Expendable Medical Supplies

CSHCN Services Program Provider Manual

July 2025

TEXAS
Health and Human
Services

EXPENDABLE MEDICAL SUPPLIES

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18.1 Enrollment

To enroll in the CSHCN Services Program, providers of expendable medical supplies must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state expendable medical supplies providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border. Providers located more than 50 miles from the Texas border will be considered for approval by the Department of State Health Services (DSHS).

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.

18.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program provides benefits for expendable medical supplies for eligible clients. Expendable is defined as being intended for single or short-term use and is typically discarded after use.

An expendable medical supply is defined as an item necessary to carry out a medical procedure or to maintain the client's health at home.

Some supplies, including, but not limited to, straight catheters, may be cleaned and reused. Supplies are a benefit only for those clients residing at home.

Expendable medical supplies are limited to a quantity used by the typical client.

Prior authorization is required when the request exceeds the limitations listed in the tables below for a client with exceptional needs. Documentation of medical necessity is required and must support the need for the additional quantities. The following tables provide listings of these supplies and limitation amounts.

Providers must fill out all sections of the prior authorization form. Providers should refer to the Instructions page for each request form.

Prior authorization and authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically-signed documents must

have an electronic date on the same page as the signature, Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable. All electronically-signed transactions and electronically-signed documents must be kept in the client's medical record. Prescribing and dispensing providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules. Providers who submit a prior authorization and authorization request must also attest that electronic signatures included in the request are true and correct to the best of their knowledge. A hard copy of electronic transactions and signed documents must be available upon request. Stamped signatures and images of wet signatures will not be accepted. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization and authorization forms and supporting documentation using electronic or wet signatures.

To complete the prior authorization process by paper, the provider must fax or mail the completed Prior Authorization Request form and retain a copy of the signed and dated form in the client's medical record.

To complete the prior authorization process electronically, the provider must complete the Prior Authorization Request form requirements through any approved electronic methods and retain a copy of the signed and dated form in the client's medical record.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity for the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record.

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

Appropriate limitations for miscellaneous procedure codes B9998 and T1999 and procedure code A9273, are determined on a case-by-case basis through prior authorization.

Note: *Products that are a form of nutritional intake requested using procedure code B9998 will be considered with medical nutritional products.*

18.2.1 Incontinence Supplies

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
A4310	2 per month	A4311	2 per month	A4312	2 per month
A4313	2 per month	A4314	2 per month	A4315	2 per month
A4316	2 per month	A4320	15 per month	A4322	30 per month
A4326	40 per month^	A4327	4 per month	A4328	4 per month
A4330	As needed	A4335	2 per month	A4338	2 per month
A4340	2 per month	A4344	2 per month	A4346	2 per month
A4349	40 per month^	A4351**	150 per month	A4352	150 per month
A4353	150 per month	A4354	2 per month	A4355	2 per month
A4356	2 per month	A4357	2 per month	A4358	2 per month
A4361	As needed	A4362	As needed	A4363	As needed
A4364	As needed	A4367	As needed	A4368	As needed

***Any combination of diapers, pull-ups, briefs, or liners limited to a maximum of 240 per month without requiring prior authorization.**
**** Modifier SC must be submitted when billing for a hydrophilic catheter.**
^ 40 per month of any combination of A4326 and A4349.

