Provider Enrollment and Responsibilities

CSHCN Services Program Provider Manual

January 2022

PROVIDER ENROLLMENT AND RESPONSIBILITIES

Table of Contents

2.1 * Provider Enrollment

Providers must be actively enrolled as a Texas Medicaid provider as a prerequisite to enrolling as a CSHCN Services Program provider. For information about Texas Medicaid enrollment requirements, or to complete an online enrollment, visit the TMHP website at www.tmhp.com. Providers can call the TMHP Contact Center at 1-800-925-9126 for additional information about Texas Medicaid enrollment, and call the TMHP CSHCN Services Program Contact Center at 1-800-568-2413 for additional information about CSHCN Services Program enrollment.

Providers of services not covered by Medicaid are not required to enroll as Medicaid providers, such as, family support providers for respite care, home and vehicle modifications, medical foods, and hospice services.

Refer to: Section 26.3, "Medical Foods" in Chapter 26, "Medical Nutrition Services."

Chapter 39, "Transportation of Deceased Clients."

To enroll in the CSHCN Services Program, a provider must complete the required CSHCN Services Program Provider Enrollment Application and enter into a written Provider Agreement with the CSHCN Services Program. The physical address, National Provider Identifier (NPI), and Tax ID on the CSHCN Services Program application must correspond to the Medicaid provider enrollment. The taxonomy code can be different from the taxonomy code selected for the Medicaid enrollment. Forms are available for download from the TMHP website at www.tmhp.com.

Providers that choose to complete the expedited enrollment application can also submit the following optional items if applicable:

- Electronic Funds Transfer (EFT) Notification
- Rehabilitation Engineering and Assistive Technology Society of North American (RESNA) certification for custom DME enrollment

Providers may also enroll online by logging into Provider Enrollment on the Portal (PEP).

Online enrollment has the following advantages:

- Updated on-screen instructions make the online application process more efficient and user-friendly.
- Applications are validated immediately to ensure that all fields have been completed.
- Most of the application can be completed online so that only a few forms need to be printed, completed, and mailed to TMHP. Forms that must be mailed are identified in the online application.
- Applicants can view incomplete and complete applications that have been submitted online.
- Some form fields are automatically completed, reducing the amount of information that has to be entered.
- Providers can complete the Provider Information Change (PIC) Form online.
- Providers will receive e-mail notifications when messages or deficiency notices about their applications are posted online. Providers may opt out of e-mail communication and receive messages or deficiency letters by mail.
- Providers can create templates, which makes it easier to submit multiple enrollment applications.
- Providers enrolling as groups (either new groups or group providers adding an additional Texas Provider Identifier [TPI] suffix) can assign portions of the application to performing providers to complete. The performing provider assignment functionality will not exist if the group is already enrolled when attempting to add a performing provider to the group.

- Performing providers can complete their portion of a group application by logging into Provider Enrollment on the Portal (PEP) with their unique user name and password.
- Providers can navigate to completed sections of the application without having to click through all pages of the application.
- Information that is on file for owners and subcontractors of the applying provider is auto-populated in the application.
- Before submitting an application to TMHP for processing, providers are required to review a portable document format (PDF) copy of the application and verify it is complete.
- Providers can edit submitted applications to correct identified deficiencies.

Providers can edit the information on the Application Services page and the Provider Type identification page. These functions are available for all new applications and for previously saved templates.

After a provider makes a change to the information on one of these pages, the provider must select **Continue/Save** through the entire application to ensure that all required fields are completed.

After an application has been accepted and a TPI generated for that application, any changes made to the template will not be reflected for that TPI; however, they will be reflected on subsequent TPIs rendered from the same application. Providers can update their demographic information online through the Provider Information Management System (PIMS) for existing TPIs. Providers can log into the PIMS system by going to the TMHP home page and selecting "Log in to My Account" on the top-right corner of the page.

Exceptions:

- The editing functions in PEP do not apply to Medical Transportation Program (MTP) applications.
- Performing provider applications created as part of a group application cannot change the group's Application Services page.

[Revised] For assistance with the application process, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

A CSHCN Services Program provider identifier is issued when all required forms and documentation have been received and the application process is completed. The provider identifier is a unique number assigned to each provider. A provider *cannot* be enrolled if his or her license is due to expire within 30 days of the date of application. TMHP verifies license information provided with the enrollment application.

If a license or certification is required by law to practice in the State of Texas, the provider must maintain the required license or certification and practice within the scope of the license, certification, registration, and any other applicable requirements. Current license information must be on file with the program or its payment contractor. If the license was submitted when enrolling with Medicaid, it does not need to be duplicated. If there are additional enrollment requirements for a specific provider type, the requirements are described in the specific provider section of this manual.

The provider's enrollment effective date will be 6 months before the date the enrollment application is received or the traditional Medicaid enrollment effective date, whichever is more current.

2.1.1 Affordable Care Act of 2010 (ACA) Enrollment Requirements

All providers must comply with the provisions of the Affordable Care Act of 2010 (ACA). CSHCN Services Program providers who have fulfilled the ACA requirements through their Texas Medicaid enrollment are considered ACA-compliant.

