

TABLE OF CONTENTS

CSHCN SERVICES PROGRAM PROVIDER MANUAL

JANUARY 2022



Table of Contents

Introduction

| | | |
|------------|---|----------|
| 1.1 | Program History | 3 |
| 1.2 | About the Provider Manual | 3 |
| 1.3 | Feedback | 4 |
| 1.4 | TMHP-CSHCN Services Program Contact Center | 5 |
| 1.5 | Copyright Acknowledgments | 5 |

TMHP and HHSC Contact Information

| | | |
|------------|--|-----------|
| 1.1 | TMHP-CSHCN Services Program Contact Information | 3 |
| 1.1.1 | CSHCN Services Program Telephone and Fax Communication | 3 |
| 1.1.2 | Written Communication with CSHCN Services Program | 3 |
| 1.1.3 | TMHP-CSHCN Services Program Contact Center | 4 |
| 1.1.4 | TMHP-CSHCN Services Program Automated Inquiry System (AIS) | 4 |
| 1.1.5 | TMHP Regional Representatives | 4 |
| 1.2 | TMHP Website Information | 5 |
| 1.2.1 | Publications | 5 |
| 1.3 | CSHCN Services Program Central and Regional Offices | 6 |
| 1.3.1 | Central Office | 6 |
| 1.3.2 | Regional Offices | 7 |
| 1.3.2.1 | Region 1 | 7 |
| 1.3.2.2 | Region 2 | 8 |
| 1.3.2.3 | Region 3 | 8 |
| 1.3.2.4 | Region 4 | 8 |
| 1.3.2.5 | Region 5 North | 10 |
| 1.3.2.6 | Regions 5 South and 6 | 11 |
| 1.3.2.7 | Region 7 | 11 |
| 1.3.2.8 | Region 8 | 13 |
| 1.3.2.9 | Regions 9 and 10 | 13 |
| 1.3.2.10 | Region 11 | 14 |
| 1.4 | DSHS Health Service Regions Map | 15 |

Provider Enrollment and Responsibilities

| | | |
|------------|--|----------|
| 2.1 | * Provider Enrollment | 3 |
| 2.1.1 | Affordable Care Act of 2010 (ACA) Enrollment Requirements | 5 |
| 2.1.1.1 | *Medical Foods and Hospice Providers | 5 |
| 2.1.1.2 | Enrollment for Ordering and Referring-Only Providers | 5 |
| 2.1.2 | Changes in Enrollment | 5 |
| 2.1.3 | Claim Filing | 6 |
| 2.1.3.1 | Provider Identifiers Terminated After 24 Months of No Claim Activity | 6 |
| 2.1.4 | Provider Enrollment Determinations | 7 |
| 2.1.5 | Provider Enrollment Application | 7 |
| 2.1.5.1 | Types of Providers | 7 |
| 2.1.5.2 | Provider Information Form (PIF-1), Principal Information Form (PIF-2), | |

- and Disclosure of Ownership Form 8
- 2.1.5.3 Provider Agreement 8
- 2.1.5.4 Request for Taxpayer Identification Number and Certification 9
- 2.1.5.5 Franchise Tax Account Status Page 9
- 2.1.5.6 Clinical Laboratory Improvement Amendments (CLIA) of 1988 9
- 2.1.5.7 Provider’s License 9
- 2.1.6 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) 10
- 2.1.7 Transplant Specialty Centers 10
- 2.1.8 Pharmacy Enrollment 10
 - 2.1.8.1 Immunizations 11
- 2.1.9 Out-of-State Providers 11
- 2.1.10 Substitute Physician 12
- 2.1.11 * Providers of Family Support Services 12
- 2.2 Provider Complaints Process 12**
- 2.3 Provider Responsibilities 13**
 - 2.3.1 Information Change Requests 14
 - 2.3.2 Required Updates 15
 - 2.3.3 General Medical Record Documentation Requirements 15
 - 2.3.4 Retention of Records 15
 - 2.3.5 Utilization Review: General Provisions 16
 - 2.3.6 Release of Confidential Information 16
 - 2.3.7 Fraud, Waste, and Abuse 17
 - 2.3.8 Provider Certification/Assignment 18
 - 2.3.9 Billing Clients 18
 - 2.3.10 Credit Balance and Recovery Vendor 19
 - 2.3.11 Texas Family Code Compliance 20
 - 2.3.11.1 Child Support 20
 - 2.3.11.2 Abuse and Neglect Reporting Requirements 20
- 2.4 TMHP-CSHCN Services Program Contact Center 20**

Client Benefits and Eligibility

- 3.1 Client Benefits 3**
 - 3.1.1 Prescription Drug Benefits 4
 - 3.1.2 Respiratory Syncytial Virus (RSV) Prophylaxis 5
 - 3.1.3 Medical Transportation Program (MTP) Benefits 5
 - 3.1.4 Services Provided Outside of Texas 5
 - 3.1.5 CSHCN Services Program Services and Supplies Limitations and Exclusions 5
- 3.2 Client Eligibility 7**
 - 3.2.1 CSHCN Services Program Application Criteria 7
 - 3.2.2 Eligibility Criteria 8
 - 3.2.3 Prematurity 8
 - 3.2.4 Program Applicants and Clients Residing in Long-Term Care 8
 - 3.2.5 Program Applicants and Clients That Are Incarcerated 9
 - 3.2.6 Sporadic Medicaid, MBIC, MBI, or CHIP Coverage 9
 - 3.2.7 Eligibility Date for Program Health Care Benefits 9
 - 3.2.8 Financial Eligibility Criteria 10
 - 3.2.9 Medical Eligibility Criteria and the Physician/Dentist Assessment Form (PAF) 10
 - 3.2.9.1 Medical Certification Definition 10
 - 3.2.9.2 Primary and Secondary Diagnoses 11

- 3.2.9.3 Important Considerations When Completing the PAF 11
- 3.3 CSHCN Services Program Notice of Eligibility12**
 - 3.3.1 Eligibility Restrictions 13
 - 3.3.2 CSHCN Services Program Notice of Eligibility Sample 14
- 3.4 Clients Eligible for Medicaid and CSHCN Services Program Benefits15**
- 3.5 Clients Eligible for CHIP and CSHCN Services Program Benefits.....15**
- 3.6 Clients Eligible for Medicaid and Comprehensive Care Program (CCP) Benefits15**
- 3.7 Medically Needy Program (MNP)16**
 - 3.7.1 MNP Spend Down Processing 16
 - 3.7.2 Provider Assistance to Clients with Spend Down..... 17
 - 3.7.3 Claims Filing Involving a Medicaid Spend Down 18
- 3.8 Renal Dialysis18**
- 3.9 Waiting List Information.....19**
- 3.10 TMHP-CSHCN Services Program Contact Center20**

Prior Authorizations and Authorizations

- 4.1 General Information3**
- 4.2 Extension of Filing Deadlines for Holidays3**
 - 4.2.1 Limitations 3
 - 4.2.2 Signature Requirements 3
 - 4.2.2.1 Electronic Signatures 4
 - 4.2.2.1.1 Authority and Definitions4
 - 4.2.2.1.2 Electronic Signature Requirements5
 - 4.2.3 Requests for Procedures That Are Pending a Rate Hearing 5
 - 4.2.4 Requests for Procedures That Are Manually Priced 6
 - 4.2.5 Clients with Third Party Resources..... 6
- 4.3 Authorizations.....7**
 - 4.3.1 Services that Require Authorization 7
 - 4.3.2 How To Submit an Authorization Request 9
- 4.4 Prior Authorizations.....9**
 - 4.4.1 Services that Require Prior Authorization 10
 - 4.4.2 Prior Authorization for Inpatient Admission After Business Hours..... 14
 - 4.4.3 Specialty Team or Center Services..... 14
 - 4.4.4 Retroactive Prior Authorizations 14
 - 4.4.5 How to Submit a Prior Authorization Request..... 15
 - 4.4.6 Prior Authorization Electronic Submissions through the TMHP Prior Authorization (PA) on the Portal 16
 - 4.4.7 Browser Compatibility and System Requirements..... 18
 - 4.4.8 Electronic Attachments 18
 - 4.4.9 Maintaining Complete Documentation..... 18
 - 4.4.10 Sending Prior Authorization Requests via Fax..... 19
- 4.5 Authorization and Prior Authorization Denials19**
 - 4.5.1 Denied Authorization and Prior Authorization Requests Resubmission 20
 - 4.5.2 Closing a Prior Authorization..... 20
 - 4.5.3 Administrative Review for Authorization and Prior Authorization Denials..... 20
 - 4.5.4 Fair Hearing 21
- 4.6 TMHP-CSHCN Contact Center21**

Claims Filing, Third-Party Resources, and Reimbursement

| | | |
|------------|---|-----------|
| 5.1 | TMHP Claims Information | 4 |
| 5.1.1 | Claims Processed by TMHP | 4 |
| 5.1.2 | Claims Processed by the CSHCN Services Program | 4 |
| 5.1.3 | CPT and HCPCS Claims Auditing Guidelines | 5 |
| 5.1.4 | CMS NCCI and MUE Guidelines for All Claims | 5 |
| 5.1.5 | TMHP Processing Procedures | 5 |
| 5.1.6 | Claims Processed by Date of Service | 6 |
| 5.1.7 | Inactive Provider Termination | 6 |
| 5.1.8 | Claims Filing Deadlines | 6 |
| 5.1.9 | Exception to Claim Filing Deadline | 7 |
| 5.1.10 | Fiscal Agent Payment Deadline | 9 |
| 5.2 | Third-Party Resource (TPR) | 9 |
| 5.2.1 | Health Maintenance Organization (HMO) | 10 |
| 5.2.2 | CSHCN Services Program Notice of Eligibility | 11 |
| 5.2.3 | Claims Filing Involving a TPR | 11 |
| 5.2.4 | Verbal Denials by a TPR | 11 |
| 5.2.5 | Filing Deadlines Involving a TPR | 12 |
| 5.2.6 | Blue Cross Blue Shield (BCBS) Nonparticipating Physicians | 12 |
| 5.2.7 | Refunds | 13 |
| 5.2.8 | Refunds to TMHP Resulting From Other Insurance | 13 |
| 5.2.9 | Accident-Related Claims | 14 |
| 5.2.9.1 | Accident Resources and Refunds Involving Claims for Accidents | 14 |
| 5.2.9.2 | Third-Party Liability for Claims Involving Accidents | 15 |
| 5.3 | Multipage Claim Forms | 15 |
| 5.4 | Tips on Expediting Paper Claims | 17 |
| 5.4.1 | General requirements | 17 |
| 5.4.2 | Data Fields | 17 |
| 5.4.3 | Attachments | 17 |
| 5.5 | Correction and Resubmission (Appeal) Time Limits | 17 |
| 5.5.1 | Claims with Incomplete Information | 18 |
| 5.5.2 | Other Insurance Appeals | 18 |
| 5.5.3 | Resubmission of TMHP EDI Rejections | 18 |
| 5.5.3.1 | TMHP EDI Batch Numbers, Julian Dates | 18 |
| 5.6 | Coding | 18 |
| 5.6.1 | Diagnosis Coding | 18 |
| 5.6.2 | Procedure Coding | 19 |
| 5.6.2.1 | Healthcare Common Procedure Coding System (HCPCS) | 19 |
| 5.6.2.2 | National Correct Coding Initiative (NCCI) Guidelines | 20 |
| 5.6.2.3 | Determining Reimbursement Rates for New HCPCS Procedure Codes | 20 |
| 5.6.2.4 | National Drug Codes (NDC) | 21 |
| 5.6.2.4.1 | Paper Claim Submissions | 22 |
| 5.6.2.5 | Drug Rebate Program | 23 |
| 5.6.2.6 | Modifiers | 24 |
| 5.6.2.7 | Modifier U8 and the Federal 340B Drug Pricing Program | 24 |
| 5.6.2.8 | Type of Services (TOS) | 24 |
| 5.6.3 | Benefit Code | 25 |
| 5.7 | Claims Filing Instructions | 25 |

