DIAGNOSTIC RADIOLOGY SERVICES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

FEBRUARY 2023

TEXAS
Health and Human
Services

DIAGNOSTIC RADIOLOGY SERVICES

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16.1 Enrollment

To enroll and be reimbursed for services in the CSHCN Services Program, diagnostic radiology services providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state and federal laws and requirements. Out-of-state radiology providers must meet all of the above conditions and be located in the United States within 50 miles of the Texas state border.

Physicians, dentists, advanced practice registered nurses (APRNs), physician assistants, hospitals, and radiological laboratories are eligible to enroll in Texas Medicaid and to receive reimbursement for CSHCN Services Program diagnostic radiology services that are within the scope of their practice to render.

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

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

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

16.2 Benefits, Limitations, and Authorization Requirements

16.2.1 Diagnostic Radiology Services Provided by Hospitals

When submitting claims for services provided in an inpatient or outpatient hospital setting, radiologists may be reimbursed only for the interpretation. All medically necessary diagnostic radiology services provided to hospital inpatients must be ordered by the client's attending or consulting physician. Additionally, the medical necessity must be documented in the client's medical record.

16.2.2 Diagnostic Radiology Services Provided by Physicians, Advanced Practice Registered Nurses (APRNs), Physician Assistants, and Clinics

In compliance with Health and Human Services (HHS) regulations, physicians, APRNs, physician assistants, and clinics may not submit claims for diagnostic radiology services provided outside of their offices. These services must be submitted directly by the facility or provider that performs the service. This regulation does not affect services performed by the physician or others under his or her personal supervision in the physician's office.

For services provided by physicians in their offices or clinics, providers may submit total or technical components, as applicable, for procedures that were performed using equipment owned by that physician and located in that physician's office. The technical component is denied when submitted by a physician in the inpatient or outpatient hospital setting. If the physician is a member of a clinic that owns and operates radiology facilities, the physician may submit these services. However, if the physician practices independently and shares space in a medical complex where radiology facilities are located, the physician may not submit these services even if he or she owns or shares ownership of the facility unless he or she personally supervises and is responsible for the daily operation of the facilities.

If a physician owns equipment and performs studies in his or her office, but has a radiologist come to the office to perform the interpretations, the physician may submit all services connected with the study and may reimburse the radiologist for an interpretation or the physician may submit the technical component and allow the interpreting physician to submit the interpretation separately. A separate charge for radiology interpretation submitted by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician's overall work-up and treatment of the client. Providers who perform the technical service and interpretation must submit the total component. Providers who perform only the technical service must submit the technical component. Providers who perform only the interpretation must submit the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure submitted with the same date of service, for the same client, any provider, are denied.

Claims are considered for reimbursement based on the order in which they are received. For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure submitted with the same dates of service for the same client by any provider, the claim for the total component is denied. The same is true if a total component has already been paid and claims are received for the individual components.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be reimbursed if a radiologist is not submitting the interpretation component of radiology procedures.

If duplicate submissions are found between a radiologist and other specialties, the radiologist's claim is considered for reimbursement and the other providers' claims are denied.

Note: *For the purposes of this chapter, "APRN" includes nurse practitioner and clinical nurse specialist providers only.*

16.2.3 Cardiac Blood Pool Imaging

Procedure codes 78472, 78473, 78481, 78483, 78494, and 78496 for cardiac blood pool imaging services are benefits of the CSHCN Services Program.

16.2.4 Computed Tomography (CT) Scan

CT imaging may be reimbursed by the CSHCN Services Program using the following procedure codes:

Procedure Codes									
70450	70460	70470	70480	70481	70482	70486	70487	70488	70490
70491	70492	70496	70498	71250	71260	71270	71275	72125	72126
72127	72128	72129	72130	72131	72132	72133	72191	72192	72193
72194	73200	73201	73202	73206	73700	73701	73702	73706	74150
74160	74170	74174	74175	74176	74177	74178	75571	75572	75573
75574	75635	76376	76377	76380	77011				

Prior authorization is not required for up to four CT imaging procedures per year.

Prior authorization will be considered for any additional CT procedures with documentation of a severe or life-threatening medical condition that requires close monitoring with CT imaging to determine appropriate treatment, and that without such monitoring and treatment, the condition could progress to severe disability or death.