Exception: *Medical foods providers and hospice providers are not required to enroll in Texas Medicaid as a prerequisite for CSHCN Services Program enrollment and are not required to pay a provider application fee to enroll in the CSHCN Services Program.*

Refer to: The TMHP website at www.tmhp.com for additional information about ACA requirements including provider types that are required to pay the application fee.

2.1.1.1 * Medical Foods and Hospice Providers

CSHCN Services Program medical foods providers and hospice providers that submit a provider enrollment application for new enrollment, a new practice location, or other type of enrollment or re-enrollment will be subject to the following ACA requirements:

- Provider screening according to the provider's level of risk as determined by DSHS.
- Enrollment revalidation at least every five years during which time the provider screening will be completed.

2.1.1.2 Enrollment for Ordering and Referring-Only Providers

Providers who are not currently enrolled in the CSHCN Services Program but who order or refer services and supplies for CSHCN Services Program clients are required to enroll in Texas Medicaid as ordering or referring-only providers.

Ordering and referring providers do not submit claims to TMHP for rendered services. Although ordering and referring providers do not submit claims for reimbursement, the ordering and referring provider's National Provider Identifier (NPI) is required on claims that are submitted by the providers that render the supplies or services.

Providers can search for ordering/referring-only providers on the Online Provider Lookup (OPL) search page to help with verification of the provider that ordered or referred services is enrolled in Texas Medicaid. The search can be done by using the Basic Provider or Advanced Provider Search.

2.1.2 Changes in Enrollment

When one of the following changes, a new enrollment application must be completed and submitted to the address above so that a new provider identifier can be assigned:

- Ownership—The new owner must take the following actions:
  - Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
  - Complete a Texas Medicaid Provider Enrollment Application and obtain a Texas Medicaid provider identifier. The provider must have a Texas Medicaid provider identifier on file before applying with the CSHCN Services Program.
  - Complete the CSHCN Services Program Provider Enrollment Application.
  - Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in language that specifies who is liable for overpayments that were identified subsequent to the change of ownership, that includes dates of service before the change of ownership).
  - Supply a listing of all of the provider identifiers affected by the change of ownership.

- Providers who join a new group or enroll as an individual must complete and submit a CSHCN Services Program Provider Enrollment Application to request enrollment in the new group.

  Note: *Providers leaving group practices must notify TMHP, in writing, within 90 days of the date of termination. A letter that includes the provider identifier, effective date of termination, and the group's provider identifier must be signed by an authorized representative of the group or the individual provider leaving the group, and mailed to TMHP at the address shown above. Failure to provide this information may lead to administrative action by the Department of State Health Services (DSHS).*

- Physical address—Providers must enroll with Texas Medicaid and obtain a Texas Medicaid provider identifier before applying with the CSHCN Services Program to enroll a new location or provider type. Alternate addresses may be added to an existing enrollment using the Provider Information Change (PIC) form.
- Provider type—Providers must submit a separate CSHCN Services Program Provider Enrollment Application for each provider enrollment type requested. For example, a hospital may want to enroll as an ambulatory surgical center. A second application to enroll in the CSHCN Services Program as an ambulatory surgical center would be required.

New enrollment applications may be completed online or mailed to the address shown above.

2.1.3 Claim Filing

New providers must follow all claims filing procedures while completing the enrollment process. This is particularly important when providing services to CSHCN Services Program clients *before* receiving a CSHCN Services Program provider identifier.

Claims should be submitted without a provider identifier until notified by TMHP of the final enrollment determination. TMHP must receive all claims for services rendered to CSHCN Services Program-eligible clients within the required filing deadlines, regardless of enrollment status. Claims filed while waiting to receive a provider identifier are denied; however, having met the claim filing deadline, a provider can *resubmit* or *appeal* the claims for payment after the CSHCN Services Program provider identifier is assigned. The resubmitted claim may be considered for payment if TMHP receives it within 120 days from the date of the denial and if services were rendered on or after the provider enrollment effective date.

Claims for group providers must include the identifiers for the performing provider as well as for the group. To be eligible for reimbursement, both the group and the performing provider must be enrolled in the CSHCN Services Program.

When a provider renders services to a CSHCN Services Program client before receiving a provider identifier and has questions about this requirement or enrollment, the provider may call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

Refer to: Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

2.1.3.1 Provider Identifiers Terminated After 24 Months of No Claim Activity

Payment denial codes are applied to a Texas Provider Identifier (TPI) that has had no claim activity for a period of 24 months. The provider identifier will be considered inactive and cannot be used to submit claims.

A courtesy letter will be sent to providers whenever a TPI goes 18 months without claims activity. The letter will inform providers that if they want to keep their provider identifier active, they must submit a claim within 6 months of the date of the letter using the TPI referenced in the letter. TMHP will apply a payment denial code to any provider identifier that has had no claims activity within 6 months of the date of the courtesy letter and will notify the provider that the provider identifier has been terminated because the provider has not submitted claims using the TPI for a period of 24 months or more.