| | | |
|-------------|---|-----------|
| 5.7.1 | Claim Details | 26 |
| 5.7.2 | Provider Types and Selection of Claim Forms | 26 |
| 5.7.2.1 | Providers and Services Billable on CMS-1500 | 26 |
| 5.7.2.2 | CMS-1500 Claim Form Provider Definitions | 27 |
| 5.7.2.3 | CMS-1500 Electronic Billing | 28 |
| 5.7.2.4 | CMS-1500 Paper Claim Form Instructions | 28 |
| 5.7.2.5 | UB-04 CMS-1450 Paper Claim Form Instructions | 33 |
| 5.7.2.6 | UB-04 CMS-1450 Electronic Billing | 34 |
| 5.7.2.7 | Instructions for Completing the UB-04 CMS-1450 Paper Claim Form | 34 |
| 5.7.2.8 | Client Status (for block 17) | 42 |
| 5.7.2.9 | Occurrence Codes (for blocks 31 through 34) | 43 |
| 5.7.2.10 | POA Indicators (for blocks 67 and 72) | 43 |
| 5.7.2.11 | Dental Claim Filing | 43 |
| 5.7.2.12 | ADA Dental Claim Electronic Billing | 43 |
| 5.7.2.13 | Instructions for Completing the Paper ADA Dental Claim Form | 44 |
| 5.7.2.14 | Electronic Claims Submission | 48 |
| 5.7.2.15 | Taxonomy Codes | 48 |
| 5.7.2.16 | Dates on Claims | 48 |
| 5.7.2.17 | Span Dates | 48 |
| 5.7.2.18 | Hospital Billing | 49 |
| 5.7.2.19 | Group Billing | 49 |
| 5.7.3 | Supervising Physician Provider Number Required on Some Claims | 49 |
| 5.7.4 | Ordering/Referring Provider NPI | 49 |
| 5.8 | Reimbursement | 49 |
| 5.8.1 | Electronic Funds Transfer (EFT) | 50 |
| 5.8.1.1 | Advantages of EFT | 50 |
| 5.8.1.2 | Enrollment Procedures | 50 |
| 5.8.1.3 | Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission | 51 |
| 5.8.2 | Texas Medicaid Reimbursement Methodology (TMRM) | 51 |
| 5.8.3 | Maximum Allowable Fee Schedule | 51 |
| 5.8.4 | Manual Pricing | 51 |
| 5.8.5 | Physician Services in Hospital Outpatient Setting | 52 |
| 5.8.6 | Inpatient Hospital Reimbursement | 52 |
| 5.8.7 | Fees | 53 |
| 5.8.7.1 | Provider-Specific Rates for Procedure Codes with Modifiers and Age-Range Criteria | 53 |
| 5.8.8 | CSHCN Services Program Reimbursement Information for Clients | 54 |
| 5.9 | CSHCN Services Program Accounts Receivables (Using Medicaid Funds to Satisfy the AR) | 54 |
| 5.10 | TMHP-CSHCN Services Program Contact Center | 55 |

Remittance and Status (R&S) Reports

| | | |
|------------|---|----------|
| 6.1 | R&S Report Information | 3 |
| 6.1.1 | Electronic Remittance and Status (ER&S) Reports | 3 |
| 6.1.2 | Banner Pages | 4 |
| 6.1.3 | Explanation of R&S Report Row Headings | 4 |
| 6.1.4 | Explanation of R&S Report Section Headings | 6 |
| 6.1.4.1 | Claims—Paid or Denied | 6 |

- 6.1.4.2 Adjustments to Claims 7
- 6.1.4.3 Financial Transactions 7
 - 6.1.4.3.1 Accounts Receivable7
 - 6.1.4.3.2 IRS Levies8
 - 6.1.4.3.3 Payouts.....9
 - 6.1.4.3.4 Claim Reissues9
 - 6.1.4.3.5 Claim Voids.....9
 - 6.1.4.3.6 Claim Refunds9
- 6.1.4.4 Financial Transactions/Void and Stop—“Stale-Dated Checks” 10
- 6.1.5 Claims Payment Summary 10
 - 6.1.5.1 Claims In Process 11
 - 6.1.5.2 EOB and EOPS Codes Section 11
- 6.1.6 R&S Report Examples 12
 - 6.1.6.1 Physician R&S Report Example: Banner Page..... 13
 - 6.1.6.2 Physician R&S Report Example: Blank Page 14
 - 6.1.6.3 Physician R&S Report Example: Claims – Paid or Denied..... 15
 - 6.1.6.4 Physician R&S Report Example: Blank Page 16
 - 6.1.6.5 Physician R&S Report Example: Payment Summary Page 17
 - 6.1.6.6 Physician R&S Report Example: Explanation of Benefits (EOB) Page 18
 - 6.1.6.7 Ambulatory Surgical Center (ASC) R&S Report Example: Banner Page..... 19
 - 6.1.6.8 ASC R&S Report Example: Adjustments R&S Report 20
 - 6.1.6.9 ASC R&S Report Example: Blank Page..... 21
 - 6.1.6.10 ASC R&S Report Example: Adjustments R&S Report 22
 - 6.1.6.11 ASC R&S Report Example: Adjustments R&S Report 23
 - 6.1.6.12 ASC R&S Report Example: Adjustments R&S Report 24
 - 6.1.6.13 ASC R&S Report Example: Blank Page..... 25
 - 6.1.6.14 ASC R&S Report Example: Claims in Process R&S Report..... 26
 - 6.1.6.15 ASC R&S Report Example: Claims in Process R&S Report..... 27
 - 6.1.6.16 ASC R&S Report Example: Payment Summary Page 28
 - 6.1.6.17 ASC R&S Report Example: Explanation of Benefits (EOB) Page 29
- 6.2 TMHP-CSHCN Services Program Contact Center30**

Appeals and Administrative Review

- 7.1 Appeals3**
- 7.2 Authorization and Prior Authorization Denials3**
 - 7.2.1 Administrative Review for Authorization or Prior Authorization Denials..... 3
 - 7.2.2 Fair Hearing Requests for Authorizations or Prior Authorizations 3
- 7.3 Claim Appeals4**
 - 7.3.1 Electronic Appeal Submission..... 4
 - 7.3.1.1 Advantages of Electronic Appeal Submission 4
 - 7.3.1.2 Disallowed Electronic Appeals 5
 - 7.3.1.3 Electronic Rejections..... 5
 - 7.3.2 AIS Claim Correction and Resubmission (Appeals) 5
 - 7.3.3 Paper Appeals..... 6
 - 7.3.3.1 Total Billed Amount Changes 7
 - 7.3.4 Appeals Submitted Incorrectly 7
 - 7.3.5 Administrative Review for Claims 7
 - 7.3.5.1 Administrative Review Requirements..... 8
 - 7.3.6 Fair Hearing for Claims..... 9

7.3.7 National Correct Coding Initiative (NCCI) Claims Appeals 9

7.4 Provider Enrollment Appeals10

7.5 TMHP-CSHCN Services Program Contact Center10

7.6 Authorization and Filing Deadline Calendars10

Advanced Practice Registered Nurse (APRN [NP/CNS])

8.1 Enrollment3

8.2 Benefits, Limitations, and Authorization Requirements3

8.2.1 Authorization Requirements 4

8.3 Claims Information4

8.4 Reimbursement4

8.5 TMHP-CSHCN Services Program Contact Center5

Ambulance

9.1 Enrollment3

9.2 General Information3

9.2.1 Origin and Destination Modifiers 4

9.2.2 Place of Service 4

9.2.3 Diagnosis Coding 5

9.2.4 General Documentation Requirements 5

9.3 Emergency Ambulance Transports6

9.3.1 Emergency Prior Authorization 6

9.3.2 Levels of Service 6

9.3.3 Emergency Medical Conditions 7

9.4 Non-Emergency Ambulance Transports7

9.4.1 Nonemergency Prior Authorizations 8

9.4.2 Nonemergency Ambulance Exception Request 10

9.4.3 Documentation of Medical Necessity 10

9.4.3.1 Run Sheets 11

9.5 Types of Transport11

9.5.1 Multiple Client Transport 11

9.5.2 Specialty Care Transport 12

9.5.3 Air or Water Specialized Medical Services Vehicle Transport 12

9.5.4 Out-of- Locality Transport 12

9.5.5 Extra Attendant 12

9.5.5.1 Extra Attendant - Emergency Ambulance Transports 13

9.5.5.2 Extra Attendant - Nonemergency Ambulance Transports 13

9.5.6 Oxygen 13

9.5.7 Ambulance Disposable Supplies 13

9.5.8 Mileage 13

9.5.9 Waiting Time 14

9.6 Relation of Service to Time of Death14

9.7 Ambulance Transport Services That Are Not Benefits14

9.8 Claims Filing and Reimbursement14

9.8.1 Claims Filing 14

- 9.8.1.1 Emergency Ambulance Claims 15
- 9.8.1.2 Non-emergency Ambulance Claims 15
- 9.8.1.3 Billing Mileage with \$0.00 16
- 9.8.1.4 National Correct Coding Initiative (NCCI) Guidelines 16
- 9.8.2 Reimbursement 16
- 9.8.2.1 One-day Payment Window Reimbursement Guidelines 16
- 9.9 TMHP-CSHCN Services Program Contact Center 16**

Augmentative Communication Devices (ACDs)

- 10.1 Enrollment 3**
- 10.2 Benefits, Limitations, and Authorization Requirements 3**
- 10.2.1 Purchases or Rentals 4
- 10.2.1.1 Prior Authorization Requirements for Purchase or Rental 5
- 10.2.2 Modifications 6
- 10.2.2.1 Prior Authorization Requirements for Modifications 6
- 10.2.3 Repairs 6
- 10.2.3.1 Prior Authorization Requirements for ACD Repairs 6
- 10.2.4 Replacement 6
- 10.2.4.1 Prior Authorization Requirements for Replacement 7
- 10.2.5 Excluded Items 7
- 10.3 Claims Information 7**
- 10.4 Reimbursement 8**
- 10.5 TMHP-CSHCN Services Program Contact Center 8**

Blood Pressure Monitoring and Devices

- 11.1 Enrollment 3**
- 11.2 Benefits, Limitations, and Authorization Requirements 3**
- 11.2.1 Blood Pressure Devices 3
- 11.2.1.1 Self-Measured Blood Pressure Monitoring and Ambulatory Blood Pressure Monitoring 3
- 11.2.1.2 Manual and Automated Blood Pressure Devices 4
- 11.2.1.3 Hospital-Grade Blood Pressure Devices 5
- 11.2.1.4 Blood Pressure Device Components Repair or Replacement 6
- 11.2.2 Authorization Requirements 6
- 11.2.2.1 Ambulatory Blood Pressure Monitoring 6
- 11.2.2.2 Manual and Automated Blood Pressure Devices 6
- 11.2.2.3 Hospital-Grade Blood Pressure Devices 6
- 11.2.2.3.1 Rental 7
- 11.2.2.3.2 Purchase 7
- 11.2.2.4 Blood Pressure Device Components Repair or Replacement 8
- 11.3 Documentation of Receipt 8**
- 11.4 Claims Information 8**
- 11.5 Reimbursement 9**
- 11.6 TMHP-CSHCN Services Program Contact Center 9**