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
A4369	As needed	A4371	As needed	A4372	As needed
A4373	As needed	A4375	As needed	A4376	As needed
A4377	As needed	A4378	As needed	A4379	As needed
A4380	As needed	A4381	As needed	A4382	As needed
A4383	As needed	A4384	As needed	A4385	As needed
A4387	As needed	A4388	As needed	A4389	As needed
A4390	As needed	A4391	As needed	A4392	As needed
A4393	As needed	A4394	As needed	A4395	As needed
A4396	1 per day	A4398	As needed	A4399	1 per day
A4400	As needed	A4402	4 per month	A4404	As needed
A4405	As needed	A4406	As needed	A4407	As needed
A4408	As needed	A4409	As needed	A4410	As needed
A4411	As needed	A4412	As needed	A4413	As needed
A4414	As needed	A4415	As needed	A4421	As needed
A4422	As needed	A4436	1 per month	A4437	1 per month
A4554	120 per month	A4927	1 per month	A5051	As needed
A5052	As needed	A5053	As needed	A5054	As needed
A5055	As needed	A5056	As needed	A5057	As needed
A5061	As needed	A5062	As needed	A5063	As needed
A5071	As needed	A5072	As needed	A5073	As needed
A5081	As needed	A5082	As needed	A5083	As needed
A5093	As needed	A5102	2 per month	A5105	4 per year
A5112	2 per month	A5113	2 per month	A5114	2 per month
A5120	50 per month	A5121	As needed	A5122	As needed
A5126	As needed	A5131	1 per month	A5200	2 per month
T1999	As needed (Prior Authorization required)	T4521	Limited per policy*	T4522	Limited per policy*
T4523	Limited per policy*	T4524	Limited per policy*	T4525	Limited per policy*
T4526	Limited per policy*	T4527	Limited per policy*	T4528	Limited per policy*
T4529	Limited per policy*	T4530	Limited per policy*	T4531	Limited per policy*
T4532	Limited per policy*	T4533	Limited per policy*	T4534	Limited per policy*
T4535	Limited per policy*	T4537	As needed	T4540	As needed

***Any combination of diapers, pull-ups, briefs, or liners limited to a maximum of 240 per month without requiring prior authorization.**
**** Modifier SC must be submitted when billing for a hydrophilic catheter.**
^ 40 per month of any combination of A4326 and A4349.

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
T4541	120 per month	T4542	120 per month	T4543	Limited per policy*
T4544	Limited per policy*	T4543			

***Any combination of diapers, pull-ups, briefs, or liners limited to a maximum of 240 per month without requiring prior authorization.**
**** Modifier SC must be submitted when billing for a hydrophilic catheter.**
^ 40 per month of any combination of A4326 and A4349.

18.2.2 Wound Care Supplies

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
A4213	As needed	A4216	As needed	A4217	10 per month
A4244	4 per month	A4246	4 per month	A4247	6 per month
A4248	As needed	A4305	As needed	A4306	As needed
A4331	2 per month	A4332	50 per month	A4333	2 per month
A4334	2 per month	A4366	As needed	A4416	As needed
A4417	As needed	A4419	As needed	A4423	As needed
A4424	As needed	A4425	As needed	A4426	As needed
A4427	As needed	A4429	As needed	A4430	As needed
A4431	As needed	A4432	As needed	A4433	As needed
A4434	As needed	A4435	As needed	A4450	100 per month
A4452	100 per month	A4455	4 per month	A4456	60 per month
A4554	120 per month	A6010	As needed	A6011	As needed
A6021	As needed	A6022	As needed	A6023	As needed
A6024	As needed	A6025	As needed	A6154	As needed
A6197	As needed	A6197	As needed	A6198	As needed
A6199	As needed	A6203	As needed	A6204	As needed
A6205	As needed	A6210	As needed	A6211	As needed
A6214	As needed	A6215	As needed	A6217	As needed
A6218	As needed	A6220	As needed	A6221	As needed
A6228	As needed	A6229	As needed	A6230	As needed
A6234	As needed	A6235	As needed	A6236	As needed
A6238	As needed	A6239	As needed	A6240	As needed
A6241	As needed	A6242	As needed	A6248	As needed
A6250	2 per month	A6251	As needed	A6252	As needed
A6253	As needed	A6254	As needed	A6255	As needed
A6256	As needed	A6258	30 per month	A6259	15 per month
A6260	As needed	A6261	As needed	A6262	As needed
A6403	As needed	A6404	As needed	A6407	As needed
A6410	As needed	A6411	As needed	A6412	As needed
A6441	As needed	A6442	As needed	A6443	As needed

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
A6444	As needed	A6445	As needed	A6446	As needed
A6447	As needed	A6448	As needed	A6449	As needed
A6450	As needed	A6451	As needed	A6452	As needed
A6453	As needed	A6454	As needed	A6455	As needed
A6456	As needed	A6550	15 per month	A9273	As needed (Prior Authorization required)

