benefits may be denied. If eligibility is renewed, a new prior authorization request must be submitted.

The following sample tables taken from the CSHCN Services Program Authorization and Prior Authorization Request Form, are examples of the information that is required to submit a request for vitamin and mineral products:

- Example 1: Vitamin D

Requested Procedure or Service Information	
Type of Request: _____ Authorization X Prior Authorization	
Procedure requested: A9152 UA **(per CPT code)**	**Service requested:** Vitamin D (ergocalciferol) 10 ml bottle (8000 units/ml)
Other: $40.00/bottle	Diagnosis:
$0.20/dose	
Additional information: (Refer to the appropriate manual section for specific authorization requirements): Dose: 400 units (0.05 ml), Route: PO, Frequency: QD	

- Example 2: Multivitamin Tables

Requested Procedure or Service Information	
Type of Request: _____ Authorization X Prior Authorization	
Procedure requested: A9153 U2 **(per CPT code)**	**Service requested:** Centrum Kids (80 tablets/ bottle)
Other: $8.99/bottle	Diagnosis:
$0.11/dose	
Additional information: (Refer to the appropriate manual section for specific authorization requirements): Dose: 1 tablet, Route: PO, Frequency: QD	

- Example 3: Poly-Vi-Sol Drops with Iron

Requested Procedure or Service Information
Type of Request: _____ Authorization X Prior Authorization

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Requested Procedure or Service Information	
Procedure requested: A9153 U1 **(per CPT code)**	**Service requested:** Poly-Vi-Sol with Iron (50 ml bottle)
Other: $10.05/bottle	Diagnosis:
$0.20/dose	
Additional information: (Refer to the appropriate manual section for specific authorization requirements): Dose: 1 ml, Route: PO, Frequency: QD	

- Example 4: Fer-In-Sol Iron Supplement

Requested Procedure or Service Information	
Type of Request: _____ Authorization X Prior Authorization	
Procedure requested: A9153 U1 **(per CPT code)**	**Service requested:** Fer-In-Sol (50 ml bottle) 30 mg BID
Other: $10.75/bottle	Diagnosis:
$0.43/dose	
Additional information: (Refer to the appropriate manual section for specific authorization requirements): Dose: 2 ml (15 mg/ml), Route: PO, Frequency: BID	

Note: *Vitamin and mineral supplements are not diagnosis restricted.*

26.2.4 Claims Information

Claims for vitamin and mineral products must be submitted with procedure code A9152 or A9153, the appropriate modifier, and the corresponding National Drug Code (NDC). Units must be based on the quantity dispensed for up to a 30-day supply.

26.2.5 Reimbursement

The CSHCN Services Program reimburses vitamin and mineral products at the lesser of:

- The provider's billed charges.
- The published fee determined by the Texas Health and Human Services Commission (HHSC).
- Manual price as determined by HHSC, which is based on one of the following:
  - MSRP less 18 percent or AWP less 10.5 percent with the calculated price per dose, whichever is applicable.
  - The provider's documented invoice cost.

A maximum of $100.00 per 30 days may be reimbursed for all vitamin and mineral products. Providers must dispense the most cost-effective product in accordance with a prescription from a licensed physician. Organic products will not be reimbursed unless medical documentation is provided to substantiate the need for that formulation.

26.3 Medical Foods

26.3.1 Enrollment

To enroll in the CSHCN Services Program, providers of medical foods are not required to be actively enrolled in Texas Medicaid. However, they must have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. The Provider Agreement is part of the paper CSHCN Services Program enrollment application. If enrolling in the CSHCN Services Program online, the Provider Agreement must be printed and mailed in separately. The mailing address is available in Section 2.1,

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"Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities." Out-of-state medical food providers may enroll and must meet all these conditions. The 50-mile within the Texas state border limitation does not apply to providers of medical foods.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures and the mailing address for the Provider Agreement if enrolling online.

26.3.2 Benefits, Limitations, and Authorization Requirements

Medical foods are a benefit of the CSHCN Services Program for clients with inborn errors of metabolism that prohibit them from eating a regular diet.