Certified Registered Nurse Anesthetist (CRNA)

| | | |
|-------------|--|----------|
| 12.1 | Enrollment | 3 |
| 12.2 | Benefits, Limitations, and Authorization Requirements | 3 |
| 12.2.1 | Authorization Requirements | 4 |
| 12.3 | Claims Information | 4 |
| 12.4 | Reimbursement | 5 |
| 12.5 | TMHP-CSHCN Services Program Contact Center | 5 |

Certified Respiratory Care Practitioner (CRCP)

| | | |
|-------------|--|----------|
| 13.1 | Enrollment | 3 |
| 13.2 | Benefits, Limitations, and Authorization Requirements | 3 |
| 13.2.1 | Prior Authorization Requirements | 4 |
| 13.3 | Claims Information | 4 |
| 13.4 | Reimbursement | 4 |
| 13.5 | TMHP-CSHCN Services Program Contact Center | 5 |

Dental

| | | |
|-------------|---|----------|
| 14.1 | Enrollment | 4 |
| 14.2 | Benefits, Limitations, and Authorization Requirements | 4 |
| 14.2.1 | Prior Authorization Requirements | 4 |
| 14.2.2 | Substitute Dentist | 5 |
| 14.2.3 | Diagnostic Services | 6 |
| 14.2.3.1 | Prior Authorization Requirements | 6 |
| 14.2.3.2 | Clinical Oral Evaluations | 7 |
| 14.2.3.3 | Cone-Beam Imaging | 8 |
| 14.2.3.4 | First Dental Home | 9 |
| 14.2.3.5 | Radiographs or Diagnostic Imaging | 10 |
| 14.2.3.6 | Tests and Oral Pathology Procedures | 11 |
| 14.2.4 | Orthodontia Services | 12 |
| 14.2.4.1 | Prior Authorization Requirements | 12 |
| 14.2.4.2 | Required Documentation | 12 |
| 14.2.4.3 | Submitting Local Codes for Orthodontic Procedures | 13 |
| 14.2.5 | Preventive Services | 17 |
| 14.2.5.1 | Authorization Requirements | 17 |
| 14.2.5.2 | Oral Hygiene Instruction | 18 |
| 14.2.5.3 | Dental Prophylaxis and Topical Fluoride Treatment | 18 |
| 14.2.5.4 | Dental Sealants | 18 |
| 14.2.5.5 | Space Maintainers | 19 |
| 14.2.5.6 | Noncovered Counseling Services | 19 |
| 14.2.5.6.1 | Dental Nutrition Counseling | 19 |
| 14.2.5.6.2 | Tobacco Counseling | 19 |
| 14.2.6 | Therapeutic Services | 20 |
| 14.2.6.1 | Prior Authorization Requirements | 20 |
| 14.2.6.2 | Anesthesia Requirements for Clients who are Six Years of Age or Younger | 20 |
| 14.2.6.3 | Interrupted Treatment Plan | 21 |
| 14.2.6.4 | Restorations | 21 |

| | | |
|-------------|---|-----------|
| 14.2.6.4.1 | <i>Direct Restorations and Other Restorative Services</i> | 24 |
| 14.2.6.5 | Endodontics | 25 |
| 14.2.6.5.1 | <i>Prior Authorization</i> | 25 |
| 14.2.6.5.2 | <i>Pulp Caps and Pulpotomy</i> | 26 |
| 14.2.6.5.3 | <i>Root Canals</i> | 26 |
| 14.2.6.6 | Periodontics | 28 |
| 14.2.6.7 | Prosthodontics (Removable) and Maxillofacial Prosthetics | 30 |
| 14.2.6.7.1 | <i>Maxillofacial Prosthetics</i> | 33 |
| 14.2.6.7.2 | <i>Implants</i> | 34 |
| 14.2.6.7.3 | <i>Fixed Prosthodontics</i> | 34 |
| 14.2.6.8 | Oral and Maxillofacial Surgery | 35 |
| 14.2.6.9 | Adjunctive General Services | 37 |
| 14.2.6.9.1 | <i>Emergency Dental Treatment Services</i> | 39 |
| 14.2.6.10 | Dental Anesthesia | 39 |
| 14.2.6.10.1 | <i>Anesthesia Permit Levels</i> | 40 |
| 14.2.6.10.2 | <i>Method for Counting Minutes for Timed Procedure Codes</i> | 41 |
| 14.2.6.11 | Dental Behavior Management | 41 |
| 14.2.6.12 | Internal Bleaching of Discolored Tooth | 42 |
| 14.2.6.13 | Noncovered Services | 42 |
| 14.2.7 | Dental Treatment in Hospitals and ASCs | 42 |
| 14.2.7.1 | Dental Hospital Calls | 42 |
| 14.2.7.2 | Authorization and Prior Authorization Requirements | 43 |
| 14.2.7.3 | Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services) | 43 |
| 14.2.8 | Doctor of Dentistry Services as a Limited Physician | 44 |
| 14.2.8.1 | Authorization Requirements | 44 |
| 14.2.8.2 | Surgery | 45 |
| 14.2.8.3 | Cleft/Craniofacial Surgery by a Dentist Physician | 47 |
| 14.2.8.4 | Evaluation and Management or Consultation | 47 |
| 14.2.8.5 | Radiology and Laboratory Procedures | 47 |
| 14.2.8.6 | Other Procedures Payable to a Dentist Physician | 47 |
| 14.2.8.7 | Anesthesia by Dentist Physician | 48 |
| 14.3 | Claims Information | 48 |
| 14.3.1 | Dental Emergency Claims | 49 |
| 14.3.2 | Tooth Identification (TID) and Surface Identification (SID) Systems | 49 |
| 14.3.3 | Supernumerary Tooth Identification | 49 |
| 14.4 | Reimbursement | 50 |
| 14.5 | TMHP-CSHCN Services Program Contact Center | 50 |

Diabetic Equipment and Supplies

| | | |
|-------------|--|----------|
| 15.1 | Enrollment | 3 |
| 15.2 | Benefits, Limitations, and Authorization Requirements | 3 |
| 15.2.1 | Glucose Monitor and Supplies | 3 |
| 15.2.1.1 | Non Diabetic Diagnosis Codes | 5 |
| 15.2.1.2 | Glucose Monitor | 5 |
| 15.2.1.3 | Glucose Testing Supplies | 6 |
| 15.2.1.3.1 | <i>Insulin-Dependent Clients</i> | 6 |
| 15.2.1.3.2 | <i>Non-Insulin-Dependent Clients</i> | 6 |

- 15.2.1.4 Glucose Tabs and Gel 7
- 15.2.1.5 Prior Authorization Requirements 7
- 15.2.2 Therapeutic Continuous Glucose Monitors (CGM) 7
 - 15.2.2.1 Prior Authorization Requirements 7
 - 15.2.2.2 Associated Supplies 8
 - 15.2.2.3 Noncovered Services 9
- 15.2.3 Insulin Pump 9
 - 15.2.3.1 Prior Authorization Requirements 10
- 15.2.4 Insulin and Insulin Syringes 11
- 15.3 Documentation of Receipt 11**
- 15.4 Claims Information 11**
- 15.5 Reimbursement 12**
- 15.6 TMHP-CSHCN Services Program Contact Center 12**

Diagnostic Radiology Services

- 16.1 Enrollment 3**
- 16.2 Benefits, Limitations, and Authorization Requirements 3**
 - 16.2.1 Diagnostic Radiology Services Provided by Hospitals 3
 - 16.2.2 Diagnostic Radiology Services Provided by Physicians, Advanced Practice Registered Nurses (APRNs), Physician Assistants, and Clinics 3
 - 16.2.3 Cardiac Blood Pool Imaging 4
 - 16.2.4 Computed Tomography (CT) Scan 4
 - 16.2.5 Contrast Material 6
 - 16.2.6 Magnetic Resonance Angiography (MRA) 6
 - 16.2.6.1 MRA Authorization Requirements 7
 - 16.2.7 Magnetic Resonance Imaging (MRI) 7
 - 16.2.7.1 MRI Authorization Requirements 7
 - 16.2.7.2 MRI Benefits and Limitations 8
 - 16.2.8 Mammography Certification 8
 - 16.2.9 Positron Emission Tomography (PET) 9
 - 16.2.10 X-ray and Ultrasound Procedures 9
 - 16.2.10.1 Diagnostic Imaging 10
 - 16.2.10.2 Interventional Radiological Procedures 10
 - 16.2.10.3 Abdominal Flat Plates (AFPs) and Kidney, Ureter, and Bladder (KUB) 10
 - 16.2.10.4 Reimbursement Information 11
 - 16.2.10.5 X-ray and Ultrasound Prior Authorization Requirements 11
 - 16.2.11 Noncovered Services 11
- 16.3 Claims Information 11**
- 16.4 Reimbursement 12**
 - 16.4.1 One-day Payment Window Reimbursement Guidelines 13
- 16.5 TMHP-CSHCN Services Program Contact Center 14**

Durable Medical Equipment (DME)

- 17.1 Enrollment 4**
 - 17.1.1 Custom DME Requirements 4
- 17.2 Program Overview and Guidelines 5**

| | | |
|-------------|---|-----------|
| 17.2.1 | Custom DME | 5 |
| 17.2.2 | Standard DME..... | 5 |
| 17.2.3 | Program Guidelines | 6 |
| 17.3 | Benefits, Limitations, and Authorization Requirements | 7 |
| 17.3.1 | Adaptive Strollers | 7 |
| 17.3.1.1 | Authorization Requirements | 7 |
| 17.3.2 | Ambulation Aids | 8 |
| 17.3.2.1 | Crutches, Walkers, Gait and Ambulation Belts, and Canes | 8 |
| 17.3.3 | Breast Prosthesis | 8 |
| 17.3.3.1 | Breast Prosthesis Prior Authorization Requirements..... | 8 |
| 17.3.3.1.1 | <i>Prior Authorization for Medically Necessary Protheses Beyond Set Limitations</i> | <i>9</i> |
| 17.3.3.1.2 | <i>Prior Authorization for Procedure Codes L8035 and L8039</i> | <i>9</i> |
| 17.3.4 | Burn Care Garments | 9 |
| 17.3.5 | Cochlear Implant Device | 10 |
| 17.3.6 | Continuous Passive Motion (CPM) Device | 10 |
| 17.3.7 | Enuresis Alarms | 10 |
| 17.3.7.1 | Prior Authorization Requirements..... | 10 |
| 17.3.8 | Gait Trainers (Supported or Sling Walkers)..... | 10 |
| 17.3.8.1 | Authorization Requirements | 10 |
| 17.3.9 | Hospital Beds (Manual and Electric) | 10 |
| 17.3.9.1 | Authorization and Prior Authorization Requirements | 11 |
| 17.3.9.2 | Pressure Reducing Pads..... | 11 |
| 17.3.9.3 | Positional Pillows and Cushions | 12 |
| 17.3.9.4 | Hospital Cribs and Enclosed Beds | 12 |
| 17.3.9.4.1 | <i>Prior Authorization Requirements.....</i> | <i>12</i> |
| 17.3.10 | Hygiene Equipment | 12 |
| 17.3.10.1 | Bath or Shower Chair | 13 |
| 17.3.10.1.1 | <i>Levels of Design.....</i> | <i>13</i> |
| 17.3.10.2 | Authorization Requirements | 14 |
| 17.3.10.3 | Adaptive Feeder Seats | 14 |
| 17.3.10.4 | Commode Chair | 14 |
| 17.3.10.4.1 | <i>Prior Authorization Requirements for Level 1: Stationary Commode Chair</i> | <i>14</i> |
| 17.3.10.4.2 | <i>Prior Authorization Requirements for Level 2: Mobile Commode Chair</i> | <i>15</i> |
| 17.3.10.4.3 | <i>Prior Authorization Requirements for Level 3: Custom Commode Chair</i> | <i>15</i> |
| 17.3.10.4.4 | <i>Authorization Requirements for Extra-wide and Heavy-Duty Commode Chair</i> | <i>15</i> |
| 17.3.10.4.5 | <i>Authorization Requirements for Foot Rest</i> | <i>15</i> |
| 17.3.10.4.6 | <i>Authorization Requirements for Replacement Commode Pail or Pan....</i> | <i>15</i> |
| 17.3.10.5 | Commode Chair with Integrated Seat Lifts..... | 15 |
| 17.3.10.6 | Commode Seat Lift Mechanism | 16 |
| 17.3.11 | Infusion Pumps..... | 17 |
| 17.3.12 | Portable Paraffin Units | 17 |
| 17.3.13 | Seat Lift Mechanism | 17 |
| 17.3.14 | Special Needs Car Seats and Travel Restraints..... | 18 |
| 17.3.14.1 | Car Seats | 18 |
| 17.3.14.1.1 | <i>Prior Authorization Requirement for Car Seats.....</i> | <i>18</i> |
| 17.3.14.2 | Travel Restraints | 19 |

