Children with Special Health Care Needs Services Program

Provider Manual

September 2015

TEXAS Department of State Health Services

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Contents

Introduction

1.1 Program History

The Children with Special Health Care Needs (CSHCN) Services Program is the oldest governmentally-administered continuous medical assistance program in Texas for low-income children with special health-care needs and people of any age with cystic fibrosis. In 1933, state legislative action initiated funding two years in advance of the first federal initiative, Title V of the *Social Security Act*.

The program currently receives part of its funding from Title V, and aligns its services with Title V objectives, such as:

- Promoting partnerships between families and providers.
- Ensuring that all children get services in the context of the medical home.
- Organizing services so that they are easy for families to access.
- Promoting the provision of services that help youth transition to adulthood.

1.2 About the Provider Manual

The *CSHCN Services Program Provider Manual* contains policy information about the program. This edition of the *CSHCN Services Program Provider Manual* supersedes all previous editions. Read this manual carefully.

The *CSHCN Services Program Provider Manual* is intended primarily for those providers who submit claims to the Texas Medicaid & Healthcare Partnership (TMHP); however, information is also provided for services reimbursed by the Vendor Drug Program and the Medical Transportation Program.

The *CSHCN Services Program Provider Manual* contains information to help providers submit and correct first-time claims in the Computerized Medicaid Claims Processing Assessment System, COMPASS21. This will help providers minimize resubmissions and appeals and help conserve their own and the Program's resources.

The TMHP website at www.tmhp.com supplements the information in this manual. The website contains:

- Enrollment information.
- Forums, polls, and questionnaires.
- Complete instructions for setting up a Provider Administrator account.
- Publications (e.g., manuals and bulletins).
- Directory of regional provider relations representatives.
- TexMedConnect.
- Provider education information (e.g., computer-based training, live workshops, radio broadcasts, webinars, etc.).

Advanced features are available for those who create a provider administrator account. All enrolled providers are eligible for this free account. Once an account is activated, providers will have access to:

- Online provider enrollment.
- Online Fee Lookup (OFL).
- Claim status inquiries (CSIs).
- Eligibility verification.
- Electronic Remittance and Status Reports.
- Claim and appeal submissions.
- Payment amounts search, view, and print capabilities.

- Notification of an invalid address on file for any Texas Provider Identifier (TPI) associated with a provider's National Provider Identifier (NPI).
- Notification of pending payments because of inaccurate or incomplete provider information.

Important: *Natural disasters, such as floods or hurricanes, can impact the delivery of health care to CSHCN Services Program clients. When disaster strikes, providers should monitor the TMHP website for special instructions.*

New provider services continue to be added to the website. Visit the TMHP website at www.tmhp.com or call the Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638 for the latest information about online services.

The CSHCN Services Program Provider Manual is the providers' principal source of information about the CSHCN Services Program. The manual is regularly updated to reflect the most recent policy and procedure changes. Updates are generally available the month following the effective date of the change. For advanced notification of upcoming changes, providers should monitor banner messages, which appear at the beginning of their Remittance and Status (R&S) reports, and the corresponding website articles published on the TMHP website at www.tmhp.com.

According to the CSHCN Services Program Agreement, providers must be thoroughly familiar with the contents of the *CSHCN Services Program Provider Manual,* the provider bulletins, and the messages contained in the R&S Reports as they apply to the CSHCN Services Program.

Providers must also comply with the following:

- CSHCN Services Program policies
- Policy notification letters
- Provider manuals
- Statutes
- Rules
- Regulations

This manual includes information about correct coding for claims. The CSHCN Services Program regrets that, due to copyright limitations, *Current Procedural Terminology* (CPT), *Current Dental Terminology* (CDT), and Healthcare Common Procedure Coding System (HCPCS) code descriptions cannot be published in CSHCN Services Program publications. Consult reference manuals published or authorized by the American Medical Association (AMA), the American Dental Association (ADA), and the Centers for Medicare & Medicaid Services (CMS) for code descriptions.

Specific procedure or diagnosis codes related to program benefits and coverage are included in the manual to provide helpful information, but should not be considered all-inclusive. From time to time, codes are added, deleted, or revised.

1.3 Feedback

The CSHCN Services Program and TMHP welcome provider comments and suggestions concerning this publication. Providers can mail them to:

Texas Medicaid & Healthcare Partnership
Attn: Publications
PO Box 204270
Austin, TX 78720–4270

1.4 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.

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Chapter

1

TMHP and DSHS Contact Information

1.1 TMHP-CSHCN Services Program Contact Information

1.1.1 CSHCN Services Program Telephone and Fax Communication

Contact	Telephone and Fax Number
TMHP-CSHCN Prior Authorization and Authorization Fax	1-512-514-4222
Provider Enrollment Fax	1-512-514-4214
Provider Enrollment Phone	1-800-568-2413, Option 2
CSHCN Services Program Customer Service Phone	1-800-252-8023, Option 2
TMHP Electronic Data Interchange (EDI) Help Desk	1-888-863-3638, Option 3
TMHP EDI Help Desk Fax	1-512-514-4228
Third-Party Resource (TPR) Phone	1-800-846-7307
TPR Fax	1-512-514-4225
Appeal Submission through AIS Line	1-800-568-2413, Option 1
CSHCN Services Program Complaints Unit Fax	1-800-441-5133 or 1-512-776-7417

1.1.2 Written Communication with CSHCN Services Program

Correspondence	Address
First-Time Claims (Resubmit all "Zero Allowed, Zero Paid" claims. Resubmit claims originally denied as an "Incomplete Claim" on an R&S Report)	Texas Medicaid & Healthcare Partnership Attn: CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0855
Appeals and Adjustments	Texas Medicaid & Healthcare Partnership Attn: CSHCN Services Program Appeals, MC-A11 12357-B Riata Trace Parkway, Suite 100 Austin, TX 78727
Provider Complaints	CSHCN Services Program ATTN: Complaints Purchased Health Services Unit, MC-1938 Texas Department of State Health Services PO Box 149347 Austin, TX 78714-9347
Prior Authorization and Authorization	Texas Medicaid & Healthcare Partnership Attn: TMHP-CSHCN Services Program Authorizations Department, MC-A11 12357-B Riata Trace Parkway, Suite 100 Austin, TX 78727
Enrollment	Texas Medicaid & Healthcare Partnership Attn: Provider Enrollment PO Box 200795 Austin, TX 78720-0795
Third-Party Resource	Texas Medicaid & Healthcare Partnership Third-Party Resource Unit PO Box 202948 Austin, TX 78720-9981

Correspondence	Address
Electronic Claims and Rejected Reports (Past the 95-day filing deadline)	Texas Medicaid & Healthcare Partnership PO Box 200645 Austin, TX 78720-0645
Other Correspondence (Must be directed to a specific department or individual)	Texas Medicaid & Healthcare Partnership Attn: CSHCN Services Program Appeals, MC-A11 12357-B Riata Trace Parkway, Suite 100 Austin, TX 78727

1.1.3 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.

1.1.4 TMHP-CSHCN Services Program Automated Inquiry System (AIS)

Dial 1-800-568-2413 (toll-free) to access the TMHP-CSHCN Services Program AIS. The call is answered automatically. Providers should follow the directions to access AIS and use the automated features to obtain information and services.

The TMHP-CSHCN Services Program AIS provides the following information and services through the use of a touch-tone telephone: claim status, client eligibility, current weekly payment amount, faxed forms, and claim appeals.

The TMHP-CSHCN Services Program AIS eligibility and claim status information is available 23 hours a day, 7 days a week with scheduled down time between 3 a.m. and 4 a.m., Central Time. All other AIS information is available Monday through Friday from 7 a.m. until 7 p.m., Central Time. AIS offers 15 transactions per call.

Note: *Pressing Star then Pound (*#) repeats any information given. Pressing Star then Star (**) begins again if an error was made. Pressing Zero then Pound (0#) at any time repeats the main menu.*

Full instructions on the use and benefits of the TMHP-CSHCN Services Program AIS can be found by clicking on the Reference Material link on the left-hand side of the CSHCN Services Program webpage on the TMHP website at www.tmhp.com, or by calling the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Monday through Friday from 7 a.m. to 7 p.m., Central Time.

Note: *All users who access www.tmhp.com are required to accept the American Medical Association (AMA) End-user Agreement on the use of Current Procedural Terminology (CPT). For each computer that accesses the TMHP website, the agreement must be accepted every 30 days from the last date on which the agreement was accepted by the user. If the end-user agreement is not accepted on a particular computer every 30 days, no user will be able to enter the website from that computer. For additional information about the AMA and CPT, refer to www.ama-assn.org/ama/pub/category/3113.html.*

1.1.5 TMHP Regional Representatives

The TMHP Provider Relations Department comprises a staff of Austin-based and field-based provider relations representatives who serve the health-care community by furnishing a variety of services and activities designed to inform and educate health-care providers about the CSHCN Services Program policies and claims filing procedures.

Provider Relations activities include the following:

- *Provider education through planned events.* Provider representatives conduct a planned program of educational workshops, webinars, computer-based training (CBT), in-services, and training sessions designed to keep all actively-enrolled providers informed of the latest policies, claim processing procedures, and federal and state regulations affecting CSHCN Services Program. Technical support and training are also provided to TexMedConnect software users.

- *Problem identification and resolution.* A staff of research coordinators is available to assist providers with clarification of Medicaid policies and assist with in-depth problem claim submission issues after initial inquiries are made with the CSHCN Contact Center. Coordinators work closely with field-based regional representatives to coordinate the educational needs of the community.
- *Relationship with professional health-care organizations.* To ensure that Texas associations that represent health-care professions have up-to-date information about the requirements for participation in the CSHCN Services Program, the Provider Relations Department maintains a working relationship with these organizations. Also, the Provider Relations Department participates in several events sponsored by Texas health-care associations, such as conventions and conferences.

Providers must call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 to speak to a representative who can answer questions.

If the Contact Center representative determines that an inquiry can best be handled by the TMHP Provider Relations department, the inquiry will be forwarded to Provider Relations. For example, providers who want to talk to their Provider Relations representative about a visit, in-service, or training, can call the Contact Center, and the Contact Center will forward the request to Provider Relations.

Provider relations representatives, the area they serve and additional information, including a regional listing by county and workshop information, is available on the TMHP website at www.tmhp.com/Pages/SupportServices/PSS_Reg_Support.aspx.

1.2 TMHP Website Information

The TMHP website at www.tmhp.com is a valuable resource that provides:

- Information and registration for upcoming provider education and training sessions.
- A file library of publications, such as bulletins, banner messages, and provider manuals.
- Announcements of current and upcoming program changes and other important information.

Additional advanced features are available for providers that create an account. There is no charge for creating an account on the TMHP website. All enrolled providers are eligible for this service. Once an account has been created, providers have access to:

- Texas Medicaid and the CSHCN Services Program enrollment information.
- Claim Status Inquiry (CSI).
- Eligibility verification (EV).
- Electronic Remittance and Status (ER&S) Report download option.
- Complete instructions for setting up a Provider Administrator account and the use of online CSI, EV, and ER&S Reports.
- E-mail the TMHP-CSHCN Services Program Contact Center.
- Workshop registration.
- Claim submission.
- Claim appeals.
- View the new provider welcome.

New services continue to be added to the website. Visit the TMHP website at www.tmhp.com or call the Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638 for the latest information about online services.

Refer to: The TMHP website at www.tmhp.com for further details and instructions on how to submit claims on the website.

1.2.1 Publications

All providers have access to the publications available on the TMHP website, including:

- Banner messages—a weekly history of banner messages.
- Bulletins—the *CSHCN Services Program Provider Bulletin*, the *Long Term Care Provider Bulletin*, and the *Texas Medicaid Bulletin*.
- *CSHCN Services Program Newsletter for Families*.
- EDI reference and connectivity guides.
- Fee schedules.
- Provider manuals.

These publications are available in the TMHP File Library. Use the following steps to access the TMHP File Library:

1) Access the homepage of the TMHP website at www.tmhp.com.
2) Click on the "Providers" tab at the top of the homepage. Click on "CSHCN" on the tabs at the top of the provider homepage.
3) Click on "Reference Material" on the left-hand side navigation bar to access provider manuals, bulletins, and other important reference materials.

1.2.1.1 Search Capabilities for the CSHCN Services Program Provider Manual

The online version of the *CSHCN Services Program Provider Manual* is available in portable document format (PDF), which can be viewed in Adobe® Acrobat® or Reader®. The Bookmarks window located on the left side of the screen provides a link to each heading within the manual. Click on the heading or link to quickly access the topic of interest.

Providers can use the following instructions to search the online version of the manual by a keyword or phrase:

1) Click the **Search** icon (binoculars) in the toolbar located at the top of the page. The Acrobat Find window opens.
2) In the Find What window, enter a keyword or phrase. Choose one of the following options, if applicable to the search:
   - Whole word only
   - Case-Sensitive
   - Include Bookmarks
   - Include Comments
3) Click **Search**. The cursor moves to the first place within the manual where the word or phrase appears. Instances found are listed in the Results window.
4) To search for a different keyword or term, click the **New Search** icon and type in the keyword or term and click **Search**.

1.3 CSHCN Services Program Central and Regional Offices

1.3.1 Central Office

The central and regional offices of the CSHCN Services Program are administratively located within the Division for Family & Community Health Services, Specialized Health Services Section, Purchased Health Services Unit (PHSU), at the Department of State Health Services (DSHS). Regular office hours are Monday through Friday from 8 a.m. to 5 p.m., Central Time.

TMHP is the claims administrator, and questions concerning provider enrollment, benefits or coverage, claims processing, and authorizations or prior authorizations should be directed to TMHP. DSHS-CSHCN Services Program welcomes provider comments and suggestions.