Medical foods are defined as:

- Lacking in the compounds which cause complications of the metabolic disorder.
- Not generally available in grocery stores, health food stores, or pharmacies.
- Not used as food by the general population.
- Not foods covered under the Food Stamps program.
- Approved products listed in enrolled provider's catalogs.

The CSHCN Services Program only pays for foods with nutritional value.

Foods with minimal nutritional value, including, but not limited to the following, are not a benefit of the CSHCN Services Program:

Foods with Minimal Nutritional Value				
Cakes	Cake mixes	Candy	Candy covered items	Chips
Chocolate	Chocolate covered items	Cookies	Cookie dough	Dessert items
Gum	Onion rings	Pies		

Foods described as gluten-free are not a benefit of the CSHCN Services Program.

A maximum of $200.00 per month may be reimbursed for all medical foods. Clients may order up to a three-month supply of food at one time.

Claims for medical foods must be submitted with procedure code S9434 or S9435.

26.3.2.1 Prior Authorization Requirements

Authorization or prior authorization is not required if the client has one of the diagnoses listed below and the request is for covered items (i.e., foods with nutritional value):

Diagnosis Codes							
E700	E701	E7020	E7021	E7029	E7030	E70329	E70330
E70331	E70338	E70339	E7039	E705	E709	E710	E7119
E7201	E7202	E7203	E7204	E7211	E7212	E7219	E7221
E7222	E7223	E724	E7229	E723	E7289	H3120	

Prior authorization and documentation of medical necessity is required for all other diagnoses, new products, or products not listed as approved.

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Prior authorization requests for products, conditions, quantities, or dollar amounts beyond the limits described in this chapter will be considered with medical necessity on a case-by-case basis after review by the DSHS-CSHCN Medical Director or a designee.

Note: *Prior authorization requests that were approved before August 1, 2012, will remain valid until the authorized period expires; services must be billed as authorized.*

Providers must complete the CSHCN Services Program Prior Authorization Request for Medical Foods Form for medical foods prior authorization requests.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

26.3.3 Claims Information

For purposes of billing, one unit is equal to one dose. The total billable units are equal to the total doses requested on the prior authorization.

Services by providers of medical foods must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

The Texas Vendor Drug Program website at www.txvendordrug.com for information about the VDP.

26.3.4 Reimbursement

The CSHCN Services Program implemented rate reductions for certain services. The Online Fee Lookup (OFL) includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at http://tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

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26.4 Medical Nutritional Counseling Services

26.4.1 Enrollment

To enroll in the CSHCN Services Program, providers of nutritional counseling services must be dieticians licensed by the Texas State Board of Examiners of Dieticians, actively enrolled in Texas Medicaid, and must be enrolled as licensed dietitians, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state medical nutritional counseling services providers must meet all of these conditions, and be located in the United States within 50 miles of the Texas state border.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

26.4.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program provides coverage for nutritional assessment and counseling to prevent, treat, or minimize the effects of illness, injury, or other impairments.

Medical nutritional counseling services are a benefit of the CSHCN Services Program when all of the following criteria are met:

- Prescribed by a physician
- Considered medically necessary or medically appropriate, as supported by documentation
- Completed by a CSHCN Services Program-enrolled dietitian licensed by the Texas State Board of Examiners of Dietitians
- Provided in the home, office, or in the outpatient hospital setting

Medical nutrition therapy (procedure codes 97802 and 97803) and medical nutritional counseling services, dietician visit (procedure code S9470) may be beneficial for disease states in which dietary adjustment has a therapeutic role. These include, but are not limited to, the following conditions:

- Abnormal weight gain
- Cardiovascular disease
- Diabetes or alterations in blood glucose
- Eating disorders
- Gastrointestinal disorders
- Hypertension
- Inherited metabolic disorders
- Kidney disease
- Lack of normal weight gain
- Nutritional deficiencies

Nutrition intervention for chronic fatigue syndrome, attention-deficit hyperactivity disorder, idiopathic environmental intolerances, and multiple food and chemical sensitivities is considered experimental and investigational and is not a benefit of the CSHCN Services Program.