- 17.3.15 Standers, Prone or Supine 19
 - 17.3.15.1 Authorization Requirements 20
- 17.3.16 TENS Units 20
- 17.3.17 Transfer Boards..... 20
- 17.3.18 Travel Chairs 20
 - 17.3.18.1 Prior Authorization Requirements..... 20
- 17.3.19 Wheelchairs 20
 - 17.3.19.1 Seating Evaluation Requirements 21
 - 17.3.19.2 Wheelchair Authorization Requirements 22
 - 17.3.19.3 Manual Wheelchairs 23
 - 17.3.19.4 Custom Manual Wheelchairs 24
 - 17.3.19.5 Power Wheelchairs 24
 - 17.3.19.6 Approval Criteria for Power Wheelchairs..... 24
 - 17.3.19.6.1 **Age**.....**25**
 - 17.3.19.6.2 **Level of Physical Function****25**
 - 17.3.19.6.3 **Cognitive Level****25**
 - 17.3.19.6.4 **Environmental Assessment****25**
 - 17.3.19.7 Wheelchair Battery 25
 - 17.3.19.8 Wheelchair Positioning Equipment..... 25
 - 17.3.19.9 Wheelchair Power Elevating Leg Lifts..... 25
 - 17.3.19.10 Wheelchair Power Seat Elevation System 26
- 17.3.20 Portable Wheelchair Ramps..... 26
- 17.3.21 Noncovered Rehabilitative and Therapeutic DME..... 27
- 17.3.22 Repairs and Modifications 27
- 17.4 Documentation of Receipt28**
- 17.5 Rental of Equipment28**
- 17.6 Claims Information.....28**
- 17.7 Reimbursement.....29**
- 17.8 TMHP-CSHCN Services Program Contact Center30**

Expendable Medical Supplies

- 18.1 Enrollment3**
- 18.2 Benefits, Limitations, and Authorization Requirements.....3**
 - 18.2.1 Incontinence Supplies 4
 - 18.2.2 Wound Care Supplies..... 6
 - 18.2.3 Examples of Covered Supplies 7
 - 18.2.4 Diapers, Briefs, Pull-ups, and Liners..... 7
 - 18.2.4.1 Gastrostomy Devices 7
 - 18.2.4.1.1 *Authorization Requirements*7
- 18.3 Claims Information.....8**
- 18.4 Reimbursement.....9**
- 18.5 TMHP-CSHCN Services Program Contact Center9**

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

- 19.1 Enrollment3**

| | | |
|-------------|---|----------|
| 19.2 | Benefits, Limitations and Authorization Requirements | 3 |
| 19.2.1 | General Medical Services | 3 |
| 19.2.2 | Preventive Care Medical Checkups | 4 |
| 19.2.3 | Telecommunication Services | 4 |
| 19.2.4 | Behavioral Health Services | 5 |
| 19.2.5 | Dental Services | 5 |
| 19.2.6 | Vision Services | 6 |
| 19.3 | Claims Filing | 6 |
| 19.4 | Reimbursement | 6 |
| 19.5 | TMHP-CSHCN Services Program Contact Center | 6 |

Hearing Services

| | | |
|-------------|---|-----------|
| 20.1 | Enrollment | 4 |
| 20.1.1 | Non-Implantable Hearing Aid Devices and Services | 4 |
| 20.1.2 | Implantable Hearing Aid Devices and Services | 4 |
| 20.2 | Benefits, Limitations, and Authorization Requirements – Non-Implantable Devices and Services | 4 |
| 20.2.1 | Hearing Screening | 5 |
| 20.2.2 | Abnormal Hearing Screens | 5 |
| 20.2.3 | Hearing Testing, Examination, and Evaluation Services | 6 |
| 20.2.3.1 | Audiometric Testing | 6 |
| 20.2.3.2 | Otological Examination | 6 |
| 20.2.3.3 | Vestibular Evaluations | 6 |
| 20.2.3.4 | Authorization/Documentation Requirements | 7 |
| 20.2.3.5 | Limitations | 7 |
| 20.2.4 | Hearing Aid Devices and Accessories | 7 |
| 20.2.4.1 | Documentation Requirements | 10 |
| 20.2.4.2 | Prior Authorization Requirements | 10 |
| 20.2.4.3 | Limitations | 11 |
| 20.2.5 | Hearing Aid Services | 11 |
| 20.2.5.1 | Documentation Requirements | 12 |
| 20.2.5.2 | Prior Authorization Requirements | 13 |
| 20.2.5.3 | Limitations | 13 |
| 20.3 | Benefits, Limitations, and Authorization Requirements – Implantable Devices and Services | 13 |
| 20.3.1 | Bone-Anchored Hearing Device (BAHD) | 13 |
| 20.3.1.1 | Electromagnetic Bone Conduction Hearing Device | 14 |
| 20.3.1.2 | Prior Authorization Requirements | 14 |
| 20.3.1.3 | Limitations | 14 |
| 20.3.2 | Cochlear Implants | 14 |
| 20.3.2.1 | Device, Implantation and Supplies | 15 |
| 20.3.2.2 | Auditory Rehabilitation | 15 |
| 20.3.2.3 | Frequency Modulation (FM) Systems | 15 |
| 20.3.2.4 | Authorization Requirements | 16 |
| 20.3.2.5 | Limitations | 16 |
| 20.3.2.6 | Sound Processor Replacement Guidelines | 17 |
| 20.4 | Claims Information | 17 |
| 20.4.1 | Claims Filing for Non-Implantable Hearing Devices and Services | 18 |

- 20.4.1.1 Claims Filing for Non-implantable Hearing Aid Devices 18
- 20.4.2 Claims Filing for Implantable Hearing Devices and Services 18
- 20.5 Reimbursement.....18**
- 20.5.1 Reimbursement for Hearing Tests 19
- 20.5.2 Reimbursement for Non-Implantable Hearing Devices and Services 19
- 20.5.3 Reimbursement for Implantable Hearing Devices and Services..... 19
- 20.6 TMHP-CSHCN Services Program Contact Center19**

Home Health Services

- 21.1 Enrollment3**
- 21.2 Benefits, Limitations, and Authorization Requirements.....3**
- 21.2.1 Prior Authorization Requirements for Home Health Services 4
 - 21.2.1.1 Authorization Requirements 4
 - 21.2.1.2 Plan of Care (POC) 5
- 21.3 Home Health Aide (HHA) Services7**
- 21.3.1 Supervision of Home Health Aides 8
- 21.3.2 Skilled Nursing and Home Health Aide Services..... 8
 - 21.3.2.1 Medical Necessity..... 9
- 21.3.3 Skilled Nursing Services..... 9
 - 21.3.3.1 Limitations for Skilled Nursing Services 10
 - 21.3.3.2 Extended Skilled Nursing Services..... 11
- 21.3.4 Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services 12
 - 21.3.4.1 Prior Authorization for Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services 12
 - 21.3.4.2 Limitations for Occupational Therapy (OT) and Physical Therapy (PT)..... 13
 - 21.3.4.3 Limitations for Speech-Language Pathology (SLP) 13
- 21.3.5 Medical Nutritional Counseling Services..... 14
 - 21.3.5.1 Prior Authorization for Medical Nutritional Counseling Services 14
- 21.3.6 Social Work Services 14
 - 21.3.6.1 Prior Authorization for Social Work Services 14
- 21.4 Claims Information.....15**
- 21.5 Reimbursement.....15**
- 21.6 TMHP-CSHCN Services Program Contact Center16**

Home Health (Skilled Nursing) Care

- 22.1 Enrollment3**
- 22.2 Benefits, Limitations, and Authorization Requirements.....3**
- 22.2.1 Authorization Requirements..... 4
- 22.3 Claims Information.....4**
- 22.4 Reimbursement.....5**
- 22.5 TMHP-CSHCN Services Program Contact Center5**

Hospice

23.1 Enrollment 3

23.2 Benefits, Limitations, and Authorization Requirements 3

 23.2.1 Prior Authorization Requirements 4

 23.2.1.1 The client’s demographic information 4

 23.2.1.2 The requested services 4

 23.2.1.3 Required provider information and signature 4

23.3 Claims Information 5

23.4 Reimbursement 6

23.5 TMHP-CSHCN Services Program Contact Center 6

Hospital

24.1 Enrollment 4

 24.1.1 Continuity of Hospital Eligibility Through Change of Ownership 4

 24.1.2 Specialty Team or Center 5

24.2 Inpatient/Outpatient Benefits, Limitations, and Authorization Requirements 5

 24.2.1 Chemotherapy 6

 24.2.2 Cochlear Implants 6

 24.2.3 Electrodiagnostic Testing (Electromyography and Nerve Conduction Studies) 6

 24.2.4 Fluocinolone Acetonide Intravitreal Implant (*Retisert*) 6

 24.2.5 Laboratory Services

 24.2.6 Magnetoencephalography (MEG) Services 7

24.3 Inpatient Services 7

 24.3.1 Benefits, Limitations, and Authorization Requirements 7

 24.3.1.1 Initial Inpatient Prior Authorization Requests 7

 24.3.1.2 Emergency Inpatient Hospital Admissions 8

 24.3.1.3 Inpatient Behavioral Health 8

 24.3.1.3.1 *Inpatient Behavioral Health Prior Authorization Requirements* 8

 24.3.1.4 Inpatient Rehabilitation Services 9

 24.3.1.4.1 *Inpatient Rehabilitation Prior Authorization Requirements* 10

 24.3.1.4.2 *Treatment for Acute Medical Episodes* 10

 24.3.1.5 Renal (Kidney) Transplants 10

 24.3.1.5.1 *Reimbursement for Renal Transplants* 11

 24.3.1.5.2 *Renal Transplant Authorization Requirements* 11

 24.3.1.6 Transplants - Nonsolid Organ 12

 24.3.1.6.1 *Stem Cell Transplant Prior Authorization Requirements* 13

 24.3.1.7 Neonatal Level of Care Designation for Inpatient Services 13

 24.3.1.7.1 *Hospitals that Do Not Meet Minimum Requirements for Neonatal Level of Care Designation* 13