Prior authorization requests for CT scans that exceed four per client, per rolling year must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request form and must include documentation of medical necessity for the procedure.

Medical necessity for CT scans includes, but is not limited to, clients with any of the following:

- Ventriculoperitoneal shunt
- Routine postoperative follow-up of ventriculoperitoneal shunt
- Congenital anomaly or deformity
- Suspected fracture when plain film is inconclusive
- Hydrocephalus
- Epilepsy
- Other neurological symptoms
- Craniofacial malformation
- Primary or metastatic cancer
- Known or suspected primary tumor (malignant or nonmalignant)
- Tumor staging
- Progressively severe symptoms despite conservative management

Note: *The American College of Radiology Practice Guidelines for CT scans may be used as a reference for specific indications.*

Documentation of medical necessity, including the specific rationale for the requested procedure, must be maintained in the client's medical record.

CT scan procedure codes are subject to National Correct Coding Initiative (NCCI) relationships with the following exceptions.

The procedure codes in Column A of the following table will be denied if they are billed with the procedure codes in Column B:

Column A (Denied)	Column B
70450	70460
70450, 70460	70470
70480	70481
70480, 70481	70482
70486	70487
70486, 70487	70488
70490	70491
70490, 70491	70492
76376, 76377	70496, 70498, 71275, 72191, 73206, 73706, 74175
71250, 76380	71260
71250, 71260	71270

Column A (Denied)	Column B
72125	72126
72125, 72126	72127
72128	72129
72128, 72129	72130
72131	72132
72131, 72132	72133
72192	72193
72192, 72193	72194
73200	73201
73200, 73201	73202
73700	73701
73700, 73701	73702
76380	74150
74150, 76380	74160
74150, 74160, 76380	74170
76376	76377
76380	77011
70480, 70481, 70482	70450, 70460, 70470

16.2.5 Contrast Material

Radiological procedures that specify *with contrast* include payment for high osmolar, low osmolar, and paramagnetic contrast material. No additional payment is made for contrast material.

16.2.6 Magnetic Resonance Angiography (MRA)

MRA procedures of the head and neck, chest, abdomen, pelvis, and the lower extremities are benefits for CSHCN Services Program clients. The use of MRA in some areas of the body (spinal canal and upper extremities) is considered investigational and is not a benefit of the CSHCN Services Program. The CSHCN Services Program may reimburse either an MRA or a conventional angiography but not both in the same day without documentation of medical necessity for both tests.

Region	Procedure Code(s)	Benefits and Limitations
Head or Neck	70544, 70545, 70546, 70547, 70548, 70549	An MRA of the head or neck is a benefit when indicated and used to visualize or rule out cerebrovascular disease, subarachnoid and intracerebral hemorrhage, and occlusion or stenosis of intracranial vessels.
Chest	71555	An MRA of the chest is a benefit when performed to evaluate coronary artery disease or anomalous arteriopulmonary systems and to identify thoracic aneurysms or pulmonary embolisms in cases when contrast material is contraindicated. MRAs are also benefits for evaluating the coronary vessels in coronary artery disease, vasculitis, or vessel patency postoperatively. An MRA of the chest is a benefit when used to diagnose a pulmonary embolism only when the client has a documented allergy to iodinated contrast material.

Region	Procedure Code(s)	Benefits and Limitations
Abdomen	74185	An MRA of the abdomen is a benefit when used to assess the main renal arteries for the evaluation of renal artery stenosis, abdominal aortic aneurysm or dissection, and associated occlusive disease.
Pelvis	72198	An MRA of the pelvis is a benefit when performed to evaluate pelvic arteries for stenosis and for the detection, grading, and differentiation of renovascular disease.
Lower Extremities	73725	An MRA of the lower extremities is a benefit when indicated for the evaluation of peripheral vascular disease related to the lower extremities, such as hemangioma, atherosclerosis, arterial embolism and thrombosis, and arterial anomalies.

If an MRA and a conventional angiography are performed on the same day, the documentation of medical necessity must indicate that a conventional angiography did not identify a viable run off vessel for bypass, that MRA results were inconclusive, or other medical necessity documentation.