If a provider is enrolled in both Medicaid and the CSHCN Services Program, the provider identifiers for both programs will be examined to determine whether any claims activity has occurred. When a provider's TPI is terminated for Traditional Medicaid, the corresponding TPIs for all other Texas state health-care programs will also be terminated.

To have the payment denial code removed from a provider identifier, providers must submit a completed application for the state health-care program in which they wish to enroll, and the application must be approved. The information on this application must match exactly the information currently on the provider's file for the payment denial code to be removed. If the provider has moved to a different address or joined a different group, the payment denial code will not be removed from the old provider identifier. Instead, a new TPI will be issued for the new address or group.

2.1.4 Provider Enrollment Determinations

The CSHCN Services Program may approve, deny, modify, suspend, or terminate a provider's enrollment for the reasons listed in the Texas Administrative Code (TAC), CSHCN Services Program Rules 25§38.6(b)(1) through (2) at www.sos.texas.gov/tac/index.shtml. Before taking action to deny, modify, suspend, or terminate enrollment, the CSHCN Services Program shall give the provider written notice of an opportunity to request an administrative review of the proposed action within 30 days of the notice. If the provider does not respond in writing within the 30-day period, the provider is presumed to have waived the administrative review as well as access to a fair hearing, and the CSHCN Services Program's action is final. If the provider so requests, the CSHCN Services Program will conduct an administrative review of the circumstances of the proposed denial, modification, suspension, or termination of provider program participation is based and give the provider written notice of the program decision and the supporting reasons within 30 days of receipt of the request for administrative review.

In addition, a fair hearing is available to any provider for the resolution of conflict between the CSHCN Services Program and the provider if the fair hearing is requested within 20 days of receipt of the administrative review decision.

Refer to: Chapter 7, "Appeals and Administrative Review."

Providers excluded or terminated by Medicaid will be excluded or terminated by the CSHCN Services Program.

Providers must maintain active enrollment in Medicaid to remain enrolled in the CSHCN Services Program. "Actively enrolled" providers are those that have filed claims for clients of the CSHCN Services Program or Texas Medicaid within the past 24 months, and that do not have any type of payment holds on their enrollment status.

Descriptions of required enrollment forms are provided in the following sections. Forms are available on the TMHP website at www.tmhp.com.

2.1.5 Provider Enrollment Application

2.1.5.1 Types of Providers

There are four types of enrollment for providers in the CSHCN Services Program, as follows:

- *Individual*. This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under the name and social security or federal tax identification number of the individual.

- *Group*. This type of enrollment applies to health-care services provided under the auspices of a legal entity, such as a partnership, corporation, limited liability company, or professional association, where the individuals providing health-care services are required to be certified or licensed in Texas. The enrollment is under the name and federal tax identification number of the legal entity.

  Note: *For any group enrollment application, there must also be at least one enrolling performing provider.*

- *Performing provider*. This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under a group. The enrollment is under the federal tax identification number of the group, and payment is made to the group.

- *Facility*. This type of enrollment applies to situations in which licensure or certification applies to the entity. Although individuals working for, or with, the entity may be licensed or certified in their individual capacity, the enrollment is based on the licensure or certification of the entity. For this reason, facility enrollment does not require enrollment of performing providers. Examples of facilities include hospitals, independent diagnostic testing facilities, ambulatory surgical centers, renal dialysis facilities, and hospices.

2.1.5.2 Provider Information Form (PIF-1), Principal Information Form (PIF-2), and Disclosure of Ownership Form

The following forms must be completed by all providers or the owner, officer, director, or principal applying for CSHCN Services Program enrollment more than one year from their Texas Medicaid enrollment date. A PIF-1 must be completed by all providers enrolling in the CSHCN Services Program. A separate PIF-2 must be completed by each principal of the provider enrolling in the CSHCN Services Program. Principals of the provider include all of the following:

- An owner with a direct or indirect ownership or control interest of five percent or more
- Corporate officers and directors
- Limited or nonlimited partners
- Shareholders of a professional corporation, professional association, limited liability company, or other legally designated entity
- Any employee of the provider who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity

The Disclosure of Ownership form is submitted by all providers, excluding the performing providers of a group. This form provides the appropriate information to enroll the provider as a sole proprietor, corporation, partnership, or nonprofit organization.

These forms were designed across multiple state agencies to help meet the requirements set forth by the 75th Legislature's Senate Bill (S.B.) 30 to enhance the enrollment requirements for potential providers, meet federal requirements for enrollment, and improve the integrity of Texas State healthcare programs.

2.1.5.3 Provider Agreement

To participate in the CSHCN Services Program, all providers must complete a Provider Agreement with DSHS. The Provider Agreement must be signed by the provider applying for enrollment. If applying as a group, the Provider Agreement must be signed by an owner, officer, director, or principal. If the provider is unable to sign, a letter showing Power of Attorney must be attached to the Provider Enrollment Application. By signing the Provider Agreement, the provider agrees to abide by CSHCN Services Program rules, policies, and procedures as a condition for participation. This form is included in the enrollment application.