Medical nutritional counseling service for the diagnosis of obesity without a comorbid condition is not a benefit of the CSHCN Services Program.

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Nutrition counseling, dietitian visit (procedure code S9470) is a less comprehensive service and does not include an assessment or reassessment. This is limited to four nutritional counseling visits (procedure code S9470) per rolling year.

Procedure codes 97802, 97803, and S9470 are not restricted to clients 20 years of age or younger; they may be submitted for clients of any age. Services may be provided in the home, office, or outpatient hospital settings.

The CSHCN Services Program reimburses procedure codes 97802, 97803, and S9470. If procedure codes 97802 or 97803 are billed for the same date of service as S9470, procedure code 97802 or 97803 is paid and procedure code S9470 is denied.

26.4.2.1 Prior Authorization Requirements

Authorization or prior authorization is not required for the following nutritional counseling services:

- One hour (four units) for nutrition assessment, and intervention for procedure code 97802 per rolling year and three hours (12 units) per rolling year for nutrition reassessment and intervention for procedure code 97803
- Four nutritional counseling visits (procedure code S9470) per rolling year

Providers are responsible for maintaining documentation to support medical necessity of nutritional counseling services in the clinical record.

Prior authorization is required for additional visits. Requests for additional visits require medical review and must be submitted in writing on the CSHCN Services Program Prior Authorization Request for Medical Nutritional Services Form with documentation to support medical necessity or appropriateness.

Use procedure codes 97802, 97803, or S9470 when requesting prior authorization or submitting claims.

Note: *Fax transmittal confirmations are not accepted as proof of timely authorization submission.*

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

26.4.3 Claims Information

Medical nutritional counseling services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

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Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

26.4.4 Reimbursement

Nutritional assessment and counseling services may be reimbursed the lower of either the billed amount or the amount allowed by Texas Medicaid.

Providers must use the following procedure codes when requesting prior authorization or submitting claims:

Procedure Codes		
97802	97803	S9470

If either procedure code 97802 or 97803 is billed with procedure code S9470 for the same date of service, then either procedure code 97802 or 97803 is paid, and procedure code S9470 is denied. Procedure code 97803 is denied as part of another service when billed for the same date of service as procedure code 97802 by any provider.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at https://www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

26.5 Medical Nutritional Products

26.5.1 Enrollment

To enroll in the CSHCN Services Program, providers of medical nutritional products must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state medical nutritional products providers may enroll and must meet all these conditions, and be approved by DSHS. The 50-mile within the Texas state border limitation does not apply to providers of medical nutritional products.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

26.5.2 Benefits, Limitations, and Authorization Requirements

Medical nutritional products including enteral formulas, food thickeners, and nutritional supplements are a benefit of the CSHCN Services Program when the client has a specialized nutritional requirement. Medical nutritional products are those nutritional products that serve as a therapeutic agent for life and health and are part of a treatment regimen. The CSHCN Services Program does not cover nutritional products for individuals who can be sustained on an age-appropriate diet.

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The CSHCN Services Program does not cover the following:

- Nutritional products that are traditionally used for infant feeding
- Pudding products
- Nutritional bars

Oral electrolyte solutions are reimbursed through VDP and will not be approved or reimbursed by the CSHCN Services Program. Electrolyte solutions (e.g., Pedialyte) that are not covered under VDP may be considered with prior authorization.

Claims for medical nutritional products must be submitted with one of the procedure codes listed in the following table:

Procedure Codes									
B4100	B4149	B4150	B4152	B4100	B4153	B4154	B4155	B4157	B4158
B4159	B4160	B4161	B4162	B9002	B9998	T1999			

Note: *Appropriate limitations for miscellaneous procedure code B9998 and T1999 are determined on a case-by-case basis through prior authorization and must be based on medical necessity.*

The following limitations apply for the rental or purchase of an enteral nutrition infusion pump, any type (procedure code B9002):

- Rental may be reimbursed once per calendar month, same procedure, any provider.
- Purchase may be reimbursed once every five rolling years, same procedure, any provider.