18.2.3 Examples of Covered Supplies

The following categories of medical supplies are a benefit of the CSHCN Services Program. This list is not all-inclusive:

- *Incontinence supplies*, including, but not limited to, diapers, briefs, pull-ups, liners, urinary catheters, gloves, lubricants, skin disinfectants, ostomy and catheterization supplies, pouches, wafers, cleaning solutions, catheters, and syringes.
- *Feeding supplies*, including, but not limited to, feeding bags for pumps, tubing, nasogastric tubes, syringes, nonobturated gastrostomy tubes, and low profile nonobturated gastrostomy devices (also known as gastrostomy button). Nonobturated gastrostomy tubes and nonobturated low profile gastrostomy devices are limited to two per year. (Enteral feeding pumps are considered durable medical equipment [DME].)
- *Wound care supplies*, including, but not limited to, dressings, tape, bandages, masks, eye patches, and ace wraps.
- *Diabetic care*, such as testing supplies and lancets. (Glucose monitors are considered DME.)
- *Miscellaneous supplies* used in the treatment of a medical condition.

Refer to: Chapter 15, "Diabetic Equipment and Supplies" for more detailed information.

Chapter 17, "Durable Medical Equipment (DME)" for more detailed information.

Chapter 36, "Respiratory Equipment and Supplies" for more detailed information.

Articles of daily living are not a benefit of the CSHCN Services Program.

18.2.4 Diapers, Briefs, Pull-ups, and Liners

Diapers, briefs, pull-ups, or liners in any combination may be covered for clients who are 4 years of age and older who are incontinent as a direct result of a medical condition. Diapers, briefs, pull-ups, or liners do not require prior authorization up to a combined total of 240 items per month.

Fax transmittal confirmations are not accepted as proof of timely prior authorization submissions.

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

18.2.4.1 Gastrostomy Devices

The CSHCN Services Program may reimburse providers for gastrostomy devices when prescribed by a physician.

18.2.4.1.1 Authorization Requirements

Four gastrostomy tubes will be allowed per client, per rolling year, without prior authorization only when prescribed by a physician.

Prior authorization is required when more than four gastrostomy or jejunostomy tubes are requested in a rolling year. This will allow for two gastrostomy or jejunostomy tubes and two for back up.

When requesting prior authorization, providers must submit documentation supporting medical necessity that includes, but is not limited to:

- A failure of the tube.
- An infection at gastrostomy site.
- The need for an extra tube to have on hand in case of dislodgement.

The following procedure codes must be used to submit claims for gastrostomy devices:

Procedure Code	Maximum Limitations
B4034	31 per month
B4035	31 per month
B4036	31 per month
B4081	As needed
B4082	As needed
B4083	As needed
B4087	4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier
B4088	4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier
B9998	As needed (Prior Authorization required)
B9998 with modifier U1	4 per month
B9998 with modifier U2	4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier
B9998 with modifier U3	4 per month, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier
B9998 with modifier U4	4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier
B9998 with modifier U5	4 per month, any combination of B9998 with U3 modifier, B9998 with U5 modifier

Providers may not bill a quantity greater than the number of days in the month for which they are submitting a claim. Claims with a quantity greater than the number of days in that month may be subject to a recoupment.

Refer to: Section 4.3, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization requirements.

Section 31.2.21, "Gastrostomy Devices" in Chapter 31, "Physician" for information related to gastrostomy tube devices.

18.3 Claims Information

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

Home health DME providers must use benefit code DM3 on all claims and authorization and prior authorization requests. All other providers must use benefit code CSN on all claims and authorization and prior authorization requests.

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

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

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

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

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

18.4 Reimbursement

Expendable medical supplies may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Supplies may be reimbursed using the appropriate HCPCS codes. The CSHCN Services Program requires the provider to submit an itemized claim form for supplies for reimbursement.

Reimbursement for miscellaneous procedure codes B9998 and T1999 is determined by prior authorization based on one of the following:

- The average wholesale price (AWP) less 10.5 percent, or the manufacturer's suggested retail price (MSRP) less 18 percent, whichever is applicable
- The provider's documented invoice cost

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

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/resources/rate-and-code-updates/rate-changes.

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

18.5 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.