2.1.5.4 Request for Taxpayer Identification Number and Certification

The Internal Revenue Service (IRS) W-9 form is completed and submitted by all providers, excluding performing providers of a group.

2.1.5.5 Franchise Tax Account Status Page

When enrolling as a "Corporation" type of entity, providers must submit a Franchise Tax Account Status Page. This information can be obtained from the Texas State Comptroller's Office website at https://comptroller.texas.gov/taxes/franchise/.

Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit the Franchise Tax Account Status Page.

2.1.5.6 Clinical Laboratory Improvement Amendments (CLIA) of 1988

To be eligible for reimbursement by the CSHCN Services Program, all providers performing laboratory tests must be CLIA certified.

Refer to: Section 25.1.1, "Clinical Laboratory Improvement Amendments (CLIA) of 1988" in Chapter 25, "Laboratory Services."

2.1.5.7 Provider's License

Evidence of current licensure or certification is required to participate in the CSHCN Services Program. Not abiding by this license and certification requirement will adversely impact a provider's qualification for continued participation in the CSHCN Services Program.

An enrolling provider submits professional license information in the enrollment form. A copy of the license does not need to be sent with the enrollment application for those providers licensed by one of the boards listed below, unless the licensing board experiences technical difficulties and cannot provide the license information to TMHP. TMHP verifies this information with the appropriate licensing board. A provider cannot be enrolled if his or her license is due to expire within 30 days of the date of application.

Once enrolled in the CSHCN Services Program, a reminder letter will be automatically generated and sent to providers whose license will expire in 60 days. The letter will notify providers that they must keep their licensure current to continue their enrollment with Texas state health-care programs. When the license is renewed, providers licensed by the boards listed below will not need to contact TMHP with renewal information as TMHP receives licensure information from these licensing boards.

- Texas Medical Board
- Texas State Board of Dental Examiners

Only licenses for registered nurses (RNs) are auto-renewed. Certified registered nurse anesthetists (CRNAs) must submit a paper copy of their license when it is renewed to maintain a current record.

Providers cannot enroll in the CSHCN Services Program if their license is due to expire within 30 days. During the enrollment process, TMHP verifies licensure using available resources. If TMHP cannot verify a license at the time of enrollment, it is the provider's responsibility to provide a copy of the active license to TMHP. Psychologists and facilities must submit a copy of their license since these licenses cannot be verified online.

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

Once a provider is enrolled in the CSHCN Services Program the license or certification must be kept current. A reminder letter for renewal will be sent to the provider 60 days before the provider's license expires.

TMHP directly obtains licensure information from the following licensing boards:

- Texas Medical Board (TMB) (for physicians only)
- Texas Board of Nursing (BON) (for RNs only, not APRNs)
- Texas State Board of Dental Examiners (TSBDE)

If the licensing board experiences technical difficulties and cannot provide the license information to TMHP, the provider must submit proof of license renewal to TMHP.

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

Refer to: Section 14.2.6.10, "Dental Anesthesia" in Chapter 14, "Dental" for information about dental anesthesia permit levels.

Copies of licenses or certifications should be sent to:

TMHP
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
Fax: 1-512-514-4214

If a provider's license has expired, a termination letter will be sent to the provider, and all claims filed on or after the expiration date will be denied. To have claim payments resumed, providers must renew their licenses, and if necessary, provide proof of the renewal to TMHP. Payment will be considered for dates of service on or after the date of return to active license status.

2.1.6 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Federally qualified health centers (FQHCs), their satellite offices, FQHC look-alikes, and rural health clinics (RHC) can enroll as providers for the Children with Special Health Care Needs (CSHCN) Services Program.

Refer to: Chapter 19, "Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)."

2.1.7 Transplant Specialty Centers

Facilities enrolled in the CSHCN Services Program that perform stem cell or kidney transplants must also be a designated specialty transplant center.

A stem cell transplant facility must be a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). The program or its designee will maintain a current listing of all approved centers.

All renal transplants must be done in a Medicaid-approved, CSHCN Services Program-enrolled transplant center facility that is certified by United Network of Organ Sharing (UNOS). For more information about how to obtain Medicaid approval as a transplant center, contact TMHP at 1-800-925-9126.

2.1.8 Pharmacy Enrollment

The CSHCN Services Program reimburses pharmacies for medications as prescribed by a practitioner licensed to do so if the medication is included in the CSHCN formulary, and if the dispensing pharmacy is an active provider with the Vendor Drug Program (VDP). VDP reimburses pharmacies providing medications to CSHCN clients with the exception of hemophilia blood factor products, which are reimbursed by TMHP. Claims for medications must be submitted to VDP. Pharmacies are reimbursed the same drug costs and dispensing fees allowed by VDP.

Pharmacies must enroll as durable medical equipment (DME) providers to provide expendable medical supplies, standard wheelchairs and other equipment.