Providers can contact the CSHCN Services Program using the following information:

- Telephone toll-free at 1-800-252-8023 (may be used only in Texas) or the Austin local number at 1-512-776-7355
- Fax to CSHCN Services Program toll-free at 1-800-441-5133 or the Austin local number at 1-512-776-7565
- Send e-mail to cshcn@dshs.state.tx.us

Mail to the following address:

CSHCN Services Program—Provider Enrollment
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714–9347
Fax: 1-800-441-5133

Deliveries and overnight mail to the following address:

CSHCN Services Program—Provider Enrollment
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
1100 West 49th Street
Austin, TX 78756–3179
Fax: 1-800-441-5133

Additional information about the CSHCN Services Program is available online at www.dshs.state.tx.us/cshcn.

1.3.2 Regional Offices

Case management and client eligibility services are provided by a statewide network of regionally-based social service program consultants and include the following activities:

- Coordination of medical services
- Linkage to available resources
- Acting as a liaison among the client, family, and caregivers
- Management of institutional services, insurance carriers, and other services required for the improved well-being of the client and family

Refer to: Appendix A, "Acronyms and Initialisms Dictionary" on page A-1 for definitions of the abbreviated academic degrees listed in the following tables.

1.3.2.1 Region 1

1C - Canyon Regional Sub-Office (Canyon)	**Provider Relations:**
Health Services Region 1 300 Victory Dr. WTAMU Station (physical address) PO Box 60968 WTAMU Station (mailing address) Canyon, TX 79016 Telephone: 1-806-477-1103 or 1-806-655-7151 Fax: 1-806-655-6448	Frannie Nuttall

1L - Lubbock Regional Office Health Services Region 1 6302 Iola Ave. Lubbock, TX 79424–2721 Telephone: 1-806-744-3577 or 1-806-783-6452 Fax: 1-806-783-6455	**Case Management Supervisor:** Judy Lara, LBSW-IPR **Provider Relations:** Shannon Fitzpatrick, LBSW

1.3.2.2 Region 2

2A - Abilene Office Health Services Region 2 4601 South First Street, Suite L Abilene, TX 79605–1466 Telephone: 1-325-795-5869 or 1-325-795-5896 Fax: 1-325-795-5894	**Provider Relations:** Ronnie Laurance
2WF-Wichita Falls Office 6515 Kemp Blvd. (physical address) PO Box 300 (mailing address) Wichita Falls, TX 76307–0300 Telephone: 1-940-689-5930 Fax: 1-940-689-5925	

1.3.2.3 Region 3

3 - Regional Office (Arlington) Health Services Region 3 1301 South Bowen Road, Suite 200 Arlington, TX 76013–2262 Telephone: 1-817-264-4624 or 1-817-264-4627 Fax: 1-817-264-4911	**Manager of Specialized Health & Social Work Services:** Blanca Sanchez, LBSW **Provider Relations:** Angela Prince, LBSW Deborah Robertson
Bonham Office PO Box 605 (mailing address) 1205-A East Sam Rayburn (physical address) Bonham, TX 75418 Telephone: 1-903-486-9258 Fax: 1-903-486-9286	
Granbury Office 214 North Travis Street Granbury, TX 79048 Telephone: 1-817-579-2117 Fax: 1-817-578-3310	
Denton Office 3612 East McKinney Denton, TX 76209 Telephone: 1-940-320-8275 or 1-888-456-2770, Ext. 287 Fax: 1-940-591-6254	

Mockingbird Office 1545 West Mockingbird Lane, Suite 3001 Dallas, TX 75235 Telephone: 1-214-819-6749 Fax: 1-214-819-6796	
Rockwall Office 1101 Ridge Road, Suite 106 Rockwall, TX 75087 Telephone: 1-972-772-6180 Fax: 1-972-771-3080	

1.3.2.4 Region 4

4/5N - Regional Office (Tyler) Health Service Region 4/5N 1517 West Front Street Tyler, TX 75702–7822 Telephone: 1-903-533-5269 Toll free: 1-877-340-8842 Fax: 1-903-535-7593	**Manager of Specialized Health & Social Work Services:** Peggy Wooten, LCSW, ACSW
Athens Office 708 East Corsicana Athens, TX 75751 Telephone: 1-903-675-9107 Fax: 1-903-675-3622	
Carthage Office 1412 South Adams Carthage, TX 75633 Telephone: 1-903-693-9322 Toll Free: 1-800-306-0568 Fax: 1-903-694-2316	
Gilmer Office 324 Yapaco Gilmer, TX 75644 Telephone: 1-903-843-3030 Fax: 1-903-843-4264	
Henderson Office 700 Zeid Blvd. Henderson, TX 75652 Telephone: 1-903-655-6256 Toll Free: 1-800-306-0568 Fax: 1-903-655-0104	**Provider Relations:** Sherry Lynn Adams
Linden Office 123 Kaufman PO Box 300 Linden, TX 75563 Telephone: 1-903-756-7231 Fax: 1-903-756-5146	**Provider Relations:** Tunga Mayfield, LMSW

Longview Office 1750 North Eastman Road Longview, TX 75601–3347 Telephone: 1-903-232-3221 or 1-903-232-3289 Toll Free: 1-866-327-1364 Fax: 1-903-232-3278	**Medical Case Manager/Provider Relations:** Tungua Mayfield, LBSW, MSW
Marshall Office 4105 Victory Drive Marshall, TX 75670 Telephone: 1-903-927-0218 Toll Free: 1-866-327-1364 Fax: 1-903-927-0290	**Medical Case Manager/Provider Relations:** Tungua Mayfield, LBSW, MSW
Mount Pleasant Office 1014 North Jefferson Mount Pleasant, TX 75455 Telephone: 1-903-577-1929 or 1-903-575-1138 Toll Free: 1-866-268-6465 Fax: 1-903-577-8957	
Palestine Office 320 E. Spring Street, Suite D Palestine, TX 75801 Telephone: 1-903-661-6089 Fax: 1-903-729-7034	
Paris Office 1460 19th Street NW Paris, TX 75460 Telephone: 1-903-737-0236 Fax: 1-903-737-0220	
Quitman Office PO Box 1704 (mailing address) 213 West Bermuda (physical location) Quitman, TX 75783 Telephone: 1-903-763-1238 Toll Free: 1-866-518-0601 Fax: 1-903-763-5449	
Sulphur Springs Office 1400 College, Suite 167 Sulphur Springs, TX 75482 Telephone: 1-903-439-9331 Toll Free: 1-866-518-0601 Fax: 1-903-439-9335	
Texarkana Office 3115 South Lake Drive, Suite 120 Texarkana, TX 75501 Telephone: 1-903-791-3229 Fax: 1-903-791-3230	**Provider Relations:** Tungua Mayfield, LMSW

1.3.2.5 Region 5 North

Center Office 912 Nacogdoches Center, TX 75935 Telephone: 1-936-598-1231 Fax: 1-936-591-0162	**Medical Case Manager/Provider Relations:** Sandra Garrett, LBSW
Crockett Office 1034 South Fourth Street Crockett, TX 75835 Telephone: 1-936-544-4734 or 1-936-545-0360 Fax: 1-936-544-0280	**Medical Case Manager/Quality Assurance:** Mable Thompson, LBSW
Jasper Office Jasper-Newton County Public Health District 130 West Lamar Jasper, TX 75951 Telephone: 1-409-384-6829, Ext. 231 Fax: 1-409-384-7861	
Kirbyville Office 314 North Herndon (physical location) PO Box 900 (mailing address) Kirbyville, TX 75956 Telephone: 1-409-423-4612, Ext. 238 Fax: 1-409-423-4027	
Livingston Office 410 East Church Street, Suite B Livingston, TX 77351 Telephone: 1-936-328-8240, Ext. 232 Toll Free: 1-888-851-4748 Fax: 1-936-328-8249	
Lufkin Office 1210 South Chestnut Lufkin, TX 75901 Telephone: 1-936-633-3657, 936-633-3769, or 1-936-633-3730 Toll Free: 1-877-340-8840 Fax: 1-936-633-3667	**Quality Assurance/CM Liaison:** Fleta Youngblood, LMSW-IPR
Nacogdoches Office 2614 N.W. Stallings Drive Nacogdoches, TX 75964-1255 Telephone: 1-936-569-4982 or 1-936-569-4918 Fax: 1-936-569-4989	
Woodville Office 930 N. Magnolia Woodville, TX 75979 Toll Free: 1-888-851-4748 Fax: 1-409-283-7679	

1.3.2.6 Regions 5 South and 6

6/5S - Regional Office (Houston) 5425 Polk Avenue, Suite J Houston, TX 77023–1497 Telephone: 1-713-767-3111 Fax: 1-713-767-3125	**Manager of Specialized Health & Social Work Services:** Raymond Turner, MA, LMSW-AP **Provider Relations:** Shannon Jones Julianne McNeff Broness Highsmith Trevore Donaldson
Beaumont Office 3105 Executive Blvd. Beaumont, TX 77701 Telephone: 1-409-730-1837 Fax: 1-409-730-1845	
Conroe Office 608 North Drive Loop 336 East Conroe, TX 77301 Telephone: 1-936-760-4704, 1-936-760-4750, or 1-936-760-4705 Fax: 1-936-760-4707	

1.3.2.7 Region 7

7T - Temple Office Health Service Region 7 2408 South 37th Street Temple, TX 76504–7168 Telephone: 254-771-6791 or 1-800-789-2865 Fax: 1-254-773-2722	**Manager of Specialized Health & Social Work Services:** Leesa Ferrero, LMSW **Supervisors:** Kimberly Langely, LBSW Suzan Cooper, LBSW **Provider Relations:** Marjorie Douglas Alice Watkins Deneice Pryor, RN
7A - Austin Office Health Services Region 7 1601 Rutherford Lane, Suite C-3 Austin, TX 78754–5119 Telephone: 1-512-873-6308, 1-512-873-6311, 1-512-873-6315 Toll Free: 1-800-789-2865 Fax: 1-512-873-6345	
Bastrop Office 104 Loop 150 West, Suite 102 Bastrop, TX 78602 Telephone: 1-512-321-2465 Fax: 1-512-321-4861	

Bryan Office 3000 Villa Maria Bryan, TX 77803 Telephone: 1-979-776-7489 Fax: 1-979-731-0191	
Copperas Cove Office 312 South Main Copperas Cove, TX 76522 Telephone: 1-800-789-2865 State Cell Phone: 1-254-598-9352 Fax: 1-254-547-9463	
Lockhart Office 1403F Blackjack Street (physical location) PO Box 43 (mailing address) Lockhart, TX 78744 Telephone: 1-512-376-1078 Fax: 1-512-398-0022	
Navasota Office 425 N. Lasalle (physical address) PO Box 1287 (mailing address) Navasota, TX 77868 Telephone: 1-936-825-7586 Fax: 1-936-825-0380	
San Saba Office 423 E. Wallace San Saba, TX 76877 Telephone: 1-325-372-5188 or 1-325-372-5191 Fax: 1-325-372-3297	
Waco Office 801 Austin Avenue, Suite 820F Waco, TX 76701 Telephone: 1-254-750-9339, 1-254-750-9337, 1-254-750-9248, or 1-254-750-9353 Fax: 1-254-753-0879	**Provider Relations:** Lilli Lessenger, LBSW

1.3.2.8 Region 8

8 - San Antonio Office Health Service Region 8 7430 Louis Pasteur Drive San Antonio, TX 78229–4507 Telephone: 1-210-949-2142 or 1-210-949-2044 Fax: 1-210-949-2047	**Manager of Specialized Health & Social Work Services:** Katherine Velasquez, PhD, RN **Supervisor of Social Work Services:** Janice Gonzales, LBSW-IPR Leticia Guerra, LBSW **Quality Assurance Program Specialist:** Lorena Felan, LBSW **Provider Relations:** Velma Stille

Uvalde Office 2201 East Main Uvalde, TX 78801 Phone: 1-830-591-4388 or 1-830-591-4384 Fax: 1-830-278-1831	
Eagle Pass Office 1593 Veterans Boulevard Eagle Pass, TX 78852 Telephone: 1-830-758-4254, 1-830-758-4252 Fax: 1-830-773-4688	
Victoria Office 2306 Leary Lane Victoria, TX 77901 Telephone: 1-361-574-7421 Fax: 1-361-574-7396	