 24.3.1.7.2 *Other Requirements* 13

 24.3.1.7.3 *Transfers* 14

 24.3.1.7.4 *Texas Provider Identifier Change Due to Split or Merge* 14

 24.3.2 Hospital Reimbursement 14

 24.3.3 Prospective Payment Methodology 14

 24.3.4 Client Transfers 15

 24.3.4.1 Admission Dates 15

 24.3.4.2 Continuous Stays - Client Transfers and Readmissions 15

 24.3.5 Observation Status to Inpatient Admission 15

 24.3.6 Outlier Adjustments 15

| | | |
|-------------|---|-----------|
| 24.3.6.1 | 24.3.5.1 Day Outliers | 16 |
| 24.3.7 | Payment Window Reimbursement Guidelines | 16 |
| 24.3.7.1 | Exceptions | 17 |
| 24.3.7.2 | Professional and Outpatient Claims for Services Related to the Inpatient Admission | 17 |
| 24.3.7.3 | Professional and Outpatient Claims for Services Unrelated to the Inpatient Admission | 18 |
| 24.4 | Outpatient Services | 18 |
| 24.4.1 | Benefits, Limitations, and Authorization Requirements | 18 |
| 24.4.1.1 | Hospital-Based Outpatient Behavioral Health Services | 18 |
| 24.4.1.2 | Hospital-Based Emergency Services Department | 19 |
| 24.4.1.2.1 | <i>Hospital-Based Emergency Services Authorization</i> | 19 |
| 24.4.1.3 | Outpatient Observation | 19 |
| 24.4.1.3.1 | <i>Direct Outpatient Observation Admission</i> | 20 |
| 24.4.1.3.2 | <i>Observation Following Emergency Room</i> | 21 |
| 24.4.1.3.3 | <i>Observation Following Outpatient Day Surgery</i> | 21 |
| 24.4.1.3.4 | <i>Observation Following Outpatient Diagnostic Testing or Therapeutic Services</i> | 21 |
| 24.4.1.3.5 | <i>Documentation Requirements for Outpatient Observation</i> | 21 |
| 24.4.1.3.6 | <i>Reporting Hours of Observation</i> | 22 |
| 24.4.1.3.7 | <i>Client Status Change</i> | 23 |
| 24.4.1.3.8 | <i>Outpatient Observation Authorization</i> | 23 |
| 24.4.1.3.9 | <i>Observation Services that are Not a Benefit</i> | 24 |
| 24.4.1.3.10 | <i>Outpatient Observation Authorization</i> | 24 |
| 24.4.1.4 | Sleep Studies | 24 |
| 24.4.1.5 | Hyperbaric Oxygen Therapy (HBOT) | 25 |
| 24.4.2 | Reimbursement Information | 25 |
| 24.4.2.1 | Hospital-Based Emergency Services Department | 25 |
| 24.4.2.2 | One-day Payment Window Reimbursement Guidelines | 26 |
| 24.5 | Ambulatory Surgical Centers | 26 |
| 24.5.1 | Benefits, Limitations, and Authorization Requirements | 26 |
| 24.5.1.1 | Freestanding Surgical Centers | 26 |
| 24.5.2 | Reimbursement Information | 27 |
| 24.6 | Claims Information | 27 |
| 24.6.1 | Inpatient Claims | 27 |
| 24.6.2 | Outpatient Claims | 28 |
| 24.6.2.1 | Revenue Code and Procedure Code Requirements for All Outpatient Services | 29 |
| 24.6.2.1.1 | <i>Revenue Codes That Require a Procedure Code</i> | 29 |
| 24.6.2.1.2 | <i>Clarification for Non-Hospital Facility Claims</i> | 30 |
| 24.6.3 | HASC Claims | 31 |
| 24.6.4 | Inpatient Stays Following Scheduled Day Surgeries | 31 |
| 24.6.5 | Inpatient Stays Following Unscheduled (Emergency) Day Surgeries | 32 |
| 24.7 | TMHP-CSHCN Services Program Contact Center | 32 |

Laboratory Services

| | | |
|-------------|---|----------|
| 25.1 | Enrollment | 3 |
| 25.1.1 | Clinical Laboratory Improvement Amendments (CLIA) of 1988 | 4 |
| 25.1.1.1 | Waiver and Physician-Performed Microscopy Procedure (PPMP) | |

Certificates 5

25.2 Benefits, Limitations, and Authorization Requirements 5

25.2.1 Hospital Laboratory Services 5

25.2.2 Independent Laboratory Services 6

25.2.3 Physician-Owned Laboratory Services 6

25.2.3.1 Other Physician Laboratory-Related Services 6

25.2.4 Clinical Pathology Services 7

25.2.5 Other Laboratory Procedures 7

25.2.5.1 Drug Testing and Therapeutic Drug Assays 7

25.2.5.2 Cytogenetics Testing 9

25.2.5.3 Genetic Testing for Colorectal Cancer 12

25.2.5.3.1 Authorization Requirements 13

25.2.5.3.2 Familial Adenomatous Polyposis (FAP) 13

25.2.5.3.3 Hereditary Nonpolyposis Colorectal Cancer (HNPCC) 14

25.2.5.4 Genetic Testing for Hereditary Breast and Ovarian Cancers 14

25.2.5.4.1 Authorization Requirements 15

25.2.6 Cytopathology of Vaginal, Cervical, and Uterine Sites 16

25.2.7 Cytopathology Studies Other Than Vaginal, Cervical, or Uterine 16

25.2.8 Evocative and Suppression Testing 17

25.2.9 Helicobacter pylori (H. pylori) 17

25.2.10 Hematology and Coagulation 18

25.2.11 Microbiology 19

25.2.11.1 Zika Virus Testing 20

25.2.12 Human Immunodeficiency Virus (HIV) Drug Resistance Testing 20

25.2.13 Organ or Disease-Oriented Panels 20

25.2.14 Urinalysis and Chemistry 21

25.2.15 Other Laboratory Services 22

25.2.16 Repeated Procedures 23

25.2.16.1 Modifier 91 23

25.2.17 Receiving Labs and Lab Handling Fees 23

25.3 Claims Information 24

25.3.1 Modifiers To Use When Billing Laboratory Procedures 24

25.4 Reimbursement 24

25.4.1 Clinical Laboratory Fee Schedule 25

25.4.2 One-day Payment Window Reimbursement Guidelines 25

25.5 TMHP-CSHCN Services Program Contact Center 25

Medical Nutrition Services

26.1 Enrollment 3

26.2 Vitamins and Minerals 3

26.2.1 Enrollment 3

26.2.2 Benefits, Limitations, and Authorization Requirements 4

26.2.3 Prior Authorization Requirements 8

26.2.4 Claims Information 9

26.2.5 Reimbursement 9

26.3 Medical Foods 9

26.3.1 Enrollment 9

26.3.2 Benefits, Limitations, and Authorization Requirements 10

| | | |
|-------------|---|-----------|
| 26.3.2.1 | Prior Authorization Requirements | 10 |
| 26.3.3 | Claims Information | 11 |
| 26.3.4 | Reimbursement | 11 |
| 26.4 | Medical Nutritional Counseling Services | 12 |
| 26.4.1 | Enrollment | 12 |
| 26.4.2 | Benefits, Limitations, and Authorization Requirements | 12 |
| 26.4.2.1 | Prior Authorization Requirements | 13 |
| 26.4.3 | Claims Information | 13 |
| 26.4.4 | Reimbursement | 14 |
| 26.5 | Medical Nutritional Products | 14 |
| 26.5.1 | Enrollment | 14 |
| 26.5.2 | Benefits, Limitations, and Authorization Requirements | 14 |
| 26.5.2.1 | Prior Authorization Requirements | 15 |
| 26.5.3 | Claims Information | 16 |
| 26.5.4 | Reimbursement | 16 |
| 26.6 | Total Parenteral Nutrition (TPN) | 17 |
| 26.6.1 | Enrollment | 17 |
| 26.6.2 | Benefits, Limitations, and Authorization Requirements | 17 |
| 26.6.2.1 | Prior Authorization | 18 |
| 26.6.3 | Claims Information | 19 |
| 26.6.4 | Reimbursement | 19 |
| 26.7 | TMHP-CSHCN Services Program Contact Center | 20 |

Neurostimulators and Neuromuscular Stimulators

| | | |
|-------------|--|-----------|
| 27.1 | Enrollment | 3 |
| 27.2 | Benefits, Limitations, and Authorization Requirements | 3 |
| 27.2.1 | Dorsal Column Neurostimulation (DCN) | 4 |
| 27.2.2 | Intracranial Neurostimulation (ICN) | 5 |
| 27.2.3 | Neuromuscular Electrical Stimulation (NMES) | 6 |
| 27.2.3.1 | NMES for Muscle Atrophy | 6 |
| 27.2.3.2 | NMES for Walking in Clients with Spinal Cord Injury | 7 |
| 27.2.4 | Percutaneous Electrical Nerve Stimulation (PENS) | 7 |
| 27.2.5 | Sacral Nerve Stimulation (SNS) | 8 |
| 27.2.6 | Transcutaneous Electrical Nerve Stimulation (TENS) | 9 |
| 27.2.6.1 | TENS Rental | 9 |
| 27.2.6.2 | TENS Purchase | 9 |
| 27.2.7 | Pelvic Floor Stimulation | 10 |
| 27.2.8 | Vagal Nerve Stimulation (VNS) | 10 |
| 27.2.9 | Electronic Analysis for Implantable Neurostimulators | 10 |
| 27.2.10 | Electrocorticogram | 11 |
| 27.2.11 | Revision or Removal of Implantable Neurostimulators | 11 |
| 27.2.12 | Implantable Neurostimulators and Neuromuscular Stimulators | 11 |
| 27.2.12.1 | NMES and TENS Garments | 12 |
| 27.2.12.2 | NMES and TENS Supplies | 12 |
| 27.3 | Claims Information | 12 |
| 27.4 | Reimbursement | 13 |
| 27.5 | TMHP-CSHCN Services Program Contact Center | 13 |

Orthotic and Prosthetic Devices

| | | |
|-------------|--|-----------|
| 28.1 | Enrollment | 4 |
| 28.2 | Benefits, Limitations, and Authorization Requirements | 4 |
| 28.2.1 | General Authorization Requirements | 5 |
| 28.2.2 | Orthoses and Prostheses (Not All-Inclusive) | 5 |
| 28.2.2.1 | Repairs, Replacements, and Modifications to Orthoses and Prostheses | 6 |
| 28.2.2.2 | Mechanical Stretching Devices | 6 |
| 28.2.2.3 | Orthoses and Prostheses Training | 7 |
| 28.3 | Orthoses and Related Services | 7 |
| 28.3.1 | Prior Authorization and Documentation Requirements | 7 |
| 28.3.2 | Orthotic and Orthopedic Devices Procedure Codes | 8 |
| 28.3.3 | Noncovered Orthotic and Prosthetic Services | 10 |
| 28.3.4 | Spinal Orthoses | 11 |
| 28.3.5 | Thoracic-Hip-Knee-Ankle (THKA) Orthoses | 11 |
| 28.3.6 | Lower-Limb Orthoses | 11 |
| 28.3.6.1 | Ankle-Foot Orthoses (AFO) | 11 |
| 28.3.6.2 | Reciprocating Gait Orthoses (RGO) | 11 |
| 28.3.7 | Foot Orthoses | 12 |
| 28.3.7.1 | Foot Inserts | 12 |
| 28.3.7.2 | Prescription Shoes | 13 |
| 28.3.7.3 | Noncovered Shoes or Shoe Inserts | 13 |
| 28.3.7.4 | Wedges and Lifts | 13 |
| 28.3.8 | Upper-Limb Orthoses | 13 |
| 28.3.9 | Other Orthopedic Devices | 14 |
| 28.3.9.1 | Protective Helmets | 14 |
| 28.3.9.2 | Cranial Molding Orthosis | 14 |
| 28.3.9.2.1 | <i>Definitions of Plagiocephaly</i> | 14 |
| 28.3.9.2.2 | <i>Authorization Requirements</i> | 15 |
| 28.3.9.3 | Static and Dynamic Mechanical Stretching Devices | 16 |
| 28.4 | Prostheses and Related Services | 16 |
| 28.4.1 | Prior Authorization and Documentation Requirements | 16 |
| 28.4.2 | Prostheses Procedure Codes | 17 |
| 28.4.3 | Preparatory or Temporary Prostheses | 19 |
| 28.4.4 | Upper-Limb Prostheses | 19 |
| 28.4.4.1 | Myoelectric Prostheses | 19 |
| 28.4.5 | Lower-Limb Prostheses | 19 |
| 28.4.5.1 | Microprocessor-Controlled Lower-Limb Prostheses | 20 |
| 28.4.5.2 | Foot Prostheses | 20 |
| 28.4.5.3 | Knee Prosthesis | 20 |
| 28.4.5.4 | Ankle Prosthesis | 21 |
| 28.4.5.5 | Sockets | 21 |
| 28.4.5.6 | Accessories | 21 |
| 28.5 | Repairs, Replacements, and Modifications to Orthoses and Prostheses | 21 |
| 28.5.1 | Other Artificial Devices | 21 |
| 28.6 | CSHCN Services Program Documentation of Receipt | 22 |
| 28.7 | Claims Information | 22 |
| 28.8 | Reimbursement | 23 |
| 28.9 | TMHP-CSHCN Services Program Contact Center | 23 |