Refer to: Chapter 17, "Durable Medical Equipment (DME)" and Chapter 18, "Expendable Medical Supplies" for more information.

2.1.8.1 Immunizations

The administration of immunizations may be a benefit of the CSHCN Services Program and may be provided by a pharmacy or pharmacist. A pharmacist must obtain and provide proof of certification by the American Council on Pharmaceutical Education (ACPE) through the ACPE Certificate Program in Pharmacy-Based Immunization Delivery to enroll in the CSHCN Services Program. The Certificate must be accompanied by written proof of the awardee's current certification in Cardiopulmonary Resuscitation (CPR) or Basic Cardiac Life Support (BCLS). All providers who enroll in the CSHCN Services Program must first be enrolled in Texas Medicaid.

A pharmacy that is certified to administer immunizations and has at least one pharmacist as a performing provider can enroll in the CSHCN Services Program as a group provider.

Refer to: Section 31.2.23, "Immunizations (Vaccines and Toxoids)" in Chapter 31, "Physician" for more information.

2.1.9 Out-of-State Providers

CSHCN Services Program policies and procedures apply for providers who care for program clients outside of Texas. This includes the requirement that providers maintain a corresponding enrollment as Medicaid providers. Out-of-state provider's licensure must be maintained if it is required in the respective state(s). Providers located in Arkansas, Louisiana, New Mexico, or Oklahoma, within 50 miles from the Texas border must be enrolled and are considered in-state providers.

Note: *This section applies only in circumstances requiring the client to travel out-of-state to receive health-care services. The limitations listed below do not apply to out-of-state providers of selected items who deliver their products to a client in Texas and for which the client does not have to travel out of state to receive the products or services (such as medical foods, augmentative communication devices, hearing amplification devices, DME supplies, reference lab services, mail order pharmacies, out of-state interpretations of imaging, electrocardiograms, or other services provided to the client in Texas but sent out-of-state for interpretation).*

Requests for medical services provided by an out-of-state provider more than 50 miles from the Texas state border must be submitted to TMHP at the address provided in Section 2.1 *, "Provider Enrollment" in this chapter.

In unique circumstances, the CSHCN Services Program may approve coverage of services if they are within the scope of the program. The CSHCN Services Program may agree that:

- The out-of-state provider is the provider of choice for quality care.
- The same treatment or another treatment of equal benefit or cost is not available from CSHCN Services Program providers in Texas.
- The out-of-state treatment should result in a decrease in the total projected CSHCN Services Program cost of the client's treatment.
- Medical literature indicates that the out-of-state treatment is accepted medical practice and is expected to improve the client's quality of life.

Refer to: Section 3.1.4, "Services Provided Outside of Texas" in Chapter 3, "Client Benefits and Eligibility."

Section 5.1.8, "Claims Filing Deadlines" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

2.1.10 Substitute Physician

Reimbursement may be made to a physician for CSHCN Services Program-covered services that are provided by another physician who is acting as his or her substitute. Such a substitution arrangement may be either an informal reciprocal arrangement of 14 days or fewer, or a long-term arrangement (up to 90 days) involving per diem or fee-for-time compensation. The arrangement may be extended for a continuous period longer than 90 days if the billing physician's absence is due to being called or ordered to active duty as a member of a reserve component of the Armed Forces.

Substitute physicians are required to enroll with the CSHCN Services Program.

Substitute physicians are also required to enroll with Texas Medicaid before enrolling in the CSHCN Services Program and cannot be on the Texas Medicaid provider exclusion list.

Refer to: Section 31.1.3, "Substitute Physician" in Chapter 31, "Physician."

2.1.11 * Providers of Family Support Services

[Revised] Providers of Family Support Services (e.g., respite care, home and vehicle modification) are enrolled and reimbursed by the CSHCN Services Program. Enrollment applications are available on the CSHCN Services Program website at hhs.texas.gov/providers/health-services-providers/children-special-health-care-needs-services-program/family-support-services. Mail completed enrollment applications to:

CSHCN Services Program—Provider Enrollment
MC-1938
PO Box 149347
Austin, TX 78714-9347
Fax: 1-512-776-7238

2.2 Provider Complaints Process

The CSHCN Services Program takes each provider complaint seriously. Depending on the level and nature of the complaint, the CSHCN Services Program works with the provider to resolve the issue.

The CSHCN Services Program provides due process for resolving all provider complaints. A complaint is defined as any dissatisfaction expressed by telephone or in writing by a provider, or on behalf of a provider, concerning the CSHCN Services Program. The definition of complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction. The definition also does not include a provider's oral or written dissatisfaction with an adverse determination or appeals regarding claim payments and denials.

Procedures governing the provider complaint process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Most complaints are resolved within 30 calendar days. If the complaint cannot be resolved within 30 calendar days, the provider is notified in writing of the status of the complaint. Referrals to other departments, such as Provider Relations or Medical Affairs, are made when appropriate.

The TMHP Complaints Resolution Department handles all provider complaints for the CSHCN Services Program. Providers may submit their complaints by email, telephone, mail, or fax. Providers will receive an acknowledgment letter from TMHP within 5 business days of receipt of the complaint.