1.3.2.9 Regions 9 and 10

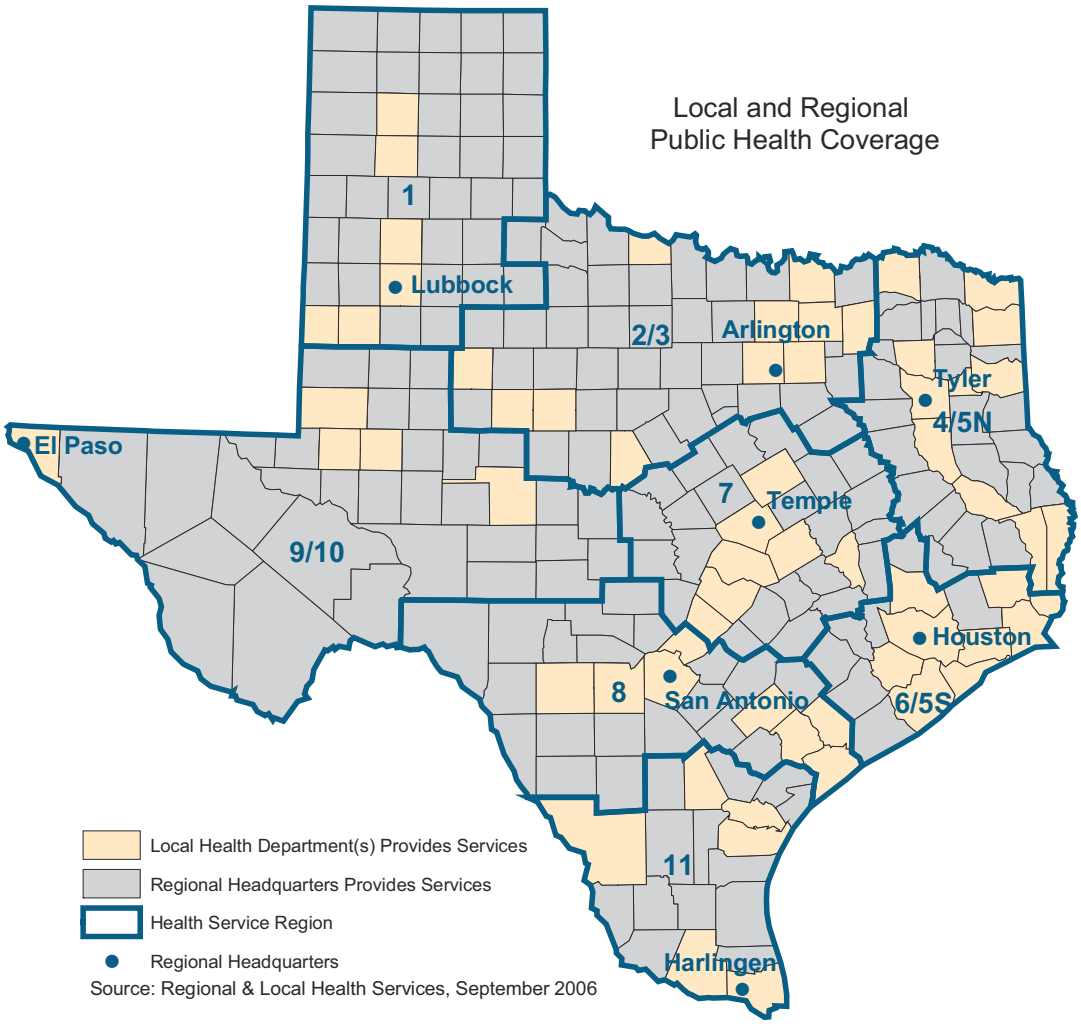
9/10 - El Paso Office Health Services Region 9/10 401 East Franklin, Suite 210 El Paso, TX 79901-1206 Telephone: 1-915-834-7675 Fax: 1-915-834-7808	**Interim Manager of Specialized Health & Social Work Services:** Armando Rodriguez, LBSW **Supervisor of Social Work Services:** Margarita Jaquez, MSW, LBSW
Midland Office 2301 N Big Spring Street, Suite 300 Midland, TX 79705 Telephone: 1-432-683-9492 Fax: 1-432-684-3932	**Social Work Services Coordinator:** Joanne Mundy, LBSW **Social Work Services Team Lead:** Beatrix Ho Guin, LBSW **Provider Relations:** Pam Rodriguez
San Angelo Office 622 South Oakes, Suite H San Angelo, TX 76903 Telephone: 1-325-659-7853 Fax: 1-915-655-6798	**Provider Relations:** Betty Rodriguez

1.3.2.10 Region 11

11H - Harlingen Office Health Service Region 11 601 West Sesame Drive Harlingen, TX 78550–4040 Telephone: 1-956-423-0130 Fax: 1-956-444-3293	**Manager of Specialized Health & Social Work Services:** Angelica Martinez, LBSW **Provider Relations:** Leticia Puente
Alice Offices 408 N. Flournoy, Suite C Alice, TX 78332 Telephone: 1-361-664-2019 Fax: 1-361-668-4000	**Unit Supervisor (Coastal Bend):** Cynthia L. Ortiz, LBSW

11C - Corpus Christi Office Health Services Region 11 5155 Flynn Pkwy. Corpus Christi, TX 78401 Telephone: 1-361-878-3420 Fax: 1-361-883-9942	**Unit Supervisor (Coastal Bend):** Cynthia L. Ortiz, LBSW **Provider Relations:** Ray R. Ramos
11L - Laredo Office 1500 Arkansas Avenue, Suite 3 Laredo, TX 78043–3049 Telephone: 1-956-725-5195 Fax: 1-956-729-8600	**Unit Supervisor:** Michelle Trisler, LBSW **Provider Relations:** Rosario Rocha
11M - McAllen Office Health Services Region 11 4501 West Business Hwy 83 McAllen, TX 78501–9907 Telephone: 1-956-971-1207 Fax: 1-956-971-1275	**Unit Supervisor:** Alberto Ramos, Jr., LBSW
Mercedes Office Health Services Region 11 202 West 2nd Street Mercedes, TX 78520 Telephone: 1-956-825-5300 Fax: 1-956-825-5320	**Unit Supervisor:** Michael Garcia, LBSW-IPR
Brownsville Office 1000 W. Price Road Brownsville, TX 78520 Telephone: 1-956-554-5500 Fax: 1-956-554-5581	**Unit Supervisor:** Angelica Martinez, LBSW
Rio Grande City Office 608 N. Garza Rio Grande City, TX 78582 Telephone: 1-956-487-5556 Fax: 1-956-487-8865	**Unit Supervisor:** Alberto Ramos, Jr., LBSW

1.4 DSHS Health Service Regions Map



Chapter

2

Provider Enrollment and Responsibilities

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.

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," on page 26-8.

Chapter 38, "Transportation of Deceased Clients," on page 38-1.

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.

Current Texas Medicaid providers that want to enroll with the CSHCN Services Program can use the CSHCN Services Program Expedited Enrollment Application found on 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.

If not completed online, the enrollment application and other completed forms must be sent to TMHP Provider Enrollment at the following address:

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

For assistance with the application process or to obtain enrollment forms, 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.

Providers can enroll or re-enroll using one of the following methods:

- The online Provider Enrollment on the Portal (PEP)
- The current paper version of the CSHCN Services Program Provider Enrollment Application available for download on the TMHP website from the TMHP Forms web page.

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 10 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," on page 5-1.

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.state.tx.us/tac. 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," on page 7-1.

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 http://comptroller.texas.gov/taxinfo/coasintr.html.

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," on page 25-3.

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 14.2.5.9, "Dental Anesthesia," on page 14-33 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)," on page 19-1.

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. The Centers for Medicare & Medicaid Services (CMS) maintains the list of certified and approved transplant facilities on the CMS website.

2.1.8 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," on page 2-2.

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," on page 3-3.

Section 5.1.8, "Claims Filing Deadlines," on page 5-5.

2.1.9 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," on page 31-6.

2.1.10 Providers of Family Support Services

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 www.dshs.state.tx.us/cshcn. Mail completed enrollment applications to:

CSHCN Services Program—Provider Enrollment
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133
or 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 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 by calling the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, by fax at 1-888-236-8399, or by submitting a written complaint 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
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133 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," on page 4-1.
- Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1.
- Chapter 7, "Appeals and Administrative Review," on page 7-1
- Section 2.1.4, "Provider Enrollment Determinations," on page 2-5.

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.state.tx.us/tac.

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 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. The American Medical Association's (AMA's) Current Procedural Terminology (CPT) descriptors of key/contributory components with level of service descriptions or the American Dental Association (ADA) Current Dental Terminology (CDT) are used to evaluate the selection of levels of service.	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 Waste, Abuse, and Fraud

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 waste, abuse, and fraud. DSHS is responsible for establishing criteria to identify cases of possible waste, abuse, and fraud 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 5.6.2.8, "Modifiers," on page 5-22.

- *Current Dental Terminology* (CDT) as published by the American Dental Association (ADA).
- *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-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 37.2.1, "Telemedicine Services," on page 37-3.

Section 31.1.3, "Substitute Physician," on page 31-6.

- 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," on page 4-1.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1.

Chapter 7, "Appeals and Administrative Review," on page 7-1.

2.3.10 Texas Family Code Compliance

2.3.10.1 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.

2.3.10.2 Abuse and Neglect Reporting Requirements

DSHS and the CSHCN Services Program expect 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.

Chapter

3

Client Benefits and Eligibility

3.1 Client Benefits

The CSHCN Services Program is a comprehensive health-care program. Clients must see providers who are enrolled in the CSHCN Services Program, and they can go to specialists without a referral. Benefits include, but are not limited to, the items in the list below. Consult the specific chapter or section for more details about coverage and authorization requirements.

- Ambulance
- Ambulatory or day surgery
- Augmentative communication devices (ACDs)
- Behavioral health
- Dental and orthodontia
- Drug copayments (except Children's Health Insurance Program [CHIP] drug copayments)
- Durable medical equipment and expendable medical supplies
- Eye prostheses
- Gastrostomy devices
- Genetic services
- Hearing services
- Hemophilia blood factor products
- Home health services
- Hospice care
- Inpatient services
- Laboratory services
- Insurance Premium Payment Assistance (IPPA) (reimburses health insurance premiums)
- Medical foods and nutritional services
- Orthotics and prosthetics
- Outpatient services
- Physical and occupational therapy (outpatient only)
- Physical medicine
- Prescription drugs
- Primary and preventive care
- Physician services, including services performed by advanced practice registered nurses (APRNs)
- Podiatry
- Prescription shoes
- Radiology and radiation therapy services
- Rehabilitation (inpatient and outpatient)
- Renal dialysis
- Renal transplants
- Respiratory care and equipment
- Speech-language pathology (outpatient only)
- Sleep studies
- Stem cell transplants ($200,000 maximum)
- Surgery
- Telemedicine
- Vision care

3.1.1 Prescription Drug Benefits

The Vendor Drug Program (VDP) processes all of the prescription drug claims for CSHCN Services Program clients. Claims for the following drugs and products may be submitted for reimbursement:

- Aerosolized tobramycin (TOBI)*
- Growth hormone products
- Human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) drugs
- Insulin/insulin syringes
- Medications for home use (including vitamins)
- Pulmozyme*
- Palivizumab (Synagis)**

*Prior authorization is required for these drugs.

** Requests for prior authorization of all the drugs listed above with the exception of Palivizumab (Synagis), must be submitted to VDP. Prior authorization requirements for Palivizumab (Synagis) are detailed in Section 3.1.2, "Respiratory Synctial Virus (RSV) Prophylaxis," below.

For VDP prior authorization requirements, providers may contact VDP at 1-800-435-4165 or online at www.hhsc.state.tx.us/HCF/vdp/vdpstart.html.

An approved prescribing physician must submit a completed and signed Pulmozyme and TOBI Medical Information Form annually to certify that the CSHCN Services Program client continues to require either of these medications. The Pulmozyme and TOBI Medical Information Form is available through VDP.

Note: *HIV/AIDS drugs are a benefit for CSHCN Services Program clients for 60 days. A denial from the Texas HIV Medicaid program and any third-party payer, if applicable, must be submitted to extend coverage for those drugs beyond 60 days.*

The CSHCN Services Program does not reimburse providers for drug waste.

3.1.2 Respiratory Synctial Virus (RSV) Prophylaxis

Prior authorization for the RSV prophylaxis drug Palivizumab (Synagis) must be obtained through the CSHCN Services Program.

To request prior authorization, a completed Children with Special Health Care Needs (CSHCN) Services Program Synagis® (Palivizumab) Prior Authorization Request & Prescription Form 2013 must be faxed to the CSHCN Services Program at (512-776-7238).

Providers may refer to the Texas Health and Human Services Commission Texas Medicaid/CHIP Vendor Drug Program website at www.txvendordrug.com/dur/prior-approval.shtml for a copy of the prior authorization form and more information about obtaining palivizumab for CSHCN Services Program clients.

For additional information about RSV criteria, refer to Section 31.2.24.15, "Respiratory Synctial Virus (RSV) Prophylaxis," on page 31-81.

3.1.3 Medical Transportation Program (MTP) Benefits

The MTP makes travel arrangements for CSHCN Services Program clients to get to their medical or dental appointments, or to the pharmacy. Clients must call MTP in advance to request travel assistance. To contact MTP, call 1-877-633-8747.

3.1.4 Services Provided Outside of Texas

CSHCN Services Program policies and procedures apply to all enrolled providers outside of the state of Texas. Out-of-state providers must be enrolled and remain enrolled as Title XIX Medicaid providers for to claims to be considered for reimbursement by the CSHCN Services Program.

Refer to: Section 2.1.8, "Out-of-State Providers," on page 2-9.