16.2.6.1 MRA Authorization Requirements

Authorization is not required for MRA services.

16.2.7 Magnetic Resonance Imaging (MRI)

MRI, including functional MRI and intraoperative MRI, is a benefit of the CSHCN Services Program.

The CSHCN Services Program considers functional MRI (fMRI) medically necessary when it is being used as a part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, and which might potentially be put at risk during the proposed surgery.

Indications for intracranial neurosurgical procedures using intraoperative MRI (iMRI) include, but are not limited to, the following:

- Oncologic neurosurgical procedures
- Epilepsy
- Chiari surgery
- Deep-brain stimulators

The following procedure codes may be used to bill MRI procedures:

Procedure Codes									
70336	70540	70542	70543	70551	70552	70553	70554	70555	70557
70558	70559	71550	71551	71552	72141	72142	72146	72147	72148
72149	72156	72157	72158	72195	72196	72197	73218	73219	73220
73221	73222	73223	73718	73719	73720	73721	73722	73723	74181
74182	74183	75557	75559	75561	75563	75565	76376	76377	77046
77047	77048	77049	77084						

16.2.7.1 MRI Authorization Requirements

Authorization is not required for up to four MRI procedures per rolling year.

Prior authorization will be considered for any additional MRI procedures with documentation of a severe or life-threatening medical condition that:

- Requires close monitoring with MRI to determine appropriate treatment.
- Could progress to severe disability or death without such monitoring or treatment.

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

16.2.7.2 MRI Benefits and Limitations

Procedure codes 75559 or 75563 must be billed in conjunction with stress testing procedure codes 93015, 93016, 93017, or 93018.

MRI procedure codes are subject to NCCI relationships with the following exceptions.

The following procedure codes in Column A will be denied when billed with the same date of service by the same provider as the procedure codes in Column B

Column A (Denied)	Column B
01922, 76350, 77021	70557
01922, 36000, 36005, 36406, 36410, 70557, 76000, 76350, 76942, 77002, 77021, 96360, 96365, 96372, 96374, 96375	70558
01922, 36000, 36005, 36406, 36410, 70557, 70558, 76000, 76350, 76942, 77002, 77021, 96360, 96365, 96372, 96374, 96375	70559
01922, 76350	71550, 74181
01922, 36000, 36005, 36011, 36406, 36410, 71550, 71551, 76000, 76350, 76942, 77002, 96360, 96365, 96372, 96374, 96375	71552
01922, 36000, 36005, 36011, 36406, 36410, 74181, 76000, 76350, 76942, 77002, 96360, 96365, 96372, 96374, 96375	74182
01922, 36000, 36005, 36011, 36406, 36410, 74181, 74182, 76000, 76350, 76942, 77002, 96360, 96365, 96372, 96374, 96375	74183

16.2.8 Mammography Certification

DSHS issues mammography certification to providers who render mammography services. Providers can submit this certification to the TMHP Provider Enrollment Department in lieu of certification issued by the Food and Drug Administration (FDA) because the FDA recognizes the DSHS certification. TMHP will continue to accept mammography certification issued by the FDA.

Providers are reminded to check the expiration date of their certification and submit an updated mammography certification prior to its expiration date. Mail or fax certifications to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
Fax: 1-512-514-4214

16.2.9 Positron Emission Tomography (PET)

The CSHCN Services Program may reimburse for PET scans (procedure codes 78608, 78811, 78812, 78813, 78815, and 78816) in the office, inpatient hospital, or outpatient hospital setting when they are used to map an epileptogenic focus prior to surgical treatment of a seizure disorder.