Outpatient Behavioral Health

- 29.1 Enrollment 3**
 - 29.1.1 Provisionally Licensed Psychologist (PLP)..... 3
- 29.2 Benefits, Limitations, and Authorization Requirements 3**
 - 29.2.1 Authorization Requirements 4
 - 29.2.2 Documentation Requirements 4
 - 29.2.3 Pharmacological Management Services Documentation 5
 - 29.2.4 Reimbursement—The 12-Hour System Limitation 5
 - 29.2.5 Procedure Codes Included in the 12-Hour System Limitation..... 6
 - 29.2.6 Psychological Testing, Neuropsychological Testing, and Neurobehavioral Status Exams..... 7
 - 29.2.7 Psychotherapy and Counseling 8
 - 29.2.7.1 Treatment for Alzheimer’s and Dementia 8
 - 29.2.8 Psychiatric Diagnostic Evaluations 9
 - 29.2.9 Noncovered Services 9
 - 29.2.10 National Correct Coding Initiative (NCCI) Guidelines 10
- 29.3 Claims Information.....10**
- 29.4 Reimbursement.....10**
- 29.5 TMHP-CSHCN Services Program Contact Center11**

Physical Medicine and Rehabilitation

- 30.1 Enrollment 3**
- 30.2 Benefits, Limitations, and Authorization Requirements 3**
 - 30.2.1 Osteopathic Manipulative Treatment (OMT) 3
 - 30.2.2 Physical Therapy (PT), and Occupational Therapy (OT) 4
 - 30.2.3 Time-based PT and OT Treatment Procedure Codes 5
 - 30.2.4 Untimed PT and OT Treatment Procedure Codes 6
 - 30.2.5 Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units..... 6
 - 30.2.6 Group Therapy 7
 - 30.2.6.1 Group Therapy Guidelines 7
 - 30.2.6.2 Group Therapy Documentation Requirements..... 7
 - 30.2.7 Noncovered Services 8
 - 30.2.8 Authorization Requirements 8
 - 30.2.8.1 Initial Prior Authorization Requests..... 9
 - 30.2.8.2 Extension of Services Requests..... 10
 - 30.2.8.3 Discontinuation of Therapy or Change of Provider 10
- 30.3 Coordination with the Public School System11**
- 30.4 Claims Information.....11**
- 30.5 Reimbursement.....12**
- 30.6 TMHP-CSHCN Services Program Contact Center12**

Physician

- 31.1 Enrollment 8**
 - 31.1.1 Group Practices 9

| | | |
|-------------|---|----------|
| 31.1.2 | Changes in Provider Enrollment | 9 |
| 31.1.3 | Substitute Physician | 9 |
| 31.2 | Benefits, Limitations, and Authorization Requirements | 9 |
| 31.2.1 | Authorization and Prior Authorization Requirements | 10 |
| 31.2.2 | Aerosol Treatments/Inhalation Therapy | 11 |
| 31.2.3 | Allergy Services | 13 |
| 31.2.3.1 | Collagen Skin Tests | 14 |
| 31.2.3.2 | Prior Authorization Requirements | 14 |
| 31.2.4 | Ambulatory Blood Pressure Monitoring | 15 |
| 31.2.5 | Anesthesia Services | 16 |
| 31.2.5.1 | Medical Direction | 16 |
| 31.2.5.2 | Monitored Anesthesia Care | 18 |
| 31.2.5.3 | Anesthesia Modifiers | 18 |
| 31.2.5.3.1 | <i>State-Defined Modifiers</i> | 18 |
| 31.2.5.3.2 | <i>Anesthesiologist Services and Modifier Combinations</i> | 18 |
| 31.2.5.3.3 | <i>CRNA, AA, or Other Qualified Professional Services</i> | 20 |
| 31.2.5.3.4 | <i>Monitored Anesthesia Care</i> | 20 |
| 31.2.5.4 | Dental General Anesthesia | 20 |
| 31.2.5.5 | Epidural and Subarachnoid Infusion (Not including Labor and Delivery) ... | 20 |
| 31.2.5.6 | Reimbursement | 20 |
| 31.2.5.7 | Conversion Factor | 21 |
| 31.2.5.8 | Time-Based Fees | 21 |
| 31.2.6 | Audiometry/Hearing Services | 21 |
| 31.2.7 | Augmentative Communication Devices (ACDs) | 22 |
| 31.2.8 | Biofeedback Services | 22 |
| 31.2.8.1 | Medical Record Documentation | 22 |
| 31.2.8.2 | Provider Certification | 22 |
| 31.2.8.3 | Authorization Requirements | 22 |
| 31.2.8.4 | Noncovered Services | 23 |
| 31.2.9 | Bone Growth Stimulators | 23 |
| 31.2.9.1 | Prior Authorization Requirements for Bone Growth Stimulators | 24 |
| 31.2.9.1.1 | <i>Low-Intensity Ultrasound Bone Growth Stimulators</i> | 25 |
| 31.2.9.1.2 | <i>Non-Invasive Bone Growth Stimulators</i> | 25 |
| 31.2.9.1.3 | <i>Invasive Bone Growth Stimulators</i> | 25 |
| 31.2.9.2 | Authorization Requirements for Bone Growth Stimulation | 26 |
| 31.2.10 | Casting | 26 |
| 31.2.11 | Chemotherapy | 27 |
| 31.2.12 | Clinician-Directed Care Coordination Services | 28 |
| 31.2.12.1 | Face-to-Face Clinician-Directed Care Coordination Services | 29 |
| 31.2.12.2 | Non-Face-to-Face Clinician-Directed Care Coordination Services | 29 |
| 31.2.12.2.1 | <i>Care Plan Oversight</i> | 31 |
| 31.2.12.2.2 | <i>Medical Team Conference</i> | 31 |
| 31.2.12.2.3 | <i>Non-Face-to-Face Specialist or Subspecialist Telephone Consultations</i> .. | 31 |
| 31.2.12.2.4 | <i>Non-Face-to-Face Prolonged Services</i> | 32 |
| 31.2.12.2.5 | <i>Authorization for Non-Face-to-Face Clinician-Directed Care Coordination Services</i> | 32 |
| 31.2.13 | Cochlear Implants | 34 |
| 31.2.14 | Colorectal Cancer Screening | 34 |
| 31.2.15 | Critical Care Services | 34 |
| 31.2.15.1 | General Limitations | 35 |
| 31.2.15.2 | Critical Care Services | 36 |

| | | |
|--------------|--|----|
| 31.2.15.3 | Pediatric Critical Care | 37 |
| 31.2.15.4 | Neonatal Critical Care | 37 |
| 31.2.15.5 | Intensive Care (Noncritical) Services | 37 |
| 31.2.15.6 | Newborn Resuscitation | 37 |
| 31.2.16 | Echoencephalography | 38 |
| 31.2.16.1 | Ambulatory Electroencephalogram | 40 |
| 31.2.17 | Evaluation and Management (E/M) Services | 41 |
| 31.2.17.1 | New or Established Patient Visits | 41 |
| 31.2.17.2 | Inpatient Professional Services | 42 |
| 31.2.17.2.1 | <i>Initial and Subsequent Hospital Care (Nonintensive Care)</i> | 42 |
| 31.2.17.2.2 | <i>Hospital Discharge Day Management</i> | 42 |
| 31.2.17.2.3 | <i>Concurrent Inpatient Care</i> | 42 |
| 31.2.17.3 | Emergency Services | 43 |
| 31.2.17.3.1 | <i>Hospital-Based Emergency Department Professional Services</i> | 43 |
| 31.2.17.4 | Consultations | 44 |
| 31.2.17.5 | Services Outside of Business Hours | 44 |
| 31.2.17.6 | Prolonged Physician Services | 45 |
| 31.2.17.7 | Observation Room Services | 45 |
| 31.2.17.8 | Preventive Care Services | 46 |
| 31.2.17.9 | Preventive Care Medical Checkups and Developmental Testing | 47 |
| 31.2.17.9.1 | <i>Laboratory Tests</i> | 47 |
| 31.2.17.9.2 | <i>Medical Checkup Follow-up Visit</i> | 47 |
| 31.2.17.9.3 | <i>Denied Medical Checkups</i> | 48 |
| 31.2.17.9.4 | <i>Developmental Screening and Testing</i> | 48 |
| 31.2.17.9.5 | <i>Developmental Screening</i> | 48 |
| 31.2.17.9.6 | <i>Developmental Testing</i> | 49 |
| 31.2.17.10 | Preventive Care Medical Checkup Components | 50 |
| 31.2.17.10.1 | <i>Oral Evaluation and Fluoride Varnish in the Medical Home (OEFV)</i> | 50 |
| 31.2.17.10.2 | <i>Mental Health Screening</i> | 51 |
| 31.2.17.10.3 | <i>Postpartum Depression Screening</i> | 51 |
| 31.2.17.10.4 | <i>Sensory Screening</i> | 53 |
| 31.2.17.11 | Teaching Physicians | 53 |
| 31.2.18 | Evoked Response Tests and Neuromuscular Procedures | 53 |
| 31.2.18.1 | Autonomic Function Tests | 54 |
| 31.2.18.2 | Electromyography and Nerve Conduction Studies | 54 |
| 31.2.18.2.1 | <i>EMG</i> | 59 |
| 31.2.18.2.2 | <i>NCS</i> | 59 |
| 31.2.18.3 | Evoked Potential Procedures | 60 |
| 31.2.18.3.1 | <i>Intraoperative Neurophysiology Monitoring</i> | 60 |
| 31.2.18.4 | Motion Analysis Studies | 61 |
| 31.2.18.5 | Prior Authorization for Unlisted Procedure Code 95999 | 61 |
| 31.2.19 | Extracorporeal Shock Wave Lithotripsy (ESWL) | 62 |
| 31.2.20 | Gastrostomy Devices | 62 |
| 31.2.21 | Genetics | 62 |
| 31.2.21.1 | Family History | 63 |
| 31.2.21.2 | Genetic Tests | 63 |
| 31.2.21.3 | Laboratory Practices | 63 |
| 31.2.21.4 | Genetic Counselors | 64 |
| 31.2.22 | Hyperbaric Oxygen Therapy (HBOT) | 64 |
| 31.2.22.1 | Prior Authorization Requirements | 65 |
| 31.2.23 | Immunizations (Vaccines and Toxoids) | 68 |