3.1.5 CSHCN Services Program Services and Supplies Limitations and Exclusions

The following are *not* CSHCN Services Program benefits (this list is not all-inclusive):

- Abortions
- Allergy treatment services, except antibiotic desensitization
- Ambulatory blood pressure monitoring
- Attendant care services
- Augmentation mammoplasty or breast reconstruction (except following a medically necessary mastectomy)
- Autopsies
- Neurofeedback (i.e., EEG biofeedback)
- Care and treatment related to any condition for which benefits are provided or available under worker's compensation laws
- Chemolase injection (chymodiactin and chymopapain)
- Chiropractic treatment
- Circumcisions (routine)
- Color vision and dark adaption exams
- Craniotomy for lobotomy
- Custodial care
- Dermabrasion or chemical peels
- Donor search for kidney transplants
- Donor search for stem cell transplants
- Dressings and supplies billed in physician's office
- Ear piercing or repair of ear piercing
- Experimental or investigational procedures
- Extracorporeal membrane oxygenation (ECMO)
- Extracorporeal photophoresis
- Fees for completing or filing a CSHCN Services Program claim form, CSHCN Services Program Physician/Dentist Assessment Form, or other documentation
- Fertility services
- Fetal medical and surgical services
- Implantation of antiesophageal reflux device
- More than 60 days of inpatient hospitalization per calendar year

  Note: *An additional 60-day hospital stay begins on the date of hospital admission for an approved stem cell transplant (refer to Section 24.3.1.4, "Transplants - Nonsolid Organ," on page 24-10).*
- Inpatient rehabilitation of more than 90 days per calendar year
- Intermittent positive pressure breathing (IPPB) (physician services)
- Intersex surgery (except to repair or treat congenital defects)
- Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity
- Lipectomies and rhytidectomies
- Manipulation of chest wall, including percussion
- Newborn services (routine)
- Obsolete diagnostic tests
- Obstetrical tests
- Outpatient cardiac rehabilitation

- Penile plethysmography or nocturnal tumescence test
- Peripheral and thermal angioplasty
- Portable X-ray services
- Prostate treatment (massage and surgery)
- Recreational therapy
- Routine blood drawing for specimens
- Salivary gland and duct diversion or ligation
- Services or supplies:
  - For which benefits are available under any other contract, policy, or insurance
  - For which claims were not submitted within the filing deadline
  - That are not reasonable and necessary for diagnosis or treatment
  - That are not specifically a benefit of the CSHCN Services Program
  - Provided before or after the eligibility time period of the client
  - Provided to clients on the CSHCN Services Program waiting list
  - Provided to a client after a finding was made during utilization review procedures that these services or supplies were not medically necessary
  - Payable by any health, accident, or other insurance coverage; by any private or other governmental benefit system; or by any legally liable third party
  - Provided by ineligible, suspended, or excluded providers
- Silicone or collagen injections (cosmetic)
- Single photon emission computerized tomography (SPECT) imaging
- Social and educational counseling
- Speech prosthesis insertion
- Sterilizations, sterilization reversals, infertility, obstetrics, and family-planning services
- Substance abuse treatment
- Tattooing
- Telephone calls, computer calculations, reports, and medical testimony
- Transplants of the heart, intestines, liver, lung or pancreas
- Travel allowance for specimen collection for homebound clients

3.2 Client Eligibility

3.2.1 CSHCN Services Program Application Criteria

Applicants who may be eligible for coverage under Medicare, Medicaid, Medicaid Buy-In (MBI), Medicaid Buy-In for Children (MBIC), or CHIP by reason of citizenship, residency status, age, or medical condition must apply for coverage. A written Medicaid and CHIP determination must be sent with the application for the CSHCN Services Program. Applicants who are not citizens or legal residents of the United States or who are currently enrolled in CHIP or Texas Medicaid are exempt from this requirement. Proof of exempt status must be sent with the application for the CSHCN Services Program.

If the CSHCN Services Program does not receive the Medicaid or CHIP determination or evidence of exemption from this requirement with the application, the applicant is given 60 days to submit the requested information. During this 60-day period, the applicant may send in any additional information that the CSHCN Services Program requires to process the application. If all information is received before the end of the 60 days, the CSHCN Services Program may grant eligibility for CSHCN Services Program health-care benefits or place the client on the waiting list, the eligibility effective date will be established as the date the application was made complete.

If the client or applicant has submitted all of the documentation required to approve his or her case for CSHCN Services Program health-care benefits except for the Medicaid and CHIP determinations, the program may approve the case for 60 days until the Medicaid and CHIP determinations are received. Services are suspended if the Medicaid or CHIP determinations are not received on or before the end of 60 days. The suspension remains until the requested information is received. Once all of the required information is received, eligibility is granted. Eligibility is suspended between the 60-day cutoff date and the date on which the requested information is received.

An extension of 30 days may be granted for exceptional circumstances when requested.

The CSHCN Services Program does not pay for any services until the client's application is approved and the client is eligible to receive CSHCN Services Program health-care benefits.

If the CSHCN Services Program denies eligibility to a program applicant, the program shall give the applicant written notice of the denial and of the applicant's right to request an administrative review of the denial within 30 days of the date of the notification.

If the CSHCN Services Program proposes to modify, suspend, or terminate a client's eligibility for health-care benefits (unless such program actions are authorized by the CSHCN Services Program Rules Title 25 Part I TAC §38.16 relating to Procedures to Address Program Budget Alignment), the CSHCN Services Program shall give the client written notice of the proposed action and of the client's right to request an administrative review of the proposed action within 30 days of the date of notification.

Any questions concerning a client's eligibility for benefits of the CSHCN Services Program must be directed to the CSHCN Services Program Central Office at 1-800-252-8023.

3.2.2 Eligibility Criteria

A person may be eligible for health-care benefits under the CSHCN Services Program if the following conditions are met:

- The applicant must be a Texas resident.
- The applicant is 20 years of age or younger. Persons diagnosed with cystic fibrosis are exempt from this requirement.
- The applicant's family meets the CSHCN Services Program financial eligibility criteria.
- The applicant's physician or dentist attests to the program's medical certification definition and provides a diagnosis that meets the definition on the CSHCN Services Program Physician/Dentist Assessment Form located in the CSHCN Services Program Application Booklet.

The applicant must be eligible for medical assistance at the time the service is provided. Having an application for CSHCN Services Program eligibility in process is not a guarantee that the applicant can become eligible. Services and supplies are not paid by the CSHCN Services Program if they are provided to a client before the effective date of his or her eligibility or after the effective date of his or her denial of eligibility.

3.2.3 Prematurity

Applicants who meet the definition of prematurity are not medically eligible for CSHCN Services Program health care benefits until they have been discharged from the hospital and remain out of the hospital for at least 14 consecutive days.

3.2.4 Program Applicants and Clients Residing in Long-Term Care

Applicants and clients who are residing in skilled nursing facilities (SNF), intermediate care facilities for individuals with intellectual disabilities (ICF/IID), state hospitals (court-ordered and not considered a public institution), or community group homes may apply for CSHCN Services Program health care benefits.

Long-term care services provided by the facilities described above are not a covered health care benefit. If an ongoing CSHCN Services Program client is admitted to any of the above-mentioned facilities, his or her eligibility for covered health care benefits remains unchanged; however, the client may qualify for Medicaid or CHIP services and must maintain that coverage to continue eligibility for covered CSHCN Services Program health care benefits.

3.2.5 Program Applicants and Clients That Are Incarcerated

If an applicant or client meets the financial, medical, age, residency, and other criteria for eligibility for CSHCN Services Program health care benefits, eligibility may be granted; however, the applicant or client is not eligible for CSHCN Services Program health care benefits until released from custody. Services provided while the client is in the custody of, or incarcerated by, any municipal, county, state, or federal governmental entity are not covered.

Exception: *Case management or prior-approved FSS not provided by the governmental entity, that are needed during the time when a client is making a transition from custody or incarceration into a community-living setting, may be covered*

3.2.6 Sporadic Medicaid, MBIC, MBI, or CHIP Coverage

If the CSHCN Services Program client loses Medicaid coverage for longer than one month, reapplication to Medicaid is required. The client is notified that reapplication is required and is given 60 days to submit the Medicaid determination. CSHCN Services Program coverage for health care benefits may be granted during the 60 day period. If the determination is not received within the 60 day period the client's eligibility may be suspended. The CSHCN Services Program may grant a 30-day extension, at the client's request, to obtain the determination for Medicaid.

If a client is disenrolled by MBIC or MBI during the coverage period, the client or family must submit written notification to the CSHCN Services Program stating the reason for disenrollment.

Acceptable reasons to end MBIC or MBI coverage include, but are not limited to:

- • Age limitations;
- • Has Medicaid coverage
- • Lost private insurance coverage
- • Found not to be a U. S. citizen

3.2.7 Eligibility Date for Program Health Care Benefits

The effective date of eligibility for CSHCN Services Program health care benefits is the date of receipt of the application, except in the following circumstances:

- *Newborn*. The effective date of eligibility for newborns that are not born prematurely is the date of birth. Newborn means a child 30 days old or younger.
- *Spenddown*. The effective date of eligibility for applicants with spenddown is the day after the earliest DOS on which the cumulative bills are sufficient to meet the spenddown amount. Only medical bills having a DOS within the 12 months prior to the date of receipt of the application denial date may be included to satisfy spenddown requirements. Medical bills from any member of the household for which the applicant, parents, guardian, or managing conservator of the applicant is responsible and that are not payable by another entity may be included. All spenddown documentation must be received within 60 days of receipt of the application denial. Medical bills that are used to meet spenddown are not payable by the CSHCN Services Program.
- *Waiting List Exception.* If an ongoing client (not on the waiting list) reapplies on or before the day that CSHCN Services Program financial and medical eligibility expires and the income is over scale, his or her name is not placed on the waiting list. Eligibility is denied until bills are received that are sufficient to meet spenddown. Eligibility then begins according to the spenddown criteria above.
- *Prematurity.* The effective date of eligibility for an applicant that is born prematurely is the day after the applicant has been out of the hospital for 14 consecutive days.

- *Trauma*. The effective date of eligibility following traumatic injury is the day after the acute phase of the treatment ends, the date of transfer to the rehabilitation facility, or the date discharged to home
- The Trauma and Accident Section of the CSHCN Services Program Physician and Dentist Assessment Form in the CSHCN Services Program Application Booklet must be completed for all first time applicants. Applicants who are currently ongoing clients and are reapplying to establish continuing eligibility, or applicants who have had CSHCN Services Program eligibility in the past are exempt from this requirement. This exemption pertains even if the returning applicant has sustained a traumatic injury or accident during any time following the submission of an original application that included this information.
- The received date is the date the application is received by the CSHCN Services Program.

3.2.8 Financial Eligibility Criteria

Prospective CSHCN Services Program clients must meet financial eligibility requirements. Additional information about CSHCN Services Program financial eligibility is available at the toll free CSHCN Services Program Inquiry Line at 1-800-252-8023 or online at www.dshs.state.tx.us. CSHCN Services Program inquires may also be mailed to:

CSHCN Services Program
Department of State Health Services, MC 1938
P.O. Box 149347
Austin, TX 78714-9347

Important: *All client eligibility information must be kept up to date. CSHCN Services Program financial eligibility must be updated annually. Medical eligibility must be updated annually; however, medical information may be updated whenever there is a change in the client's condition.*

3.2.9 Medical Eligibility Criteria and the Physician/Dentist Assessment Form (PAF)

An important element of determining client eligibility is the CSHCN Services Program Physician/Dentist Assessment Form (PAF). The PAF provides the CSHCN Services Program with vital information about the client's medical condition, qualifies the client as medically eligible for benefits, and is used when clients are considered for removal from the waiting list. The PAF also provides a medical certification for a diagnosis that meets the CSHCN Services Program's definition of a child with special health-care needs and also allows for identification and explanation of an urgent need for medical care.

CSHCN Services Program applicants and clients are required to submit proof of their medical condition with the initial application, notify the CSHCN Servcies Program of any changes in the client's condition, and certify at least once annually that the client is medically eligible. This information is completed and submitted on the CSHCN Services Program Physician/Dentist Assessment Form.

Copies of the form are included with the application packet, and clients or their families must ensure that a physician or dentist provides the information necessary to meet the medical eligibility requirements of the CSHCN Services Program.

3.2.9.1 Medical Certification Definition

The CSHCN Services Program rules state that the following medical criteria should be used when referring clients to the program:

- A chronic developmental condition must include physical manifest and may not be solely a delay in intellectual, mental, behavioral, or emotional development.

CSHCN Services Program rules state the following for a chronic physical condition:

- Such a condition may exist with accompanying developmental, mental, behavioral, or emotional conditions, but is not solely a delay in intellectual development or solely a mental, behavioral, or emotional condition.

A diagnosis of mental retardation, autism, or attention deficit hyperactivity disorder (ADHD) does not indicate a physical disability by itself. If the client also has cerebral palsy or another condition causing physical disability, use that diagnosis on the PAF to expedite the processing of the application.

The physician or dentist who completes the PAF must also certify that the applicant meets the CSHCN Services Program's definition of a person with special health-care needs outlined below:

- 21 years of age or younger
- Must have a chronic physical or developmental condition that will last or is expected to last for at least 12 months and may result in limits to one or more major life activities or result in death if not treated
- Must have a chronic physical or developmental condition that requires health and related services of a type or amount beyond those generally required by children
- Must have a physical (body, bodily tissue, or organ) manifestation
- May have an accompanying developmental, mental, behavioral, or emotional condition(s) that is not solely a delay in intellectual development or solely a mental, behavioral, or emotional condition
- A person of any age who has cystic fibrosis

3.2.9.2 Primary and Secondary Diagnoses

The CSHCN Services Program is not diagnosis-restricted; however, a valid *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM) code that indicates an applicant's chronic physical condition is required on the PAF. This information is important for program data purposes and to ensure that the applicant meets the program's definition of a child with special health-care needs.

The primary diagnosis on the PAF must be medical in nature and an ICD-9-CM diagnosis code that meets the CSHCN Services Program's criteria. Any additional diagnoses may be listed in the Other Diagnoses section located below the Primary Diagnosis line.

For example, if a CSHCN Services Program client has a diagnosis of autism and cerebral palsy, use cerebral palsy as the primary diagnosis because it indicates a physical disability, and autism does not.

To facilitate applications to the CSHCN Services Program for certain applicants, the CSHCN Services Program medical director may accept written documentation of medical criteria certification submitted by a physician or dentist who is licensed to practice in a state or jurisdiction of the United States of America other than Texas.

The CSHCN Services Program does not reimburse providers for written documentation of medical criteria certification. In addition, providers may not request or accept payment from the client or applicant, or the client or applicant's family, for completing any CSHCN Services Program forms.

3.2.9.3 Important Considerations When Completing the PAF

- Use as the primary diagnosis, a medical diagnosis that indicates the client's chronic condition that meets the CSHCN Services Program's definition of a child with special health-care needs, and/or identifies the urgent need for care.
- Use the full ICD-9-CM code, including any suffixes (e.g., "281.3" rather than "281").
- If YES is noted in the Determination of Urgent Need for Services section, an explanation must be entered to justify the YES answer. If this section is incomplete, the PAF will be rejected.
- A physician or dentist must complete the Physician/Dentist Data section of the form, sign it, and date it. The signature must be an original signature. Electronic or stamped signatures are not accepted. The form can only be signed by a physician (doctor of medicine [MD], doctor of osteopathy [DO], doctor of dental surgery [DDS], or doctor of dental medicine [DMD]) who has seen the client in the previous 12 months.
- An original signature is required. Electronic or stamped signatures are not accepted.