Provide the following information when reporting the complaint:

- Point of contact name and phone number or email address
- Provider name
- Provider NPI and TPI, if available

- Description of the complaint situation
- Client name
- Client PCN
- Date of service

Providers and clients can report complaints to TMHP by using the following methods:

- By using the Email Us button on the TMHP Contact web page
- By calling the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 or the TMHP-CSHCN Services Program Client Line at 1-877-888-2350
- In writing to:

TMHP
Complaints Resolution Department
PO Box 204270
Austin, TX 78720-4270

Questions regarding the complaint process or the status of a complaint should be directed to the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

Providers who believe they did not receive due process regarding the complaint from TMHP may submit a request for an administrative review to the CSHCN Services Program in writing or by fax to:

CSHCN Services Program
ATTN: Administrative Review
MC-1938
PO Box 149347
Austin, TX 78714-9347
Fax: 1-512-776-7238 or 512-776-7162

The appeals and administrative review processes are covered in greater detail in the following sections of this manual:

- Chapter 4, "Prior Authorizations and Authorizations"
- Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement"
- Chapter 7, "Appeals and Administrative Review"
- Section 2.1.4, "Provider Enrollment Determinations" in this chapter.

2.3 Provider Responsibilities

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 responsible not only for knowledge of the adopted CSHCN Services Program agency rules published in 25 TAC, Part 1, Chapter 38, 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. TAC rules can be found at www.sos.texas.gov/tac/index.shtml.

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 clients 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, Part 1, §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 clients 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.

2.3.1 Information Change Requests

Providers must promptly advise TMHP Provider Enrollment of address changes (office or accounting), name changes, and federal tax identification number changes. Change information may be communicated in writing to TMHP on the Provider Information Change Form, which is available on the TMHP website. A W-9 is required if the provider is changing the mailing or accounting address by written communication sent to TMHP.

CSHCN Services Program providers are able to make information changes using the Online Provider Lookup (OPL) while logged into the TMHP portal.

The OPL is used primarily by clients to search for providers.

The following functions are available in the OPL:

- Clients are able to search for providers in up to five counties in a single search.
- Doing business as (DBA) names appear for providers or provider groups.
- The default ZIP code radius for provider search is ten miles.
- Providers can indicate practice limitations, such as gender and age of patient.
- Providers can indicate whether or not they are accepting new patients.

The Medicaid and CSHCN Services Program provider agreements require providers to keep their correct physical address on file with TMHP. The physical address is also displayed in the OPL so that clients can locate providers. Providers who practice at multiple locations are required to enroll each location at which health-care services will be rendered. It is important that each location's correct physical address and telephone number are available on the OPL.

Providers should verify that the physical address for their provider identifier is correct on the OPL. Providers can confirm and update the address and other demographic information on the TMHP website at www.tmhp.com. To locate the OPL information, providers can sign into the My Account page and choose the option to Change/verify address information.

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

Refer to: The Affordable Care Act (ACA) Provider Enrollment Frequently Asked Questions on the TMHP website at www.tmhp.com/sites/default/files/file-library/topics/provider-enrollment/provider-enrollment-frequently-asked-questions.pdf for more information on risk category screening requirements.

Providers who have an e-mail address on file with TMHP will receive a confirmation e-mail from TMHP when a physical address has been updated. Providers can make other demographic changes online; however, the form must be printed, signed, and mailed to TMHP, as indicated on the printed copy.

Physical address changes may also be communicated in writing to TMHP on the Provider Information Change Form as noted below.

2.3.2 Required Updates

Certain providers are required to verify and update key demographic information every six months to ensure that their information is correct in the OPL. Affected provider types include physicians, nurses, dentists, and durable medical equipment (DME) providers.

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

2.3.3 General Medical Record Documentation Requirements

TMHP routinely performs a retrospective review of all providers. This review may include comparing services billed to the client's clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client's medical record subjects the associated services to recoupment.

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

Requirement	Mandatory/ Desirable
All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.	Mandatory
Each page of the medical record documents the client's name and CSHCN Services Program client identification number.	Mandatory
Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.	Mandatory
The selection of evaluation and management codes (levels of service) is supported by the client's clinical record documentation. Providers must follow either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services published by CMS, when selecting the level of service provided.	Mandatory
Necessary follow-up visits specify the time of return by at least the week or month.	Mandatory
The history and physical documents the presenting complaint with appropriate subjective and objective information, e.g., medical and surgical history, current medications and supplements, family history, social history, diet, pertinent physical examination measurements and findings, etc.	Mandatory
The services provided are clearly documented in the medical record with all pertinent information regarding the client's condition to substantiate the need for the services.	Mandatory
Medically necessary diagnostic lab and X-ray results are included in the medical record, and abnormal findings include an explicit notation of follow-up plans.	Mandatory
Unresolved problems are noted in the record.	Mandatory
Immunizations are noted in the record as complete or up-to-date.	Mandatory
Personal data includes the parent, guardian, or caretaker's address, employer, home and work telephone numbers, sex, marital status, and emergency contacts.	Desirable

2.3.4 Retention of Records

The provider must maintain and retain all necessary records and claims to fully document the services and supplies provided to a client, for full disclosure to the CSHCN Services Program or its designee. These records and claims must be retained for a period of 5 years from the date of service, until the client's 21st birthday, or until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever occurs last.