| | | |
|---------------|--|----|
| 31.2.23.1 | Texas Vaccines for Children (TVFC) Program | 68 |
| 31.2.23.2 | Documentation Recommendations | 68 |
| 31.2.23.3 | Vaccine Reporting to the DSHS..... | 69 |
| 31.2.23.3.1 | <i>Vaccine Adverse Event Reporting System (VAERS)</i> | 69 |
| 31.2.23.4 | Authorization Requirements | 69 |
| 31.2.23.5 | Vaccine Reimbursement | 69 |
| 31.2.23.6 | Vaccine Administration | 70 |
| 31.2.23.6.1 | <i>Administration With Counseling</i> | 70 |
| 31.2.23.6.2 | <i>Administration Without Counseling</i> | 71 |
| 31.2.23.7 | Vaccine and Toxoid Procedure Codes | 72 |
| 31.2.23.8 | Influenza Vaccines | 73 |
| 31.2.23.9 | Bacille Calmette-Guerin (BCG) Vaccine..... | 74 |
| 31.2.23.10 | Botulinum Antitoxin | 74 |
| 31.2.23.11 | Hepatitis B Vaccine | 74 |
| 31.2.23.12 | Rabies Postexposure Prophylaxis..... | 74 |
| 31.2.23.13 | Respiratory Syncytial Virus (RSV) Prophylaxis | 75 |
| 31.2.24 | Injections and Oral Medications..... | 75 |
| 31.2.24.1 | Reimbursement for the Unused Portion of the Single-Dose Vial | 76 |
| 31.2.24.2 | Injection Administration Billed by a Physician..... | 76 |
| 31.2.24.3 | Unit Calculations for Billing Drugs | 76 |
| 31.2.24.4 | JW Modifier Claims Filing Instructions | 77 |
| 31.2.24.5 | Injection Procedure Codes | 78 |
| 31.2.24.6 | Adalimumab | 80 |
| 31.2.24.7 | Ado-Trastuzumab Emtansine | 81 |
| 31.2.24.8 | Bevacizumab | 82 |
| 31.2.24.9 | Botulinum Toxin (Type A and Type B)..... | 82 |
| 31.2.24.9.1 | <i>Prior Authorization Requirements</i> | 85 |
| 31.2.24.9.2 | <i>Reimbursement</i> | 85 |
| 31.2.24.10 | Denileukin Diftitox..... | 85 |
| 31.2.24.11 | Epirubicin Hydrochloride | 86 |
| 31.2.24.12 | Erythropoietin Alfa (EPO) and Darbepoetin | 86 |
| 31.2.24.13 | Growth Hormone..... | 89 |
| 31.2.24.13.1 | <i>Prior Authorization Requirements</i> | 89 |
| 31.2.24.14 | Immune Globulins | 90 |
| 31.2.24.14.1 | <i>Authorization Requirements</i> | 91 |
| 31.2.24.15 | Infliximab, Inflectra, and Renflexis | 91 |
| 31.2.24.16 | Inotuzumab ozogamicin (Besponsa)..... | 92 |
| 31.2.24.17 | Leuprolide Acetate Injection | 93 |
| 31.2.24.18 | Monoclonal Antibodies - Asthma and Chronic Idiopathic Urticaria..... | 93 |
| 31.2.24.18.1 | <i>Omalizumab</i> | 93 |
| 31.2.24.18.2 | <i>Benralizumab</i> | 93 |
| 31.2.24.18.3 | <i>Mepolizumab</i> | 93 |
| 31.2.24.18.4 | <i>Reslizumab</i> | 93 |
| 31.2.24.18.5 | <i>Prior Authorization Requirements</i> | 94 |
| 31.2.24.18.6 | <i>Chronic Idiopathic Urticaria</i> | 94 |
| 31.2.24.18.7 | <i>Asthma Moderate to Severe (Omalizumab) and Severe (Benralizumab, Mepolizumab, and Reslizumab)</i> | 94 |
| 31.2.24.18.8 | <i>Omalizumab</i> | 95 |
| 31.2.24.18.9 | <i>Benralizumab</i> | 95 |
| 31.2.24.18.10 | <i>Mepolizumab</i> | 96 |
| 31.2.24.18.11 | <i>Reslizumab</i> | 96 |

| | | |
|---------------|---|-----|
| 31.2.24.18.12 | <i>Requirements for Continuation of Therapy</i> | 96 |
| 31.2.24.19 | Trastuzumab | 97 |
| 31.2.24.20 | Triamcinolone Acetonide | 97 |
| 31.2.25 | Intracranial Pressure Monitoring | 97 |
| 31.2.26 | Laboratory Services | 98 |
| 31.2.26.1 | Clinical Pathology Services and Pathology Consultations | 98 |
| 31.2.26.2 | Claims Filing for Laboratory Tests | 98 |
| 31.2.26.3 | Reimbursement | 98 |
| 31.2.26.4 | Cytopathology Studies (Gynecological, Pap Smears) | 98 |
| 31.2.26.5 | Cytogenetics Testing | 99 |
| 31.2.26.6 | Helicobacter pylori (H. pylori) | 99 |
| 31.2.26.7 | CLIA Requirement | 99 |
| 31.2.27 | Magnetoencephalography (MEG) | 99 |
| 31.2.27.1 | Authorization Requirements | 99 |
| 31.2.27.2 | Documentation Requirements | 100 |
| 31.2.27.3 | Exclusions | 100 |
| 31.2.28 | Neurostimulator Devices and Supplies | 100 |
| 31.2.29 | Ophthalmological Services | 100 |
| 31.2.29.1 | Intraocular Lenses (IOL) | 100 |
| 31.2.29.2 | Vitrasert Ganciclovir Implant | 101 |
| 31.2.30 | Osteopathic Manipulative Treatment (OMT) | 101 |
| 31.2.31 | Physical Medicine and Physical Therapy (PT) Services | 101 |
| 31.2.32 | Podiatry | 101 |
| 31.2.33 | Psychological Testing | 102 |
| 31.2.34 | Sign Language Interpreting Services | 102 |
| 31.2.35 | Skin Therapy | 103 |
| 31.2.36 | Sleep Studies | 104 |
| 31.2.36.1 | Polysomnography | 104 |
| 31.2.36.2 | Multiple Sleep Latency Test | 106 |
| 31.2.36.3 | Pediatric Pneumogram | 106 |
| 31.2.36.4 | Home Sleep Study Test | 106 |
| 31.2.37 | Surgery | 107 |
| 31.2.37.1 | Anesthesia Administered by Surgeon | 107 |
| 31.2.37.2 | Primary Surgeons | 107 |
| 31.2.37.3 | Assistant Surgeons | 107 |
| 31.2.37.4 | Cosurgery | 108 |
| 31.2.37.5 | Bilateral Procedures | 109 |
| 31.2.37.6 | Global Fees | 109 |
| 31.2.37.6.1 | <i>Modifiers</i> | 110 |
| 31.2.37.6.2 | <i>Documentation Requirements</i> | 110 |
| 31.2.37.6.3 | <i>Preoperative Services</i> | 110 |
| 31.2.37.6.4 | <i>Intraoperative Services</i> | 111 |
| 31.2.37.6.5 | <i>Postoperative Services</i> | 111 |
| 31.2.37.6.6 | <i>Return Trips to the Operating Room</i> | 113 |
| 31.2.37.7 | Multiple Surgeries | 113 |
| 31.2.37.8 | Second Opinions | 113 |
| 31.2.37.9 | Unlisted Surgical Procedure Code Considerations | 114 |
| 31.2.37.10 | Circumcision | 114 |
| 31.2.37.11 | Cleft/Craniofacial Procedures | 115 |
| 31.2.38 | Diagnostic and Surgical/Reconstructive Breast Therapies | 116 |
| 31.2.38.1 | Breast Therapies | 117 |

| | | |
|-------------|---|------------|
| 31.2.38.1.1 | <i>Diagnostic Breast Procedures</i> | 117 |
| 31.2.38.2 | Surgical Breast Procedures | 118 |
| 31.2.38.2.1 | <i>Mastectomy</i> | 118 |
| 31.2.38.2.2 | <i>Prophylactic Mastectomy</i> | 119 |
| 31.2.38.2.3 | <i>Mastectomy for Gynecomastia</i> | 119 |
| 31.2.38.2.4 | <i>Breast Reconstruction</i> | 119 |
| 31.2.38.2.5 | <i>Excision or Destruction of Benign Lesions</i> | 121 |
| 31.2.38.2.6 | <i>Treatment for Complications of Breast Reconstruction</i> | 122 |
| 31.2.38.2.7 | <i>Reduction Mammoplasty</i> | 122 |
| 31.2.38.2.8 | <i>External Breast Protheses</i> | 122 |
| 31.2.38.3 | Prior Authorization and Authorization Requirements | 122 |
| 31.2.38.4 | Prior Authorization and Authorization Requirements for Mastectomy, Breast Reconstruction, and External Protheses | 122 |
| 31.2.38.4.1 | <i>Mastectomy and Breast Reconstruction</i> | 123 |
| 31.2.38.4.2 | <i>Breast Reconstruction</i> | 123 |
| 31.2.38.4.3 | <i>Mastectomy for Gynecomastia</i> | 124 |
| 31.2.38.4.4 | <i>Reduction Mammoplasty</i> | 124 |
| 31.2.38.4.5 | <i>Unlisted Procedure</i> | 124 |
| 31.2.38.4.6 | <i>Breast Protheses</i> | 125 |
| 31.2.38.5 | Documentation Requirements | 125 |
| 31.2.38.6 | Reconstructive and Corrective Procedures (Not Related to Breast Therapies) | 126 |
| 31.2.38.7 | Prior Authorization and Authorization for Corrective Procedures | 127 |
| 31.2.38.7.1 | <i>Oral Procedures</i> | 127 |
| 31.2.38.7.2 | <i>Dermatological and Blepharoplasty Procedures</i> | 127 |
| 31.2.38.7.3 | <i>Panniculectomy and Abdominoplasty</i> | 127 |
| 31.2.38.7.4 | <i>Noncovered Services</i> | 127 |
| 31.2.38.8 | Rhizotomy | 128 |
| 31.2.38.9 | Septoplasty | 128 |
| 31.2.39 | Therapeutic Apheresis | 128 |
| 31.2.40 | Transplants | 130 |
| 31.2.40.1 | Renal (Kidney) Transplant | 130 |
| 31.2.40.2 | Transplants - Nonsolid Organ | 131 |
| 31.2.40.2.1 | Physician Reimbursement | 133 |
| 31.2.41 | Wound Care Management | 133 |
| 31.2.41.1 | First-Line Wound Care Therapy | 133 |
| 31.2.41.1.1 | <i>Compression</i> | 134 |
| 31.2.41.1.2 | <i>Debridement</i> | 134 |
| 31.2.41.2 | Second-Line Wound Care Therapy | 134 |
| 31.2.41.2.1 | <i>Pulsatile-Jet Irrigation</i> | 135 |
| 31.2.41.2.2 | <i>Application of Metabolically Active Skin Equivalents and Wound Preparation</i> | 135 |
| 31.2.41.3 | Documentation Requirements | 135 |
| 31.3 | Claims Information | 136 |
| 31.3.1 | General Medical Record Documentation Requirements | 137 |
| 31.4 | Reimbursement | 138 |
| 31.4.1 | Physician Services in Outpatient Hospital Setting | 139 |
| 31.4.1.1 | Reimbursement Reduction | 139 |
| 31.5 | TMHP-CSHCN Services Program Contact Center | 139 |

Physician Assistant (PA)

| | | |
|-------------|--|----------|
| 32.1 | Enrollment | 3 |
| 32.2 | Benefits, Limitations, and Authorization Requirements | 3 |
| 32.2.1 | Authorization Requirements | 4 |
| 32.3 | Claims Information | 4 |
| 32.4 | Reimbursement | 4 |
| 32.5 | TMHP-CSHCN Services Program Contact Center | 5 |