- Instructions for updating the PAF are also available on the TMHP website.

Refer to: Physician/Dentist Assessment Form Instructions (English)
Physician/Dentist Assessment Form Instructions (Spanish)

Tip: *Providers can photocopy this form, but should retain the original for future use. The instructions and form are available on the TMHP website at www.tmhp.com.*

3.3 CSHCN Services Program Eligibility Form

The CSHCN Services Program Eligibility Form gives clients, parents, and providers a quick way to verify CSHCN Services Program eligibility. The form is designed to convey all of the information necessary to document identification information. Medicaid or other insurance information (including CHIP) listed on the form at the time of application is valid and must be verified independently.

Refer to: CSHCN Services Program Eligibility Form Sample on page 3-12.

CSHCN Services Program Eligibility Forms are valid for a 12-month coverage period. Clients must reapply for CSHCN Services Program health-care benefits annually. A new application and all proof of financial eligibility must be submitted each time a client reapplies for the CSHCN Services Program. This form is one way to verify client eligibility.

The client eligibility form shows:

- The client's case number (also called the client ID number). The case number for the CSHCN Services Program will always begin with a 9 and end with 00.
- The client's name, date of birth, and sex.
- The 12 months of the client's eligibility.
- Information about any other insurance the client may have had at the time of application. This is indicated by the text "Medicaid/Insurance" below the client's date of birth. More about what to do when a client has other insurance coverage is in Section 3.5 and Section 3.7.

Providers should ask for the form when scheduling a client for an appointment. Under certain circumstances, the form may not be valid at the time the provider sees the client.

Providers can also verify client eligibility by using the following options:

- CSHCN Services Program Automated Inquiry System (AIS) at 1-800-568-2413.
- CSHCN Services Program at 1-800-252-8023.
- TMHP Electronic Data Interchange (EDI) Gateway.
- TMHP website at www.tmhp.com.

If the client is not eligible when they arrive for an appointment, the provider must advise the client that they are being accepted as a private-pay client at the time the service is provided. The client will be responsible for paying for all services received. Providers are encouraged to ensure that the client signs written notification indicating that the client is being accepted as a private-pay client.

Refer to: The "Client Eligibility" computer-based training on www.tmhp.com.

The CSHCN Services Program Eligibility Form provides the reapplication deadlines that are specific to each client. It identifies the date on which they can start the reapplication process and lets them know that they must submit a renewal application before their eligibility ends.

Approximately 60 days before the eligibility renewal date, the CSHCN Services Program mails a letter and a reapplication packet containing the CSHCN Services Program Application Booklet (T-3) to clients. Clients who have not received the packet within 30 days prior to the renewal date can request one from their local CSHCN Services Program Regional Office (refer to the listing at Section 1.3.2, "Regional Offices," on page 1-6 of this manual), or by calling the CSHCN Services Program Central Office at 1-800-252-8023, or downloading the booklet from the CSHCN Services Program website at www.dshs.state.tx.us/cshcn/clapplforms.shtm.

3.3.1 Eligibility Restrictions

Under certain circumstances, the client eligibility form *may not* be valid at the time of the client's appointment. For example, restrictions are sometimes placed on clients' cases after they receive their eligibility form. Some reasons for restrictions are:

- The CSHCN Services Program needs a Medicaid or CHIP determination.
- The client or family has moved.
- The family circumstances have changed, possibly making the client ineligible for the CSHCN Services Program.
- The client or family must apply to the Medically Needy Program.

The restriction period usually lasts 60 days. A 30-day extension may be granted when requested.

The client can continue to receive CSHCN Services Program benefits while there is a pending restriction on the case. However, there are a few important conditions to keep in mind.

- If the CSHCN Services Program receives the requested information or documentation before the end of the 60-day restriction period, the restriction ends, and there is no lapse in the client's eligibility.
- If the CSHCN Services Program receives the information or documentation after the end of the 60-day period (and the added 30-day extension, if requested), but before the end of the client's eligibility, their eligibility will lapse from the time the restriction period deadline until the time the CSHCN Services Program received the information.
- If the CSHCN Services Program receives the information after the client's eligibility expires, the client's name is placed on the program's waiting list. Clients on the waiting list are not eligible for health benefits.

3.3.2 CSHCN Services Program Eligibility Form Sample

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347 • Austin, Texas 78714-9347
1-888-963-7111 • http://www.dshs.state.tx.us

DAVID L. LAKEY, M.D..
COMMISSIONER

Children with Special Health Care Needs Services Program
Automated Inquiry System (AIS):
1-800-568-2413
Phone: 1-800-252-8023 or 512-458-7355

PARENT/GUARDIAN NAME
STREET ADDRESS
CITY, TX ZIPCODE

CSHCN Services Program
Case # 9-123456-00

Name: CLIENT NAME
Birth: 06/05/00 Sex: M
Medicaid/Insurance
Medicaid Number: 123456789
Valid xx/**01**/2xxx thru xx/**03**/2xxx

CSHCN Services Program Eligibility Form

This form may be used for services only between the "valid" dates listed in the box above.

This is your NEW CSHCN Services Program Eligibility Form. If you already have a form, throw away the old one. Take this form with you when you visit CSHCN Services Program providers. Do not loan this form to other people. Service providers can copy the form for their files. If you lose this form, call the CSHCN Services Program Eligibility Section. Whenever you call or write to the CSHCN Services Program, use the case number (Case #) shown on this form.

You must reapply for the CSHCN Services Program every 12 months. Send a new application and all proofs each time you reapply for CSHCN Services Program financial eligibility.

To stay on the CSHCN Services Program after this form runs out you must fill out a new CSHCN Services Program application and send the application to the CSHCN Services Program on or after xx/**22**/2xxx. However, your application must be received by the CSHCN Services Program not later than xx/**03**/2xxx. To get a new CSHCN Services Program application, call the CSHCN Services Program at 1-800-252-8023.

Este formulario se puede usar para conseguir servicios solamente durante las fechas válidas (*valid*) indicadas en la casilla de arriba.

Éste es su NUEVO formulario de elegibilidad para el Programa de Servicios de CSHCN. Si usted ya tiene un formlario, tire el formulario viejo. Lleve este formulario consigo para obtener servicios de los proveedores del Programa de Servicios de CSHCN. No preste este formulario a otras personas. Los proveedores pueden hacer una copia de este formulario para sus archivos. Si usted pierde este formulario, llame al personal de la Sección de Elegibilidad del Programa de Servicios de CSHCN. Siempre y cuando usted llame o escriba al Programa de Servicios de CSHCN, use el número de caso (*Case #*) que aparece en este formulario.

Usted tiene que presentar una nueva solicitud para el Programa de Servicios de CSHCN cada 6 meses. Mande una nueva solicitud y todos los comprobantes cada vez que usted presente una solicitud para elegibilidad financiera al Programa de Servicios de CSHCN.

Para continuar en el Programa de Servicios de CSHCN después de que termine su elegibilidad, tiene que rellenar una nueva solicitud del Programa de Servicios de CSHCN y mandar la solicitud al Programa de Servicios de CSHCN después del xx/ **22**/2xxx. Sin embargo, el Programa de Servicios de CSHCN tiene que recibir su solicitud al más tardar el xx/ **03**/2xxx. Para obtener una nueva solicitud para el Programa de Servicios de CSHCN, llame al Programa de Servicios de CSHCN al número 1-800-252-8023.

Provider Information

The client named on this form is eligible for CSHCN Services Program benefits for the period indicated. Service providers may duplicate this form for their files. Providers must be enrolled in the CSHCN Services Program. Prior authorization is required for some services. The CSHCN Services Program may revoke eligibility in the event of policy changes, changes in client medical or financial condition, or error. See the CSHCN Services Program Provider Manual for details. For more information, contact the CSHCN Services Program.

Under certain circumstances, the eligibility form MAY NOT be valid at the time you see this client. Please verify client's eligibility for CSHCN Services Program Benefits by calling CSHCN-AIS at 1-800-568-2413 or the TMHP-CSHCN Contact Center at 1-800-568-2413.

3.4 Clients Eligible for Medicaid and CSHCN Services Program Benefits

The CSHCN Services Program requires all applicants to apply for Medicaid and include the determination or exemption letter in their program application. The CSHCN Services Program will not pay for services until the client's Medicaid eligibility is determined. The CSHCN Services Program also does not pay for services provided to children who are also eligible for Medicaid, with the exception of the transportation of a deceased client's body.

Information about Medicaid is printed on the CSHCN Services Program Eligibility Form. The coverage is indicated by the word Medicaid, below the date of birth in the CSHCN Services Program Client Number block. This information is obtained at the time of application, and it must be verified at the time the service is provided.

If the CSHCN Services Program pays benefits that also were paid by Medicaid, providers are responsible for refunding the full CSHCN Services Program payment. Providers must make the refund check payable to TMHP and send it to the attention of the TMHP Financial Unit. Send the refund check along with the CSHCN Services Program Refund Information Form to the following address:

Texas Medicaid & Healthcare Partnership
Attn: Financial Unit
12357B Riata Trace Parkway, Suite 100
Austin, TX 78727

Include the following information:

- Client name and CSHCN Services Program client number
- Copies of the Remittance and Status (R&S) Reports from both Texas Medicaid and the CSHCN Services Program that show the claims were paid
- Date of service
- Provider name
- Provider identifiers

Note: *If the Medicaid claims administrator (TMHP) denies a claim with the explanation of benefits (EOB) code 00182 (client not eligible), but the family has evidence that the client is eligible for Medicaid, providers must appeal or resubmit the claim to TMHP. Client Medicaid eligibility information may not have been available at the time of the first claim submission.*

3.5 Clients Eligible for CHIP and CSHCN Services Program Benefits

CHIP offers comprehensive health-care coverage to thousands of Texas children who are uninsured. CHIP provides services such as physician care, medications, medical equipment, therapies, hospitalization, and much more.

Many children in the CSHCN Services Program are eligible for CHIP. Children may receive CHIP and CSHCN Services Program benefits at the same time. The CSHCN Services Program may pay for meals, transportation, lodging, other services not available from CHIP, or services beyond the CHIP maximum benefit. The CSHCN Services Program is the payer of last resort for medical services.

CHIP benefits apply to all children in the family, including the child who is also eligible for the CSHCN Services Program. For more information about CHIP (children and perinatal coverage), contact CHIP/Children's Medicaid at 1-877-KIDS-NOW (1-877-543-7669) or visit the CHIP website at www.chipmedicaid.com.

3.6 Clients Eligible for Medicaid and Comprehensive Care Program (CCP) Benefits

The Texas Comprehensive Care Program (CCP) and Texas Medicaid (Title XIX) Home Health Services cover medically necessary services for enrolled clients who are 20 years of age or younger.

The CSHCN Services Program does not pay claims for its clients who are eligible for CCP and whose claims were denied by Medicaid for any reason, including late filing, limited client, duplicate services, incorrect claim form, or additional information required.

Additional information about CCP is available toll free at 1-800-846-7470, Monday through Friday, from 7 a.m. to 7 p.m, Central Time.

3.7 Medically Needy Program (MNP)

MNP provides access to Medicaid benefits for children who are 18 years of age or younger and whose family income exceeds the eligibility limits under Temporary Assistance to Needy Families (TANF) or one of the medical-assistance-only programs for children, but whose income and assets are not sufficient to meet their medical expenses.

The CSHCN Services Program requires all applicants to include a Medicaid determination or exemption along with their application. No services are paid by the CSHCN Services Program until Medicaid eligibility is determined.

Once eligibility is established, the client can receive the same care and services available to all other Medicaid clients.

The CSHCN Services Program may ask clients to apply to MNP if $2,000 or more in medical bills were paid or are expected to be paid by the CSHCN Services Program. Clients are given 60 days to apply to MNP and send the determination to the CSHCN Services Program.

CSHCN Services Program client benefits are not limited during this 60-day period; however, the Program will suspend a client's eligibility if he or she does not comply with the request to apply to MNP.

3.7.1 MNP Spend Down Processing

MNP applicants must meet basic TANF eligibility requirements. Eligibility may be determined with or without spend down (the difference between the applicant's net income and the MNP income limits). When the applicant is eligible without spend down (income is below MNP income limits), the applicant is certified to be Medicaid-eligible.

Prospective MNP clients who do not qualify for Medicaid must participate in the "Spend Down" program which is based on income and health-care expenses. The spend down amount and duration of Medicaid coverage is determined by HHSC. The client is issued a Medical Bills Transmittal (Form H1120 or H1122) that indicates the spend down amount and the months of potential coverage (limited to the month of application and any of the 3 months before the application month).

During spend down, program participants are responsible for paying a portion of their health-care bills and submitting those bills or completed claim forms, also referred to as invoices, to the Medically Needy Clearinghouse (MNC). All medical bills (for all family members) must be submitted to the TMHP-MNC, along with the Form H1120 or H1122 for application toward the spend down amount.

Texas Medicaid & Healthcare Partnership Medically Needy Clearinghouse
PO Box 202947
Austin, TX 78720-2947

Charges from the bills are applied in date-of-service order to the spend down amount. The spend down is met when the accumulated charges equal the spend down amount.

Once the client has met the total spend down amount and becomes eligible for Medicaid, MNC will return the invoices to the client, and the client will receive a Medicaid Identification form. Spend down program participants are required to notify their providers once their Medicaid eligibility has been established. Providers are expected to submit claims to Medicaid for those clients after that time. MNC will also mail notification letters to providers who have not yet submitted claims for clients who have become eligible for Medicaid by meeting their spend down amount.

Note: *Providers must include the CSHCN Services Program client number and the CSHCN Services Program client name on all of the documentation sent to the CSHCN Services Program or TMHP-MNC.*

The CSHCN Services Program can assist with the submission of medical bills to apply for Medicaid coverage through the spend down process. TMHP MNC accepts paid or unpaid medical bills from the CSHCN Services Program for application toward the spend down amount regardless of the date of service. This process enables TMHP MNC to expedite the conclusion of the case and inform DSHS when the spend down is met.