Upon request, these records must be made available promptly by submitting copies of such records, at no cost, to TMHP and representatives of the Office of Inspector General (OIG) or DSHS.

If the provider places the required information in records that are in the custody of another legal entity, such as a hospital, the provider is responsible for obtaining a copy of such records at no cost, for use by TMHP and representatives of the Office of Inspector General (OIG) or DSHS during any investigation or study of the appropriateness of the claims submitted by the provider.

2.3.5 Utilization Review: General Provisions

Utilization review activities required by the CSHCN Services Program are accomplished through a series of monitoring systems developed to ensure that services are necessary and of the optimum quality and quantity. Both clients and providers are subject to utilization review monitoring. Utilization review procedures safeguard against unnecessary care and services, monitor quality, and ensure that payments are appropriate according to the payment standards defined by the CSHCN Services Program.

One goal of utilization review is to identify the provider whose practice patterns are not consistent with the CSHCN Services Program requirements and the scope of benefits.

Educating the provider is the principal approach to resolution of inappropriate use. This education must include either a provider representative visit or letter to assist with the technical aspects of the program or a physician visit, telephone call, or letter to explain program guidelines relative to medical necessity, intensity of service, and the appropriateness of the service. The purpose of the letter or the visit is to discuss the inappropriate practices so that the provider may institute measures to remedy the problem.

Depending on the intensity of the identified problem, the letter or visit may result in review of claims before payment. Medical staff develops parameters for prepayment review according to the identified problem. The purpose of the review is to provide additional information enabling the provider to understand the scope of benefits by correlating billing practices and medical policy as billing occurs. As part of the prepayment review process, providers may be required to submit documentation. The documentation is used to ascertain the medical necessity of the services rendered. Prepayment review occurs for a minimum of 6 months. Services not consistent with medical policy are adjudicated in accordance with the established policies.

Recoupment of excess payments for intensity of service not supported by the medical documentation may occur at any phase in the review process.

A provider is removed from prepayment review after achieving compliance with the established medical policy. A follow-up review is performed to monitor continued appropriate utilization of resources.

When the provider is consistently noncompliant with policies, the provider history is provided to the CSHCN Services Program for possible administrative sanctions.

2.3.6 Release of Confidential Information

The *Health Insurance Portability and Accountability Act* (HIPAA) Privacy Regulations are intended to protect individually identifiable health information by restricting disclosure of protected health information (PHI).

Information concerning the diagnosis, evaluation, or treatment of a client by a person licensed or certified to perform the diagnosis, evaluation, or treatment of any medical disorder is normally confidential information that the provider must disclose only to authorized persons. The client's signature is not required on the claim form for payment of a claim; however, TMHP strongly recommends that the provider obtain written authorization from the client before releasing confidential medical information. The client's authorization for release of such information is not required when the release is requested by and made to the CSHCN Services Program or TMHP.

2.3.7 Fraud, Waste, and Abuse

DSHS is responsible for minimizing the opportunity for provider fraud and abuse. DSHS takes appropriate action to protect clients and the CSHCN Services Program when providers of services are suspected of committing fraud, waste, and abuse. DSHS is responsible for establishing criteria to identify cases of possible fraud, waste, and abuse and recouping all overpayments to a provider. Some circumstances may result in referring a provider for legal evaluation and possible prosecution while other circumstances may result in administrative sanctions.

Providers are responsible for the delivery of health-care items and services to CSHCN Services Program clients in full accordance with all applicable licensure and certification requirements, and in full accordance with accepted medical community standards and standards that govern occupations. Such standards include, without limitation, those related to medical record and claims filing practices, documentation requirements, and records maintenance. The requirement to follow all such standards in the CSHCN Services Program is incorporated by reference to the program's requirements, in 1 TAC section 371.1659.

Accepted medical community standards and standards that govern occupations include standards for coding and billing. CSHCN Services Program providers must follow the coding and billing requirements in the *CSHCN Services Program Provider Manual*. However, if coding and billing requirements for the particular service are not addressed in the provider manual, and if coding and billing requirements are not otherwise specified in program policy (such as in the provider bulletins or banner messages), then providers must follow the most current coding guidelines. These include the following:

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

Exception: *NCCI outlines the use of modifiers, some of which are not currently recognized by the CSHCN Services Program.*

Refer to: Section 5.6.2.6, "Modifiers" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

- *Current Dental Terminology* (CDT) as published by the American Dental Association (ADA).
- *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM)
- *Current Diagnostic and Statistical Manual of Mental Disorders*.