Procedure code 78608 must be submitted with one of the following diagnosis codes:

Diagnosis Codes					
G249	G40201	G40209	G40211	G40219	R569

Procedure codes 78811, 78812, 78813, 78815, and 78816 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
C000	C001	C003	C004	C005	C006	C008	C430
C43111	C43112	C43121	C43122	C4321	C4322	C4330	C4331
C4339	C434	C4351	C4352	C4359	C4361	C4362	C4371
C4372	C438	C439	C4400	C4409	C441021	C441022	C441091
C441092	C441121	C441122	C441191	C441192	C441221	C441222	C441291
C441292	C441921	C441922	C441991	C441992	C44202	C44209	C44292
C44299	C44301	C44309	C44390	C44391	C44399	C4440	C4449
C44500	C44501	C44509	C44590	C44591	C44599	C44602	C44609
C44692	C44699	C44702	C44709	C44792	C44799	C4480	C4489
C4490	C4499	C518	C6201	C6202	C6210	C6291	C6292
C710	C711	C712	C713	C714	C715	C716	C717
C718	C719	C7641	C7642	C792	C7931	D030	D03111
D03112	D03121	D03122	D0321	D0322	D0330	D0339	D034
D0351	D0352	D0359	D0361	D0362	D0371	D0372	D038
D039	D4011	D4012	D430	D431	D432		

In addition to the diagnosis codes listed above, procedure codes 78813 and 78815 may also be considered for reimbursement with the following diagnosis codes:

Diagnosis Codes							
C4000	C4001	C4002	C4010	C4011	C4012	C4020	C4021
C4022	C4030	C4031	C4032	C4080	C4081	C4082	C4090
C4091	C4092	C410	C411	C412	C413	C414	C419

Note: *Other diagnoses may be considered on a case-by-case basis through prior authorization after review by the CSHCN Services Program Medical Director or a designee.*

16.2.10 X-ray and Ultrasound Procedures

Radiology services include, but are not limited to, diagnostic imagining and interventional radiological procedures.

16.2.10.1 * Diagnostic Imaging

The following procedure codes for diagnostic imaging may be considered for reimbursement by the CSHCN Services Program:

[Revised] Procedure Codes					
70030	76831	76881	76882	76883	93980

The following procedure codes for contrast material may be considered for reimbursement when used during an echocardiography.

Procedure Codes		
Q9950	Q9956	Q9957

Procedure codes Q9950, Q9956, or Q9957 must be billed in conjunction with procedure code 93306.

16.2.10.2 Interventional Radiological Procedures

Interventional radiological procedures employ image guidance methods to gain access to deep soft tissue and organs.

The following procedure codes for interventional radiological procedures may be considered for reimbursement by the CSHCN Services Program:

Procedure Codes					
74235	75956	75957	75958	75959	76937

Physicians may be reimbursed for only the professional interpretation component of procedure codes 75956, 75957, 75958, and 75959.

Procedure code 75956 may be reimbursed when it is billed in conjunction with procedure code 33880.

Procedure code 75957 may be reimbursed when it is billed in conjunction with procedure code 33881.

Procedure code 75958 may be reimbursed when it is billed in conjunction with procedure code 33883.

Note: *Procedure code 33884 may be reimbursed when it is billed in conjunction with procedure code 33883 on the same day, by the same provider. Therefore, if procedure code 75958 is rendered with procedure code 33884, procedure codes 33884 and 33883 must be billed to prevent denial of the claim.*

Procedure code 75959 may be reimbursed when it is billed in conjunction with procedure code 33886.

Procedure code 76937 is an add-on code and must be billed in conjunction with the appropriate primary procedure, on the same day, by the same provider.

16.2.10.3 Abdominal Flat Plates (AFPs) and Kidney, Ureter, and Bladder (KUB)

The following procedure codes for AFPs and KUB procedures are included in the cost of the more complicated X-ray and will not be reimbursed separately:

Procedure Codes		
74000	74010	74020

Exception: *The AFP and KUB procedures may be reimbursed separately if documentation is submitted with the claim that indicates that the results of these X-rays required more complicated X-rays.*

16.2.10.4 Reimbursement Information

The CSHCN Services Program may reimburse the facility/provider that performs the X-ray or ultrasound service. Physicians, group practices, and clinics are not reimbursed for radiology services that are provided outside their offices.

Physicians may be reimbursed for the total component for radiology and ultrasound services that are rendered in the office using equipment owned by the physician.

Separate charges for injectable radioactive materials may be reimbursed.

X-ray and ultrasound procedure codes are subject to NCCI relationships with the following exceptions. The procedure codes in Column A of the following table will be denied if they are billed with the same date of service by the same provider as the procedure codes in Column B:

Column A (Denied)	Column B
75958	75956, 75957

16.2.10.5 X-ray and Ultrasound Prior Authorization Requirements

Procedure code 93980 requires prior authorization.