When the spend down is met and the client is certified as Medicaid-eligible, the CSHCN Services Program may consider whether any of the services used to meet the spend down amount (client liability) may be considered for CSHCN Services Program health-care benefits coverage.

3.7.2 Provider Assistance to Clients with Spend Down

Providers may assist clients in meeting their spend-down amount by:

- Submitting bills to TMHP MNC for the CSHCN Services Program client that are not payable by the program.
- Submitting bills to TMHP MNC for services provided to any other member of the family.
- Providing clients and families with current itemized statements.
- Encouraging clients to submit all of the medical bills they incurred from all of their providers.

Only medical bills having a date of service (DOS) within the 12 months preceding the date of receipt of the application denial date may be included to satisfy spenddown requirements. Medical bills from any member of the household for which the applicant, parents, foster parents, guardian, or managing conservator of the CSHCN Services Program applicant is responsible and which are not payable by another entity may be included. All spenddown documentation must be received within 60 days of receipt of the application denial Medical bills used to meet spenddown are not payable by the CSHCN Services Program.

Submitted bills must be itemized and must show the provider's name, client's name, CSHCN Services Program client number, MNP client number, dates of service, services provided, charge for each service, total charges, amounts of payments, dates of payments, and total due.

Bills for past accounts must be itemized statements dated in the last 60 days from the provider and must verify the outstanding status of the account and the current balance due. Accounts with payments made by an insurance carrier, including Medicare, must be accompanied by the carrier's EOB or a Medicare Summary Notice (formerly known as a Medicare Explanation of Benefits) that shows the specific services covered and amounts paid.

When additional information is requested by TMHP MNC, the applicant has 30 days from the date of the letter to respond. The provider may assist the client by furnishing the additional information to the applicant or sending it directly to TMHP MNC in a timely manner.

Note: *TMHP MNC does not pay bills; it only applies the charges toward the spend-down amount. The provider must file a Medicaid claim after the client's Medicaid eligibility is established so that Medicaid can consider the claim. During the spend-down period, the client does not have Medicaid coverage, and providers cannot send claims to Medicaid. Any claim filed at that time is denied due to client ineligibility.*

Providers may make inquiries regarding status, months of potential eligibility, Medicaid or case number, and general client information by contacting the TMHP Contact Center at 1-800-925-9126, from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

3.7.3 Claims Filing Involving a Medicaid Spend Down

TMHP MNC will mail notification letters to providers whenever clients meet spend down and TMHP has not yet received any claim for the client's bills. The notification letter will state that an invoice was submitted for the spend down and that the provider should submit claims for any bills that fall within the indicated spend down month.

Clients are also responsible for informing their medical providers of their Medicaid eligibility and making arrangements to pay the charges used to meet the spend down amount. For CSHCN Services Program clients, the CSHCN Services Program may consider paying the charges used to meet the spend down for covered services.

TMHP MNC notifies the client of:

- Bills or charges that were used to meet the spend down.
- Bills or charges that the client is financially responsible to pay.
- Bills or charges that the provider should submit to Texas Medicaid for consideration of payment.

Bills or charges not applied toward spend down or not previously submitted to the CSHCN Services Program, must be received by TMHP for Medicaid consideration. These claims must be received within 95 days from the date the client's eligibility was added to the TMHP file (add date) and must be on the appropriate claim form (such as CMS-1500 and UB-04 CMS-1450).

The client's payment responsibilities are as follows:

- When a portion of the entire bill was used to meet spend down, the client is responsible for the payment of the specific portion or the entire bill. For CSHCN Services Program clients, submit the bill to the CSHCN Services Program for payment consideration.

Claims are subject to the following:

- The claim must show the total billed amount for the services provided. Charges for ineligible days or spend down amounts must not be deducted or included on the claim.
- A client's payment toward spend down must not be reflected on the claim submitted to TMHP.

Note: *Payments made by the client for services that were not used in the spend down but that were incurred during an eligible period must be reimbursed to the client before the provider files a claim with TMHP.*

Once eligibility is established, the client is eligible to receive the same care and services available to all other Medicaid clients.

3.8 Renal Dialysis

Eligibility for clients needing renal dialysis begins with the initial date of eligibility or the first dialysis treatment date, whichever is later, and may continue for a period of three months. All CSHCN Services Program clients who need dialysis due to end-stage renal disease (ESRD) are referred to the Kidney Health Care (KHC) program and to Medicare for coverage. These clients are notified that they must apply to KHC and Medicare and are given 60 days to submit the determinations to the CSHCN Services Program. Coverage for health care benefits continues for ongoing clients and waiting list clients may receive eligibility during the 60-day period. A 30-day extension may be granted to obtain the determinations. If the client is not eligible for KHC or Medicare, eligibility for CSHCN Services Program coverage continues.

3.9 Waiting List Information

The CSHCN Services Program may establish a waiting list when budgetary limitations exist. The waiting list is maintained continually from one fiscal year to the next.

Clients are placed on the waiting list for one of two reasons:

1) They are new applicants to the program.
2) They are current clients who did not renew on time.

Clients placed on the waiting list are notified of their status. The CSHCN Services Program periodically contacts waiting list clients to confirm their eligibility for CSHCN Services Program services.

Clients on the waiting list do not receive a CSHCN Services Program Eligibility Form. The CSHCN Services Program sends information about the waiting list process to adult clients, the parent, guardian, caretaker, or managing conservator of a minor child, the DSHS Regional Office, and the client's physician or dentist. Applicants are not placed on the waiting list until it is determined that they meet all of the eligibility criteria for the program.

If all of the documentation necessary to complete the application has been received except the Medicaid or CHIP determinations, the client is placed on the waiting list. The Medicaid or CHIP determinations must be received before the client is removed from the waiting list.

Each month the CSHCN Services Program reviews its funds to see if it can take people off the list. The Program can only take a group of clients off the list and does not take one person off at a time. Clients are removed from the list when funds become available.

Funding decisions concerning the waiting list are based both on the amount of program funds available and the anticipated amounts required to provide health-care benefits. The order in which clients are removed is not purely sequential; it depends on a combination of factors, including the urgent medical need of the condition as reported by a physician or dentist on the CSHCN Services Program Physician/Dentist Assessment Form, the availability of other health insurance, the client's age, and the date and time of the latest uninterrupted eligibility period.

When a client is removed from the waiting list, the client receives a new program approval letter and a CSHCN Services Program Eligibility Form with the active eligibility dates and information regarding the range of services. If there is a change in the client's condition, the client's medical information must be updated. It is important that all client eligibility information is current.

Clients' placement on the waiting list is also based on the date and time their application is processed and approved for the program. Clients must maintain program eligibility to remain on the waiting list. A lapse in eligibility changes their placement on the waiting list.

Waiting list clients who wish to remain eligible to be considered for program health-care benefits must reapply for eligibility before their eligibility is scheduled to end. The eligibility coverage period is 12 months (i.e., 365 days from the first day of the client's current eligibility period, or 366 days during a Leap Year). Clients are notified of program deadlines to re-establish eligibility. Within 60 days of the client's eligibility end date, the CSHCN Services Program mails the client a CSHCN Services Program application booklet and a letter advising that it is time to reapply.

If a waiting list client submits an application without all of the required documentation, the application is considered incomplete, and the client is given 60 days to complete it. If the reapplication process is not completed within the 60-day period, the client's place on the waiting list is forfeited. When the CSHCN Services Program receives a complete reapplication after the 60-day period, the client is placed at the end of the waiting list according to the approval date of his or her complete application.

3.10 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.

Chapter

4

Prior Authorizations and Authorizations

4.1 General Information

Some services require authorization or prior authorization as a condition for reimbursement. Authorization or prior authorization is not a guarantee of payment.

- Authorization must be obtained no later than 95 days after the date of service.
- Prior authorization must be obtained before the service is provided.

TMHP sends a notification to providers and clients when it approves, denies, or modifies an authorization or prior authorization request. It is strongly recommended that providers maintain a list that details the authorizations, including:

- Client name
- CSHCN Services Program client number
- Date of service
- Provider number
- Items submitted

Providers will need this information if they request an administrative review after an authorization or prior authorization is denied. In addition, providers should keep a copy of the request for authorization and the response received from TMHP.

Refer to: 2014 Authorization and Filing Deadline Calendar

2015 Authorization and Filing Deadline Calendar

4.1.1 Limitations

Authorization and prior authorization requests will be denied if the provider is not actively enrolled with 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.

Refer to: Chapter 2, "Provider Enrollment and Responsibilities," on page 2-1 for more information on becoming a CSHCN Services Program provider.

- Providers are responsible for verifying client eligibility before providing services. If the client is not eligible at the time of the authorization or prior authorization request, the request will be denied. If the client becomes eligible at a later date, providers can submit a new authorization or prior authorization request form.
- Any services provided beyond the limitations of the CSHCN Services Program are not reimbursed.

4.1.2 Signature Requirements

Authorization and prior authorization request forms submitted to TMHP must be signed and dated by the client's medical provider, dental provider, or medical supplier. If indicated on the form, an authorized representative's signature is acceptable.

4.1.3 Requests for Procedures That Are Pending a Rate Hearing

Some procedure codes that require authorization or prior authorization may be pending a rate hearing. In these cases, providers must follow the established authorization or prior authorization processes for these procedure codes and must not wait until the procedure codes have gone through the rate hearing process to request authorization or prior authorization.

Providers are responsible for meeting all filing deadlines and for ensuring that the authorization or prior authorization number appears on the claim the first time it is submitted.

TMHP will deny the affected procedure codes as pending a rate hearing until the rates are adopted and implemented. Once the rates are adopted and implemented, TMHP will automatically reprocess the claims. However, if the required authorization or prior authorization number is not on the claim at the time of reprocessing, the claim will be denied as lacking authorization or prior authorization.

4.2 Authorizations

Providers must submit authorization requests on a CSHCN Services Program-approved form. Requests with insufficient information will be denied and providers will receive notification of the reason for denial. If a form is not available for a specific service, providers must submit the request using the CSHCN Services Program Authorization and Prior Authorization Request form and follow the guidelines and requirements listed in the chapter for that service.

Authorization requests must be submitted and approved no later than 95 days after the date of service and may be submitted before the service is provided. If the service has already been provided, the authorization form may be submitted before the claim, or attached to the paper claim form. Claims for services requiring authorization are denied if the authorization number is not indicated on the claim or if the authorization and all required documentation is not attached to the claim.

The 95-day deadline applies to all services requiring authorization, including extensions and emergency situations. Fax transmittal confirmations and postal registered mail receipts are not accepted as proof of timely authorization submission. Authorization requests are reconsidered only when resubmitted, received, and approved within 95-days of the date of service.

Important: *No extensions beyond the 95-day initial deadline are given.*

Providers can correct and resubmit requests for authorization. Questions, concerns, or requests for clarification may be included in authorization resubmissions. The TMHP-CSHCN Services Program Authorization Department will respond to questions, concerns, or requests for clarification by phone, fax, or mail. Corrected requests must meet authorization and prior authorization submission deadlines. Requests that do not meet the deadlines will be denied.

Providers must mail or fax written authorization requests and all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

4.2.1 Services that Require Authorization

The following is a list of many of the services that require authorization. The list below is not all-inclusive. Information about specific authorization requirements for each of the services that is a benefit of the CSHCN Services Program is included in the chapter for each service.

Most outpatient surgery services no longer require authorization or prior authorization unless otherwise indicated in the specific sections of the Children with Special Health Care Needs (CSHCN) Services Program Provider Manual. All requests for prior authorizations or authorizations must be submitted in writing on the CSHCN Services Program-approved authorization and prior authorization forms. Forms are available on Forms page of the TMHP website. This form must be used when indicted for procedures as outlined in specific sections of the CSHCN Services Program Provider Manual.

Refer to the specific provider sections in this manual or call TMHP at 1-800-568-2413 for more information.

Blood Pressure Devices, In Specific Instances	
Refer to:	Chapter 11, "Ambulatory Blood Pressure Monitoring and Devices," on page 11-1.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Botulinum Toxin (Type A and B)	
Refer to:	Section 31.2.25.6, "Botulinum Toxin (Type A and Type B)," on page 31-85.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons

Clinician-Directed Care Coordination Services	
Refer to:	Section 31.2.13, "Clinician-Directed Care Coordination Services," on page 31-26.
Use:	The CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services form

Durable Medical Equipment (DME)	
Refer to:	Chapter 17, "Durable Medical Equipment (DME)," on page 17-1.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)
Exception:	Custom DME and more complex equipment requires prior authorization.

Hemophilia Blood Factor Products	
Refer to:	Section 31.2.9, "Blood Factor Products," on page 31-20.
Use:	The CSHCN Services Program Authorization Request for Hemophilia Blood Factor Products" form

Home Health (Skilled Nursing Only) Up to 200 Hours Per Calendar Year	
Refer to:	Chapter 22, "Home Health (Skilled Nursing) Care," on page 22-1.
Use:	The CSHCN Services Program Home Health (Skilled Nursing) Referral and Treatment Plan

Nebulizers, In Specific Instances	
Refer to:	Section 35.2.8, "Nebulizers," on page 35-9.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Outpatient Dental Surgical Procedures	
Refer to:	Section 14.2.6, "Dental Treatment in Hospitals and ASCs," on page 14-35.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons
Use:	The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services
Use:	The CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia

Telecommunication Services	
Refer to:	Section 37.2.3, "Telemonitoring Services," on page 37-6.
Use:	The Home Telemonitoring Services Prior Authorization Request Form

4.2.2 How To Submit an Authorization Request

Providers must mail or fax written authorization requests and all applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

4.3 Prior Authorizations

Providers must submit prior authorization requests on a CSHCN Services Program-approved form. If a form is not available for a specific service, providers must submit the request using the CSHCN Services Program Authorization and Prior Authorization Request form and follow the guidelines and requirements listed in the chapter for that service. Only complete prior authorization requests will be considered. Incomplete requests are denied.