26.5.2.1 Prior Authorization Requirements

Prior authorization is required for medical nutritional products.

Prior authorization is required every six months if the client has ONE of the following conditions that is expected to be permanent* or of indefinite duration. Prior authorization for other conditions must be reviewed by the CSHCN Services Program Medical Director or designee.

- Anatomical, physiological, or motility disorder of the gastrointestinal tract.
- Anatomical abnormality or disease of digestive system
- Malignancy
- Infantile cerebral palsy
- Cystic fibrosis
- Dysphagia
- Major trauma and burns
- Nutritional deficiencies (e.g., severe malnutrition, significant weight loss, low birth weight status)
- Inborn errors of amino acid metabolism
- Gastrostomy status or artificial opening of GI tract
- Metabolic disorder

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- Immunity disorder

  Note: *Permanent impairment does not require a determination that there is no possibility that the client's condition may improve in the future. If medical documentation substantiates that the impairment can reasonably be expected to exceed 3 months (90 days), the test of permanence is considered met. This is consistent with Center for Medicare and Medicaid Services (CMS) guidelines.*

Important: *For a client to qualify for medical nutritional products, a primary diagnosis of failure to thrive, failure to gain weight, or lack of growth is insufficient. The underlying cause of failure to thrive, gain weight, and lack of growth is required.*

Prior authorization requests for any indications other than those listed above or in Section 26.6.2, "Benefits, Limitations, and Authorization Requirements" in this chapter must be reviewed by the CSHCN Services Program Medical Director or designee.

Prior authorization requests must be submitted on the CSHCN Services Program Prior Authorization Request for Medical Nutritional Services Form. The request must include the following information:

- The name of the product
- The appropriate procedure code
- Indication that part or all nutritional intake is via tube (e.g., nasogastric, gastrostomy, or jejunostomy)
- Identification or explanation of the medical condition that requires a special nutritional product. Documentation must include:
  - The client's height and weight.
  - The client's growth history, growth charts, or both.
  - Why the client cannot be maintained on an age-appropriate diet.
- Total caloric intake prescribed by a physician

All medical nutritional products are subject to retrospective review and recoupment.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

26.5.3 Claims Information

In order to be considered for reimbursement, providers should not submit claims for procedure code B9998 with modifiers U1 - U5.

The quantity billed should always be the number of cans, not units or calories.

Medical nutritional services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

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Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

26.5.4 Reimbursement

Reimbursement for medical nutritional products is determined by using the lesser of the following:

- The billed amount
- The amount allowed by the CSHCN Services Program

Reimbursement for prescribed products that are included in the current edition of the *Drug Reference* is the listed AWP, less 10.5 percent.

Reimbursement for prescribed products that are not included in the current edition is the AWP that is supplied by the manufacturer of the product, less 10.5 percent.

Reimbursement for miscellaneous procedure codes B9998 and T1999 is determined by prior authorization limitations, based on the average wholesale price (AWP) less 10.5 percent or the manufacturer's suggested retail price (MSRP) less 18 percent; whichever is applicable.

The AWP or MSRP must be submitted with the appropriate procedure code to be considered for reimbursement.

A prior authorization request for pure amino acids, including, but not limited to, glycine, L-arginine, and L-orthinine, will be considered using procedure code B9998.

Enteral formula is reimbursed on the number of "units" of a specific formula provided to a client. A "unit" is defined as 100 calories of formula. The supplier must submit claims for reimbursement with "units" per day that are prescribed for the client and not the number of cans or cases used.

In the case of enteral formulas, the HCPCS code assignments and reimbursement rates are based on the composition and source of ingredients in each individual formula, as well as the intended therapeutic benefit of the formula.

Enteral formulas are reimbursed using the appropriate covered HCPCS code, which must be submitted in order to be reimbursed.