Documentation for procedure code 93980 must include at least one of the following:

- An occurrence of trauma
- Signs and symptoms of a vascular occlusion, which includes, but is not limited to, pain, discoloration, or abnormal visualization of penile area
- Evaluation success of surgical treatment of Peyronie's disease

16.2.11 Noncovered Services

The following services are included in other services and will not be reimbursed separately by the CSHCN Services Program:

- Intraoperative ultrasonic guidance is considered a part of a surgical procedure and will not be reimbursed separately.
- The attending or consulting physician will not be reimbursed for an interpretation that is billed with the same date of service for the same client as an interpretation that is billed by the radiologist. The attending or consulting physician's interpretation is included in the reimbursement for the client workup and will not be reimbursed separately.
- Oral preparations for X-rays are included in the charge for the X-ray and will not be reimbursed separately.

The following services are not benefits of the CSHCN Services Program:

- Portable X-ray services
- Baseline screening and comparison studies
- Infertility and obstetrical services

16.3 Claims Information

Claims for diagnostic radiology services must include the referring provider. Radiologists are required to identify the referring provider by full name and address or NPI in Block 17 of the CMS-1500 paper claim form.

Diagnostic radiology services must be submitted to TMHP in an approved electronic format on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms and UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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

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

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

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

Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper UB-04 CMS-1450 claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

If the client is admitted as an inpatient within 24 hours of treatment in the emergency room or clinic, the emergency room or clinic charges must be billed on the UB-04 CMS-1450 paper claim form as an ancillary charge. Hospitals are not required to submit itemized charge tickets with their UB-04 CMS-1450 paper claim forms for inpatient stays, but a description including the location and the number of views must be provided or the applicable HCPCS code may be provided.

Professional services provided by a physician must be billed separately by the physician. The NPI of the ordering physician must be in Block 78-79. The itemized charges must be retained by the facility for at least 5 years from the date of service.

16.4 Reimbursement

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

APRN and physician assistant providers may be reimbursed for the technical component for radiology and ultrasound services that are rendered in the office setting using equipment owned by the APRN or physician assistant provider at the lower of the billed amount or 85 percent of the amount reimbursed to physicians for the same service by Texas Medicaid.

When submitting claims for services provided in an inpatient or outpatient hospital setting, radiologists may be reimbursed only for the interpretation.

Hospital inpatient services may be reimbursed at 80 percent of the rate authorized by *Tax Equity and Fiscal Responsibility Act* of 1982 (TEFRA), which is equivalent to the hospital's Medicaid interim rate.

Outpatient imaging services rendered by outpatient hospital providers may be reimbursed at a flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code.

Reimbursement of the separate technical and interpretation components cannot exceed reimbursement for the total component.

For MRA, MRI, and PET imaging services, providers may be reimbursed according to the following reimbursement methodology:

- MRA services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- For MRI services, both professional and radiological services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- For PET services, physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid, and outpatient facilities may be reimbursed at a flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code.

For X-ray and ultrasound services, providers may be reimbursed according to the following reimbursement methodology:

- Physicians may be reimbursed at the lower of the billed amount or the amount allowed by Texas Medicaid.
- APRN and physician assistant providers may be reimbursed at the lower of the billed amount or 85 percent of the amount reimbursed to physicians for the same service by Texas Medicaid.
- Outpatient facilities are reimbursed at a flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code.

  Refer to: Section 24.6.2.1, "Revenue Code and Procedure Code Requirements for All Outpatient Services" in Chapter 24, "Hospital" for information about the revenue code and procedure code claim requirements for outpatient services.

- Inpatient facilities are reimbursed at 80 percent of the rate allowed by TEFRA. Reimbursement of the separate components, technical and interpretation, will not exceed the reimbursement for the total component.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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

16.4.1 One-day Payment Window Reimbursement Guidelines

According to the one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within 1 day of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

The one-day payment window reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

Refer to: Section 24.3.7, "Payment Window Reimbursement Guidelines" in Chapter 24, "Hospital" for additional information about the one-day payment window reimbursement guidelines.

16.5 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.