To the extent that the above authorities do not conflict with any specific requirement stated in CSHCN Services Program policy, the requirements of these authorities are incorporated by reference into CSHCN Services Program policy. Failure to comply with these authorities may result in a provider or person being found to have engaged in one or more program violations, as identified in this section and also set forth in 1 TAC, Chapter 371.

2.3.8 Provider Certification/Assignment

Providers of the CSHCN Services Program are required to certify compliance with, or agreement to, various provisions of state laws and regulations. Upon submitting a signed claim to TMHP, the provider certifies that the following provisions were upheld:

- Services were personally rendered by the *billing provider* or under the personal supervision of the billing provider.

Exception: *As allowed under substitute physician and telemedicine services rulings.*

Refer to: Section 38.2.2, "Telemedicine Services" in Chapter 38, "Telecommunication Services."

Section 31.1.3, "Substitute Physician" in Chapter 31, "Physician."

- The information contained on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the diagnosis or treatment of the client.
- Medical records document all services billed.
- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees that are charged to private pay clients.
- Services were provided without regard to race, color, sex, national origin, age, disability, political beliefs, or religion.
- Before providing services, providers should always discuss with, and inform clients and their families of their liability for services not a benefit of the CSHCN Services Program.
- The provider of medical care and services files a claim with the CSHCN Services Program, agreeing to accept CSHCN Services Program reimbursement as payment in full for services that are a benefit of the CSHCN Services Program. The CSHCN Services Program client, or others on the client's behalf, must not be billed for amounts above the amount the CSHCN Services Program paid on allowed services, or for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure to follow the appropriate appeal process. The client may be billed for services that are not a CSHCN Services Program benefit.
- The provider understands that endorsing or depositing a CSHCN Services Program check is accepting money from state or federal funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under state or federal laws.

Payment for services is made on behalf of clients to the provider of the service by TMHP in accordance with the limitations and procedures of the program.

If the claim is prepared by a billing service or printed by data processing equipment physically removed from the provider's office, it is permissible to print "Signature on File" in place of the provider's signature. The billing service must obtain and retain a letter on file signed by the provider authorizing the submission of his or her claims. Providers delegating signatory authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment.

2.3.9 Billing Clients

CSHCN Services Program clients, parents, or guardians of children eligible for CSHCN Services Program benefits must not be billed for CSHCN Services Program covered services. CSHCN Services Program providers must agree to accept the CSHCN Services Program allowed amount of payment (regardless of payer) as payment in full for covered services provide to CSHCN Services Program clients. Providers may collect allowable insurance or health maintenance organization co-payment, in accordance with those plan provisions.

CSHCN Services Program providers must agree to accept the CSHCN Services Program allowed amount of payment (regardless of payer) as payment in full for covered services provided to CSHCN Services Program clients. A provider must not require a down payment, bill, or take recourse against an eligible client for a denied or reduced claim for services that are within the amount, duration, and scope of benefits of the CSHCN Services Program when the action is the result of any of the following provider errors:

- Failure to submit a claim, including claims not received by TMHP.
- Failure to submit a complete authorization or prior authorization request, on a program-approved form, within the established deadlines.
- Failure to submit a claim within the 95-day filing deadline.
- Filing an incorrect claim.
- Failure to resubmit a corrected claim or to appeal a claim within the 120-day correction and resubmission period.
- Errors made in claims preparation, claims submission, or in the correction and resubmission (appeal) process.
- Failure to submit a request for Administrative Review to the CSHCN Services Program within 30 days of the date of the resubmission (appeal) denial.

A provider attempting to bill or recover money from a client is in violation of the above conditions and may be subject to termination from the CSHCN Services Program.

A provider may bill the client for:

- Any service that is not a benefit of the CSHCN Services Program, such as obstetrical care.
- All services incurred on noncovered days due to eligibility or inpatient hospital or inpatient rehabilitation day-limitations. Total client liability must be determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered day.

Each provider must furnish services to eligible CSHCN Services Program clients in the same manner, to the same extent, and of the same quality as services provided to other clients. Services made available to other clients must be made available to CSHCN Services Program clients when the services are benefits of the CSHCN Services Program.

Clients must not be billed for the completion of a claim form, even when it is a provider's office policy to do so.

Refer to: Chapter 4, "Prior Authorizations and Authorizations."

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

Chapter 7, "Appeals and Administrative Review."

2.3.10 Credit Balance and Recovery Vendor

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

2.3.11 Texas Family Code Compliance

2.3.11.1 Child Support

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

The law also requires that payments be stopped when notified that the contractor or provider is more than 30 days delinquent in paying child support. CSHCN Services Program payments are placed on hold upon notification that a provider is delinquent in child support payments. A provider application may also be denied or a provider agreement terminated when the provider is delinquent in paying child support.

2.3.11.2 Abuse and Neglect Reporting Requirements

The CSHCN Services Program expects providers to comply with the provisions of state law as set forth in Chapter 261, Texas Family Code, related to the reporting of child abuse and neglect.

Note: *A professional may not delegate to or rely on another person to make the report of abuse or neglect.*

2.4 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.