All claims for medical nutritional products may be subject to retrospective review and recoupment.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at https://www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

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26.6 Total Parenteral Nutrition (TPN)

26.6.1 Enrollment

To enroll in the CSHCN Services Program, a provider of TPN must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state TPN providers must be located in the United States, within 50 miles of the Texas state border, and approved by DSHS.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

26.6.2 Benefits, Limitations, and Authorization Requirements

TPN is a benefit of the CSHCN Services Program and is reimbursed at a global fee. Services included in the global fee include, but are not limited to, the following:

Parenteral solutions and additives,with the exception of lipids (procedure codes B4185 and B4187).

- Supplies and equipment, including refrigeration if necessary.
- Education of the client or caregiver regarding the administration of the TPN. Education must include the use and maintenance of supplies and required equipment.
- Visits by a registered nurse appropriately trained in the administration of TPN. The nurse must visit the client at least one time each month to monitor the client's status and to provide ongoing education.
- Customary and routine laboratory work required to monitor the client's status.
- No more than a one-week supply of solutions and additives may be reimbursed even if the solutions and additives are shipped and not used. Any days that the client is an inpatient in a hospital or other medical facility or institution must be subtracted from the daily billing. Payment for partial months is prorated based on actual days of administration.

Lipids solution (procedure codes B4185 and B4187) will be considered for separate reimbursement when billed for the same date of service as any other TPN procedure code (S9364, S9365, S9366, S9367, or S9368) with a valid prior authorization.

Procedure code B4187 is a benefit for clients who are birth through 18 years of age.

Providers can use the following procedure codes to request prior authorization and submit claims:

Procedure Codes								
B4185	B4187	B9004	B9006	S9364	S9365	S9366	S9367	S9368

Procedure codes B9004 and B9006 are a benefit of the CSHCN Services Program when the item is purchased new or rented monthly. Procedure codes B9004 and B9006 will no longer be a benefit of the CSHCN Services Program when purchased as used durable medical equipment (DME).

Procedure codes B9004 and B9006 are denied as included in another procedure when they are submitted for the same date of service as related procedure codes S9364, S9365, S9366, S9367 or S9368 by any provider.

When purchased as new, procedure code B9004 will be limited to one service every five rolling years, any provider.

Note: *Procedure codes B9004 and B9006 when purchased new or rented monthly require prior authorization.*

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The procedure codes in the above table are a benefit only in the home setting when provided by a home heath DME provider, medical supplier (DME), or a medical supply company.

If the rental of a parenteral nutrition infusion pump is expected to exceed a period of 6 months, purchase of the equipment will be considered with prior authorization.

A client whose eligibility expires will no longer receive benefits for prior authorized services. If the client renews eligibility, the provider must submit a new prior authorization request in order to receive reimbursement for the services.

TPN contains all the nutrients needed to sustain the client's life development. The administration of intravenous fluids and electrolytes alone is not TPN.

26.6.2.1 Prior Authorization

Prior authorization is required for all TPN services, including lipids solution.

Providers must complete the CSHCN Services Program Authorization and Prior Authorization Request Form for TPN authorization requests. Documentation must include the following items:

- Diagnosis
- Start date of TPN
- Estimated time TPN is needed
- Documentation to support medical necessity of TPN. If lipids are medically necessary, the prior authorization request must also include documentation supporting the need for procedure code B4185 and B4187.

Prior authorization will be considered for clients with one of the following conditions.

- Anatomical, physiological, or motility disorder of the gastrointestinal tract.
- Prolonged bowel rest
- Gastrointestinal fistula
- Malignancies
- Inborn errors of amino acid metabolism
- Cystic Fibrosis
- Major trauma and burns
- Severe malnutrition, significant weight loss and/or hypoproteinaemia when enteral therapy is not possible
- Other disease states or conditions in which oral or enteral feeding are not an option

TPN may be approved up to a six-month duration.

Note: *Prior authorization requests for clients with conditions other than those listed will be forwarded to the CSHCN Services Program Medical Director or designee for consideration.*

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

26.6.3 Claims Information

TPN services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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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.

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

26.6.4 Reimbursement

TPN services may be reimbursed a global daily rate based on the lower of the amount billed or the fee allowed by Texas Medicaid. TPN is payable only once per day, per client.

For fee information, providers can refer to the OFL on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at http://tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

26.7 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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