Prior authorization requests must be submitted and approved *before* the service is provided. However, if the service is provided after business hours (business hours are Monday through Friday, from 8 a.m. to 5 p.m., Central Time), on a weekend, or on a holiday (see list in Section 4.4 below), then the prior authorization request may be submitted on the next business day.

Providers should allow three business days to receive a response to an authorization or prior authorization request.

The TMHP Contact Center receives calls from CSHCN Services Program providers with inquiries related to prior authorization. Contact Center agents make every attempt to answer the provider's questions and/or resolve the provider's concerns. If a provider requires a call back from a Prior Authorization (PA) clinician and the request for call back is not related to urgent/emergent services, the provider should submit a call back request via fax to 1-512-514-4222.

All inpatient admissions must be prior authorized. The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only must be submitted to the claims contractor for review and approval before the date of service, or the entire hospital stay will be denied. Partial approvals for a hospital stay will no longer be granted.

Requests for emergency hospital admissions must be authorized by the next working day after admission date for the coverage of the entire hospital stay. Requests for emergency admissions received after the next business day will be denied for the entire hospital stay.

If a client requires a service that exceeds policy limitations, providers may request prior authorization with documentation of medical necessity.

If a client requires a service that has diagnosis restrictions, providers may request prior authorization with documentation of medical necessity for diagnoses not listed in the policy.

Claims submissions must include the prior authorization number in the appropriate field.

Refer to: Section 5.7, "Claims Filing Instructions," on page 5-24 for claims filing instruction details.

Important: *The Program does not grant extensions to these deadlines to allow providers to complete or correct and resubmit their prior authorization requests.*

4.3.1 Services that Require Prior Authorization

The following is a list of many of the services that require prior authorization. The list below is not all-inclusive. Information about specific prior authorization requirements for each service that is a benefit of the CSHCN Services Program is included in the chapter for each service.

Most outpatient surgery services no longer require authorization or prior authorization unless otherwise indicated in the specific sections of the Children with Special Health Care Needs (CSHCN) Services Program Provider Manual. All requests for prior authorizations or authorizations must be submitted in writing on the CSHCN Services Program-approved authorization and prior

authorization forms. Forms are located on the Forms page of the TMHP website. This form must be used when indicted for procedures as outlined in specific sections of the CSHCN Services Program Provider Manual.

Refer to the specific provider sections in this manual or call TMHP at 1-800-568-2413 for more information.

Augmentative Communication Devices (ACDs)	
Refer to:	Chapter 10, "Augmentative Communication Devices (ACDs)," on page 10-1.
Use:	The CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs)

Stem Cell Transplants (initial and one subsequent transplant)	
Refer to:	Section 31.2.39.2, "Transplants - Nonsolid Organ," on page 31-130.
Use:	The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant

Certified Respiratory Care Practitioner	
Refer to:	Chapter 13, "Certified Respiratory Care Practitioner (CRCP)," on page 13-1.
Use:	The CSHCN Services Program Prior Authorization Request for Respiratory Care—Certified Respiratory Care Practitioner (CRCP)

Cleft/Craniofacial Surgical Procedures	
Refer to:	Section 31.2.37.11, "Cleft/Craniofacial Procedures," on page 31-115.
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons

Cranial Molding Devices (Dynamic Orthotic Cranioplasty [DOC™] only)	
Refer to:	Section 28.2.2, "Orthoses and Prostheses (Not All-Inclusive)," on page 28-3.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Dental Procedures (some), Including Inpatient Admissions for Dental Surgical Procedures	
Refer to:	Chapter 14, "Dental," on page 14-1.
Use:	The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only

Diapers, Liners, and Pull-ups (or any combinations of these supplies)	
Require prior authorization for quantities that exceed 240 per month.	
Refer to:	Chapter 18, "Expendable Medical Supplies," on page 18-1.
Use:	The CSHCN Services Program Prior Authorization Request for Diapers, Pull-ups, Briefs, or Liners

Home Health (Skilled Nursing) Services Over 200 Hours per Calendar Year	
Refer to:	Chapter 22, "Home Health (Skilled Nursing) Care," on page 22-1.
Use:	The CSHCN Services Program Home Health (Skilled Nursing) Referral and Treatment Plan

Home Health Services	
Refer to:	Chapter 21, "Home Health Services," on page 21-1.
Use:	The CSHCN Services Program Authorization and Prior Authorization Request

Hospice Services	
Refer to:	Chapter 23, "Hospice," on page 23-1.
Use:	The CSHCN Services Program Prior Authorization Request for Hospice Services

Inpatient Admissions and Extensions	
Refer to:	Section 24.3, "Inpatient Services," on page 24-6.
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only

Inpatient Rehabilitation Admissions	
Refer to:	Section 24.3.1.2, "Inpatient Rehabilitation Services," on page 24-7.
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Rehabilitation Admission

Medical Foods, In Specific Instances	
Refer to:	Section 26.3, "Medical Foods," on page 26-8.
Use:	The CSHCN Services Program Prior Authorization Request for Medical Foods

More Than One Hour (Four Units) of Nutritional Assessments and Intervention per Rolling Year and More Than Two Nutritional Counseling Visits per Rolling Year	
Refer to:	Section 26.4, "Medical Nutritional Counseling Services," on page 26-10.
Use:	The CSHCN Services Program Prior Authorization Request for Medical Nutritional Services

Non-Emergency Ambulance Transports	
Refer to:	Section 9.4, "Non-Emergency Ambulance Transports," on page 9-11.
Use:	The Non-emergency Ambulance Prior Authorization Request The Texas Medicaid and CSHCN Services Program Nonemergency Exception Form and Instructions ***Note:*** *CSHCN Services Program providers must not complete any portion of the Non-emergency Ambulance Prior Authorization Request form to ensure the integrity of the request form. Prior Authorization must be obtained by the facility or the physician's staff for all non-emergency transports. The Non-emergency Ambulance Prior Authorization Request form must be filled out and faxed or mailed to TMHP by the facility or the physician's staff that is most familiar with the client's condition. The CSHCN Services Program ambulance provider must not assist in completing or submitting any portion of this form.*

Orthodontia (except for the initial orthodontic visit)	
Refer to:	Section 14.2.3, "Orthodontia Services," on page 14-9.
Use:	The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services

Orthotics and Prosthetics	
Refer to:	Chapter 28, "Orthotic and Prosthetic Devices," on page 28-1.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Outpatient Physical Therapy and Occupational Therapy Services	
Refer to:	Section 30.2.2, "Physical Therapy (PT), and Occupational Therapy (OT)," on page 30-3.
Use:	The CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1)
Use:	The CSHCN Services Program Authorization Request for Extension of Outpatient Therapy (TP2)

Outpatient Speech-Language Pathology Services (all services except initial evaluations)	
Refer to:	Chapter 36, "Speech-Language Pathology (SLP) Services," on page 36-1.
Use:	The CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1)
Use:	The CSHCN Services Program Authorization Request for Extension of Outpatient Therapy (TP2)

Pediatric Hospital Cribs and Tops	
Refer to:	Section 17.3.9, "Hospital Beds (Manual and Electric)," on page 17-9.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Prescription Shoes	
Refer to:	Section 28.3.7.2, "Prescription Shoes," on page 28-11.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Radiation Therapy Services (some), Including Proton- or Neutron-Beam Treatment Delivery, Intensity Modulated Radiation Therapy, and Stereotactic Radiosurgery	
Refer to:	Chapter 33, "Radiation Therapy Services," on page 33-1.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons

Reduction Mammoplasties	
Refer to:	Section 31.2.37.12, "Mastectomy and Related Services," on page 31-117.
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

Renal Dialysis	
Refer to:	Chapter 34, "Renal Dialysis," on page 34-1.
Use:	The CSHCN Services Program Prior Authorization Request for Renal Dialysis Treatment

Renal Transplants	
Refer to:	Section 31.2.39, "Transplants," on page 31-129.
Use:	The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant

Rhizotomies	
Refer to:	Section 31.2.37.14, "Rhizotomy," on page 31-123.
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

Ultrasonic Nebulizers, In Specific Instances	
Refer to:	Section 35.2.8, "Nebulizers," on page 35-9.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Wheelchair Purchases (custom manual and standard or custom power) and Custom Seating Systems	
Refer to:	Section 17.3.19, "Wheelchairs," on page 17-19.
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)
Use:	The CSHCN Services Program Wheelchair Seating Evaluation Form

4.3.2 Clients with Third Party Resources

If a client has other coverage from a third-party resource (TPR), prior authorization and authorization requests will be approved or denied according to CSHCN Services Program prior authorization and authorization guidelines. The approved services will be considered for payment:

- If the TPR does not pay because of co-insurance or deductible amounts.
- When the total amount paid (including all payers) to the provider does not exceed the amount allowed by the program for the covered service.

If clients have dual coverage with the Children's Health Insurance Program (CHIP), prior authorization and authorization requests will be approved or denied according to CSHCN Services Program prior authorization and authorization guidelines. The approved services will be considered for payment as follows:

- Dental services and durable medical equipment may be reimbursed after the CHIP cap has been met.
- Orthodontic services not covered under the CHIP medical plan may be reimbursed.
- Other covered program benefits specifically excluded from or capped by the CHIP benefit plan may be reimbursed.
- The provider submits an explanation of benefits (EOB) from the TPR with a valid claim.

4.3.3 Prior Authorization for Inpatient Admission After Business Hours

Tip: *Photocopy these forms and retain the originals for future use.*

For prior authorization of an inpatient admission after business hours in an emergency or when required medical services cannot be delayed, submit requests the next business day by completing the CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only.

Requests for emergency admissions received after the next business day will be denied for the entire hospital stay.

Both the facility and the attending physician, surgeon, or supplier must be enrolled in the CSHCN Services Program for inpatient claims to be considered for payment.

Refer to: "Initial Inpatient Prior Authorization Requests," on page 24-6 for additional information.

4.3.4 Retroactive Prior Authorizations

Retroactive prior authorizations will be considered for clients who are eligible for the CSHCN Services Program when all of the following conditions are met:

- The service is a benefit of the CSHCN Services Program.
- A Medicaid prior authorization has been approved and issued for the requested service(s) but the client is no longer eligible for Medicaid on the date of service.

- The CSHCN Services Program prior authorization or authorization requirements have been met.
- All other billing requirements are met.

The retroactive CSHCN Services Program prior authorization request must include documentation that indicates approval of the Medicaid prior authorization request. The provider will be issued a new prior authorization number for the CSHCN Services Program prior authorization.

Note: *The CSHCN Services Program prior authorization request must contain the same information that was submitted to Medicaid.*

After a prior authorization has been approved by the CSHCN Services Program, the provider must resubmit the claim with the CSHCN Services Program client ID number and the approved CSHCN Services Program prior authorization number.

4.3.5 How to Submit a Prior Authorization Request

Providers must complete all essential fields on prior authorization forms submitted to TMHP to initiate the prior authorization process.

If any essential field on a prior authorization request is missing, incomplete, or completed with illegible information, TMHP will return the original request to the provider with the following message:

TMHP Prior Authorization could not process this request because the request form submitted has missing, incorrect, or illegible information in one or more essential fields. Please resubmit the request with all essential fields completed with accurate information for processing by TMHP within 14 business days from the request receipt date.

TMHP will use the date that the complete and accurate request form is received to determine the start date for services. Previous submission dates of incomplete forms returned will not be considered when determining the start date of service.

Providers have 14 business days from the request receipt date to respond to an incomplete prior authorization request. Incomplete prior authorization requests are requests received by TMHP with missing, incomplete, or illegible information.

Prior to denying an incomplete request, TMHP's Prior Authorization (PA) department will continue to communicate with the requesting provider in an effort to obtain the required additional information. A minimum of three attempts will be made to contact the requesting provider before a letter is sent to the client regarding the status of the request and the need for additional information.

If the additional information needed to make a prior authorization determination is not received within 14 business days from the request receipt date, the request will be denied as "incomplete." To ensure timely processing, providers should respond to requests for missing or incomplete information as quickly as possible.

CSHCN Services Program requests that do not appear to meet CSHCN medical policy, the TMHP PA Nurse will refer those requests to CSHCN Services Program for review and determination. CSHCN Services Program will complete the review within three business days of receipt of the completed prior authorization request.

Note: *Providers may re-submit a new, complete request after receiving an incomplete denial; however, submission requirements related to timeliness will apply.*

TMHP requires information in the essential fields. Essential fields contain information needed to process a prior authorization request and include the following:

- Client name
- Client CSHCN Services Program number
- Client date of birth
- Provider name
- CSHCN Texas Provider Identifier (TPI)
- National Provider Identifier (NPI)

- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code
- Quantity of service units requested based on the CPT or HCPCS code requested

Providers must mail or fax written prior authorization requests and all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

4.3.6 Authorization and Manually Priced Claims

Certain procedure codes do not have an established fee and must be priced manually by the TMHP-CSHCN Services Program medical staff. The medical staff determines the reimbursement amount by comparing the services to other services that require a similar amount of skill and resources.

If an item requires manual pricing, providers must submit with the prior authorization request or the claim the appropriate procedure codes and documentation of one of the following, as applicable:

- The manufacturers suggested retail price (MSRP) or average wholesale price (AWP)
- The provider's documented invoice cost if a published MSRP or AWP is not available

Note: *The AWP is for nutritional products only.*

For appropriate processing and payment, providers should bill the applicable MSRP or AWP rate instead of the calculated manual pricing rate. The calculated rate or the Pay Price that is indicated on the authorization letter for prior authorized services should not be billed on the claim.