Prescribed Pediatric Extended Care Centers

| | | |
|-------------|--|-----------|
| 33.1 | Enrollment | 3 |
| 33.2 | Benefits, Limitations, and Authorization Requirements | 3 |
| 33.2.1 | Prior Authorization and Authorization Requirements | 5 |
| 33.2.1.1 | Initial Prior Authorization Requests | 5 |
| 33.2.1.2 | Revisions to the POC | 8 |
| 33.2.1.3 | Extension of PPECC Services | 9 |
| 33.3 | Documentation Requirements | 9 |
| 33.4 | Coordination of Services | 10 |
| 33.5 | Exclusions | 10 |
| 33.6 | Reimbursement | 11 |
| 33.7 | TMHP-CSHCN Services Program Contact Center | 12 |

Radiation Therapy Services

| | | |
|-------------|---|----------|
| 34.1 | Enrollment | 3 |
| 34.2 | Benefits, Limitations, and Authorization Requirements | 3 |
| 34.2.1 | Prior Authorization Requirements | 4 |
| 34.2.2 | Clinical Brachytherapy | 4 |
| 34.2.3 | Clinical Treatment Planning | 5 |
| 34.2.4 | Intensity Modulated Radiation Therapy (IMRT) | 5 |
| 34.2.5 | Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services | 5 |
| 34.2.6 | Proton-Beam and Neutron-Beam Delivery | 6 |
| 34.2.6.1 | Prior Authorization Requirements | 6 |
| 34.2.6.1.1 | Proton-Beam Treatment Delivery | 6 |
| 34.2.6.1.2 | Neutron-Beam Treatment Delivery | 6 |
| 34.2.7 | Radiation Treatment Management and Delivery | 6 |
| 34.2.7.1 | Radioisotope Therapy | 7 |
| 34.2.8 | Stereotactic Radiosurgery | 7 |
| 34.2.8.1 | Prior Authorization Requirements | 7 |
| 34.2.9 | Strontium-89 | 8 |
| 34.2.10 | Technetium TC 99M Tetrofosmin | 8 |
| 34.3 | Claims Information | 8 |
| 34.4 | Reimbursement | 9 |
| 34.5 | TMHP-CSHCN Services Program Contact Center | 9 |

Renal Dialysis

| | | |
|-------------|--|-----------|
| 35.1 | Enrollment | 3 |
| 35.2 | Client Eligibility | 3 |
| 35.3 | Benefits, Limitations, and Authorization Requirements | 3 |
| 35.3.1 | In-Facility Services and Method I Home Dialysis Services | 4 |
| 35.3.2 | Method II Home Dialysis (Dealing Direct) | 8 |
| 35.3.3 | Maintenance Hemodialysis | 9 |
| 35.3.4 | Dialysis Training | 9 |
| 35.3.5 | Unscheduled or Emergency Dialysis in a Non-Certified ESRD Facility | 9 |
| 35.3.6 | Ultrafiltration | 10 |
| 35.3.7 | Evaluation and Management | 10 |
| 35.3.8 | Renal Transplants | 11 |
| 35.3.9 | Prior Authorization Requirements | 12 |
| 35.4 | Claims Information | 12 |
| 35.5 | Reimbursement | 13 |
| 35.6 | TMHP-CSHCN Services Program Contact Center | 13 |

Respiratory Equipment and Supplies

| | | |
|-------------|---|----------|
| 36.1 | Enrollment | 4 |
| 36.2 | Benefits, Limitations, and Authorization Requirements | 4 |
| 36.2.1 | General Authorization Requirements | 8 |
| 36.2.2 | Noninvasive Positive Pressure Ventilation (NPPV) | 8 |
| 36.2.2.1 | Continuous Positive Airway Pressure (CPAP) System | 9 |
| 36.2.2.2 | Respiratory Assist Devices (RADs), including BiPAP | 10 |
| 36.2.2.2.1 | <i>RAD for Treatment of Obstructive Sleep Apnea (OSA)</i> | 10 |
| 36.2.2.2.2 | <i>RAD for Treatment of Restrictive Thoracic Medical Conditions</i> | 10 |
| 36.2.2.2.3 | <i>RAD for Treatment of Severe COPD</i> | 11 |
| 36.2.2.2.4 | <i>RAD for Treatment of Central sleep Apnea (CSA) or Complex Sleep apnea (CompSA)</i> | 11 |
| 36.2.2.2.5 | <i>RAD for Treatment of Hypoventilation Syndrome</i> | 12 |
| 36.2.2.2.6 | <i>Extension Request for RAD With or Without a Set Backup Rate</i> | 12 |
| 36.2.3 | Controlled Dose Inhalation Drug Delivery System | 13 |
| 36.2.4 | Secretion and Mucus Clearance Devices | 13 |
| 36.2.4.1 | Cough Augmentation Device (Insufflation Devices or Cough Assist Machine) | 14 |
| 36.2.4.2 | Electrical Percussors | 14 |
| 36.2.4.3 | High Frequency Chest Wall Oscillation (HFCWO) System | 14 |
| 36.2.4.4 | Percussion Cup | 16 |
| 36.2.4.5 | Intermittent Positive Pressure Breathing (IPPB) Devices | 16 |
| 36.2.5 | Nebulizers | 16 |
| 36.2.5.1 | Medications Small Volume Nebulizer | 17 |
| 36.2.5.2 | Large Volume Nebulizer | 18 |
| 36.2.5.3 | Compressors and other DME used with Large Volume Nebulizers | 18 |
| 36.2.5.4 | Filtered Nebulizer | 18 |
| 36.2.5.5 | Ultrasonic Nebulizers | 19 |
| 36.2.6 | Oxygen Therapy | 19 |
| 36.2.6.1 | Stationary Oxygen Systems | 22 |

36.2.6.2 Portable Oxygen Systems 22

36.2.7 Pulse Oximeters 22

36.2.8 Tracheostomy Tubes and Related Supplies 23

 36.2.8.1 Tracheostomy Tube Inner Cannula 24

36.2.9 Cardiorespiratory Monitor (CRM) 25

36.2.10 Mechanical Ventilation 26

36.2.11 Negative Pressure Ventilators 26

36.2.12 Home Ventilators (any type) with or without Invasive Interface 27

36.2.13 Repair to Client -Owned Equipment 27

36.2.14 Aerosol Treatments 28

36.2.15 Diagnostic Testing 28

36.2.16 Other Equipment 29

36.3 Claims Information 29

36.4 Reimbursement 29

36.5 TMHP-CSHCN Services Program Contact Center 30

Speech-Language Pathology (SLP) Services

37.1 Enrollment 3

37.2 Benefits, Limitations, and Authorization Requirements 3

 37.2.1 Speech Therapy Limitations 4

 37.2.2 Authorization Requirements 5

 37.2.2.1 Paper and Electronic Prior Authorization Documentation 6

 37.2.2.2 Initial Prior Authorization Request for Therapy Services 6

 37.2.2.2.1 Supporting Documentation 6

 37.2.2.3 Prior Authorization Request for Extension of Therapy Services 7

 37.2.2.3.1 Supporting Documentation 7

 37.2.2.3.2 Discontinuation of Therapy or Change of Provider 8

 37.2.3 Services That Are Not a Benefit 8

37.3 Coordination with the Public School System 8

37.4 Claims Information 9

37.5 Reimbursement 9

37.6 TMHP-CSHCN Services Program Contact Center 9

Tele-communication Services

38.1 Enrollment 3

38.2 Benefits, Limitations, and Authorization Requirements 3

 38.2.1 Patient Health Information Security 4

 38.2.2 Telemedicine Services 4

 38.2.2.1 Distant Site 5

 38.2.2.2 Other Patient Site 5

 38.2.2.3 Patient Site 6

 38.2.3 Telehealth Services 7

 38.2.3.1 Distant Site 8

 38.2.3.2 Patient Site 8

 38.2.4 Telemonitoring Services 9

38.2.4.1 Collection and Interpretation of Client Data 10

38.2.4.2 Facility Services 10

38.2.4.3 Prior Authorization Guidelines 11

38.3 Claims Information.....12

38.4 Reimbursement.....13

38.5 TMHP-CSHCN Services Program Contact Center13

Transportation of Deceased Clients

39.1 Enrollment3

39.2 Benefits, Limitations, and Authorization Requirements.....3

39.2.1 Authorization Requirements 3

39.3 Claims Information.....3

39.4 Reimbursement.....4

39.5 TMHP-CSHCN Services Program Contact Center4

Vision Services

40.1 Enrollment3

40.2 Benefits, Limitations, and Authorization Requirements.....3

40.2.1 Frames, Lenses, and Contact Lenses 4

40.2.1.1 Frames 4

40.2.1.2 Eyeglass Lenses 4

40.2.1.3 Special Eyeglass Lenses 5

40.2.1.4 Contact Lenses 5

40.2.1.4.1 Contact Fitting for Corneal Bandage Lens7

40.2.1.5 Eye Wear 7

40.2.1.6 Services Requiring Authorization 8

40.2.1.6.1 Contact Lenses, Prescriptions, and Fittings8

40.2.1.6.2 Scleral Lenses and Liquid Bandages8

40.2.1.7 Services Not Requiring Authorization..... 9

40.2.1.8 Services Requiring Prior Authorization..... 9

40.2.1.9 Eye Prostheses..... 10

40.2.2 Eye and Vision Examinations 10

40.2.2.1 Vision Examinations with Refraction..... 10

40.2.2.2 Medical Eye Examinations..... 11

40.2.2.3 Services Requiring Authorization..... 11

40.2.3 Special Vision Services 11

40.2.3.1 Ophthalmological Examination and Evaluation with General Anesthesia ... 11

40.2.3.2 Ophthalmic Ultrasound..... 12

40.2.3.3 Corneal Topography..... 12

40.2.3.4 Sensorimotor Examination..... 13

40.2.3.5 Orthoptic or Pleoptic Training..... 13

40.2.3.6 Ophthalmoscopy 13

40.2.3.7 Ocular Viewing and Diagnostic Testing Procedures 14

40.3 Claims Information.....14

40.4 Reimbursement.....15

40.5 TMHP-CSHCN Services Program Contact Center15

TMHP Electronic Data Interchange (EDI)

- 41.1 TMHP EDI Overview 3**
- 41.2 Advantages of Electronic Services 3**
 - 41.2.1 Getting Help 3
 - 41.2.2 Electronic Services Available 3
- 41.3 Electronic Billing 4**
 - 41.3.1 Step 1—Choose How Claims Are Submitted 4
 - 41.3.1.1 TexMedConnect 4
 - 41.3.1.2 Vendor Software 4
 - 41.3.1.3 Third-Party Billing Agents 5
 - 41.3.1.4 Automated Maintenance Process for All Electronic Submitters 5
 - 41.3.2 Step 2—Gaining Access 5
 - 41.3.3 Step 3—Training 5
- 41.4 Request for Electronic Transmission Reports 6**
- 41.5 Provider Check Amounts Available Online 6**
- 41.6 Third-Party Vendor Implementation 6**
 - 41.6.1 EDI Version 5010 Claims Response and Electronic Remittance & Status (R&S) Files 7
 - 41.6.1.1 Batch ID Included in Filename for 227CA Claims Response File 7
 - 41.6.1.2 Setting up the 835 File (ER&S) 7
 - 41.6.1.3 Trading Partners Who Submit 837 Files and Receive 835 Files 7
 - 41.6.1.4 Trading Partners Who Have a Clearinghouse or Third Party Submit Their Claims but Receive Their Own 835 Files 7
 - 41.6.1.5 Clearinghouses or Third-Party Billers That Submit Transactions and Receive the 835 Files on Behalf of Trading Partners 7
- 41.7 Supported File Types 7**
- 41.8 Forms 8**
- 41.9 TMHP-CSHCN Services Program Contact Center 8**

Appendix A: Acronyms and Initialisms Dictionary