4.3.7 Sending Prior Authorization Requests via Fax

Providers must include specific information when sending prior authorization requests via fax. The following information is required:

- A working fax number to receive faxed responses or correspondence from TMHP
- The last four digits of the client's CSHCN Services Program Identification number on the fax coversheet

Note: *This requirement applies to submissions of new prior authorization requests, re-submissions, and additional information needed to complete a request. The fax number listed on the prior authorization form is the fax number used to send faxed responses or correspondences from TMHP.*

4.4 Extension of Filing Deadlines for Holidays

For holidays that extend the filing deadline, please refer to Section 5.1.8, "Claims Filing Deadlines," on page 5-5.

4.5 Specialty Team or Center Services

In addition to requiring prior authorization, the following services have additional requirements for physicians or facilities:

- For stem cell transplant services, the facility must attest on the PA form that it is 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). Prior authorization must be obtained by both the facility and the physician.

- For cleft/craniofacial surgical procedures, the surgeon must be a member of a comprehensive cleft/craniofacial team.

If the specialty team or center requirements are not met, all services related to the procedure are denied.

Note: *Anesthesiologists and assistant surgeons are not required to be enrolled as a specialty team or specialty center. An anesthesiologist may be paid if all enrollment and filing deadlines are met. However, when a procedure or admission is denied by the CSHCN Services Program because the primary surgeon or hospital is not appropriately specialty team- or center-enrolled, the assistant surgeon's claims also are denied.*

Refer to: Section 2.1.7, "Transplant Specialty Centers," on page 2-9 for more information about transplant specialty centers enrollment.

4.6 Authorization and Prior Authorization Denials

Authorization and prior authorization requests will be denied if they:

- Do not contain all of the information necessary for the Program to make a determination,
- Do not meet medical necessity criteria, or
- Exceed the benefit limitation.

Some of the most common reasons for the denial of authorizations and prior authorizations are because the request:

- Is incomplete,
- Is submitted on the wrong form,
- Lacks the necessary documentation,
- Contains inaccurate information,
- Fails to meet the submission deadline,
- Is for an ineligible client, benefit, or provider, or
- Is for a client that does not qualify for the health-care benefit requested.

Denied authorization and prior authorization requests may be corrected and resubmitted. Corrected requests must meet authorization and prior authorization submission deadlines to be considered.

Providers can also submit questions or requests for clarification of a denied authorization or prior authorization by fax. The TMHP-CSHCN Services Program Authorization Department will respond by phone, fax, or mail. The department will not respond by e-mail in order to comply with *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 requirements.

Providers dissatisfied with TMHP's decision to deny authorization and prior authorization of services may submit a request for an administrative review to the CSHCN Services Program.

Refer to: Section 7.3.5, "Administrative Review for Claims," on page 7-6 for information about the administrative review process.

4.6.1 Denied Authorization and Prior Authorization Requests Resubmission

Providers can correct and resubmit requests for authorization and prior authorization, and can include questions, concerns, or requests for clarification. The TMHP-CSHCN Services Program Authorization Department will respond to questions, concerns, or requests for clarification by phone, fax, or mail.

Corrected requests must meet authorization and prior authorization submission deadlines. Requests that do not meet the deadlines will be denied.

Requests for services requiring authorization or prior authorization as a condition for reimbursement must be submitted on a CSHCN Services Program-approved form and contain all of the information that is necessary for the Program to make a decision. Requests submitted with insufficient information will be denied and providers will receive notification of the reason for denial.

4.6.2 Administrative Review for Authorization and Prior Authorization Denials

Clients and providers will receive written notice of denied authorization and prior authorization requests within 30 days of the date of the notification. A provider or a client who has received a denied authorization or prior authorization to TMHP may submit a request for an administrative review to the CSHCN Services Program if they are dissatisfied with TMHP's decision to deny the authorization or prior authorization. A client or provider may not request an administrative review of the program's denial of a prior authorization or authorization request for program services or provider reimbursement amounts that are in accordance with established fee schedules and budget alignment methodologies authorized by the CSHCN Services Program Rules Title 25 Part 1 TAC §38.16.

All clients and providers must submit requests for an administrative review within 30 days of the date TMHP denied the authorization or prior authorization. Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program—Administrative Review
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133

Additional information requested by the CSHCN Services Program must be returned to the Program within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case is closed.

4.6.3 Fair Hearing

After an administrative review, providers may request a fair hearing if they are dissatisfied with the CSHCN Services Program's decision and the supporting reason.

The fair hearing is the final appeal process and is described in the *Texas Administrative Code* (TAC) Title 25, Part 1, Chapter 1, Subchapter C (www.sos.state.tx.us). The fair hearing process is conducted by the Office of General Counsel at the Department of State Health Services (DSHS).

Providers may choose to represent themselves or have legal counsel or another spokesperson at the hearing. If providers are unable to attend the hearing in person, they may request arrangements to attend by teleconference.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived their right to request a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program—Fair Hearing
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133 or 1-512-776-7162 (in Austin)

Refer to: Section 7.2.2, "Fair Hearing Requests for Authorizations or Prior Authorizations," on page 7-2.

4.7 TMHP-CSHCN 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.

Chapter

5

Claims Filing, Third-Party Resources, and Reimbursement

5.1 TMHP Claims Information

5.1.1 Claims Processed by TMHP

COMPASS21 (C21) is the claims and encounters processing system currently used by the Texas Medicaid & Healthcare Partnership (TMHP) to process Children with Special Health Care Needs (CSHCN) Services Program claims. C21 is an advanced Medicaid Management Information System (MMIS) that incorporates the latest claims processing methods and offers access to data and flexibility for future program changes.

There are two ways to submit claims to C21. Providers can submit claims to TMHP through TexMedConnect or a third party vendor. Electronic filing is the most efficient and effective way to submit claims. TMHP also accepts paper claims. Providers that file paper claims are encouraged to switch to electronic submission.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1.

A listing of the providers and services that are paid by TMHP can be found in Chapter 3, "Client Benefits and Eligibility," on page 3-1 of this manual.

All claims sent by mail to TMHP for the first time must be addressed to:

Texas Medicaid & Healthcare Partnership
Attn: CSHCN Services Program Claims
PO Box 200855
Austin, TX 78720-0855

Claim corrections and appeals sent by mail to TMHP must be addressed to:

Texas Medicaid & Healthcare Partnership
Attn: CSHCN Services Program Appeals
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

All other correspondence sent by mail must be directed to a specific department or individual at the following address:

Texas Medicaid & Healthcare Partnership
Attn: *(Department)*
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

5.1.2 Claims Processed by the CSHCN Services Program

Family Support Services (FSS) can help families care for clients with special health-care needs. FSS can also help a client be more independent and able to take part in family life and community activities.

FSS includes, but is not limited to:

- Respite care to allow caretakers a short break from caring for their child.
- Specialized childcare costs above and beyond the cost for typical childcare and related to the child's disability or medical condition.
- Vehicle modifications, such as wheelchair lifts and related modifications such as wheelchair tie-downs, a raised roof, and hand controls.
- Home modifications, such as ramps, roll-in showers, or wider doorways.
- Special equipment that is not listed as a possible benefit in the child's health insurance plan, such as porch lifts or stair lifts, positioning equipment, or bath aids.

CSHCN Services Program case managers assist clients and their families with obtaining FSS. A list of DSHS Regional Health Service offices and contact information is provided in Chapter 1, "TMHP and DSHS Contact Information."

5.1.3 CPT and HCPCS Claims Auditing Guidelines

Claims with dates of service on or after October 1, 2010,Claims must be filed in accordance with Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) guidelines as defined in the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) coding manuals. Claims that are not filed in accordance with CPT and HCPCS guidelines may be denied, including claims for services that were prior authorized or authorized based on documentation of medical necessity.

If a rendered service does not comply with CPT or HCPCS guidelines, medical necessity documentation may be submitted with the claim for the service to be considered for reimbursement; however, medical necessity documentation does not guarantee payment for the service.

Important: *Prior authorization and authorization based on documentation of medical necessityis a condition for reimbursement; it is not a guarantee of payment.*

5.1.4 CMS NCCI and MUE Guidelines for All Claims

All claims must be filed in accordance with the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) and Mutually Exclusive Edit (MUE) guidelines, including claims for services that have been prior authorized or authorized with medical necessity documentation.

The CMS NCCI and MUE guidelines can be found in the NCCI Policy and Medicare Claims Processing manuals, which are available on the CMS website at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

Note: *Providers are required to comply with NCCI and MUE guidelines as well as the guidelines that are published in this manual, all currently-published website articles, fee schedules, and all other application information published on the TMHP website.*

5.1.5 TMHP Processing Procedures

The provider who performed the service must file an assigned claim and agree to accept the allowable charge as full payment.

Regulations prohibit providers from charging clients or TMHP a fee for completing or filing claim forms. The cost of claims filing is considered a part of the usual and customary charges for services provided to all CSHCN Services Program clients.

Claims filed with TMHP for reimbursement by the CSHCN Services Program are subject to the following procedures:

- TMHP verifies that all required information is present on the claim form.
- The claim is processed using clerical and automated procedures. Claims requiring special consideration are reviewed by medical professionals.
- All claims from the same provider that are ready for disposition at the end of each week are paid by a single check or electronic funds transfer (EFT) sent to the provider with an explanation of each payment or denial. This explanation is called the Remittance and Status (R&S) Report. If no payment is made to the provider, an R&S Report identifying denied or pending claims is sent to the provider. If there is no claim action during that time period, the provider does not receive an R&S Report that week.

Refer to: Chapter 6, “Remittance and Status (R&S) Reports,” on page 6-1.

5.1.6 Claims Processed by Date of Service

Some services, such as DME, inpatient behavioral health, and outpatient mental health services, have limits to what the CSHCN Services Program can pay. The CSHCN Services Program uses the date of service to determine whether to pay, deny, or recoup claims for services that have benefit limitations for providers.

The CSHCN Services Program may recoup claims that have been submitted and paid if a new claim with an earlier date of service is submitted, depending on the benefit limitations for the services rendered. Services that have been authorized for an extension of the benefit limitation will not be recouped.

Providers can submit an appeal with medical documentation if the claim has been denied. This rule also applies to National Correct Coding Initiative (NCCI)/Medically Unlikely Edit (MUE) editing.

5.1.7 Inactive Provider Termination

Providers are required to attest their National Provider Identifier (NPI) for each of their enrolled Texas Provider Identifiers (TPIs); any claim that is submitted to TMHP without an attested NPI will be rejected. Additionally, at least one claim must be submitted to TMHP every 24 months in order for the provider to remain an "active provider" in the CSHCN Services Program. 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.

TMHP will send a courtesy letter to providers whenever Medicaid and CSHCN Services Program TPIs go 18 months without claims activity. The letter will inform providers that if they want to keep TPIs active, they must submit a claim within 6 months of the date of the letter using one of the TPIs referenced in the letter. TMHP will apply a payment denial code to any TPI that has had no claims activity following 6 months of the date of the courtesy letter and will notify the provider that the TPI has been inactivated because the provider has not submitted claims using the TPI for a period of 24 months or more.

To have the payment denial code removed from a provider identifier, providers must submit a completed application for the Medicaid and CSHCN Services Program. 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 TPI(s). Instead, new TPI(s) will be issued for the new address or group.

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for additional information.

5.1.8 Claims Filing Deadlines

For claims payment to be considered, providers must adhere to the following time limits. Claims received after the following time limits are not payable because the CSHCN Services Program does not provide coverage for late claims.

- Inpatient claims filed by a hospital must be submitted to TMHP within 95 days from the discharge date. Hospitals may submit interim claims before discharge. These claims must be submitted to TMHP within 95 days from the last date of service on the claim.
- Outpatient hospital services must be submitted to TMHP within 95 days from the date of service.
- For clients receiving retroactive eligibility, TMHP must receive claims within 95 days from the date the eligibility was added to the TMHP eligibility file (add date).
- Claims for clients with other group or private health insurance coverage must be received by the CSHCN Services Program within 95 days of the date of disposition by the other third-party resource (TPR) and no later than 365 from the date of service. A copy of the disposition must be submitted with the claim and mailed to TMHP.
- TMHP must receive claims from out-of-state providers within 365 days of the date of service.
- All other claims must be submitted to TMHP within 95 days from each date of service.
- When a service is a benefit of Medicare, Medicaid, and the CSHCN Services Program, and the client is covered by all programs, the claim must be filed with Medicare first, then with Medicaid. If a Medicaid claim is denied or recouped for client ineligibility, the claim may be submitted to the CSHCN Services Program within 95 days from the date of Medicaid disposition.

When a filing deadline falls on a weekend or holiday, the filing deadline is extended to the next business day following the weekend or holiday. Holidays that may extend the deadlines in 2013 and 2014 are:

Date	Holiday
January 1, 2014	New Year's Day
January 20, 2014	Martin Luther King, Jr. Day
February 17, 2014	Presidents Day
May 26, 2014	Memorial Day
July 4, 2014	Independence Day
September 1, 2014	Labor Day
October 13, 2014*	Columbus Day (federal holiday)
November 11, 2014	Veteran's Day
November 27, 2014	Thanksgiving Day
November 28, 2014	Day After Thanksgiving
December 24, 2014	Christmas Eve Day
December 25, 2014	Christmas
December 26, 2014	Day After Christmas
January 1, 2015	New Year's Day
January 19, 2015	Martin Luther King, Jr. Day
February 16, 2015	Presidents Day
May 25, 2015	Memorial Day
July 4, 2015	Independence Day

* Federal holiday, but not a state holiday. The claims filing deadline will be extended for providers because the Post Office will not be operating on this day.

Refer to: 2014 Filing Deadline Calendar
2015 Filing Deadline Calendar

5.1.9 Exception to Claim Filing Deadline

The DSHS manager with responsibility for oversight of the CSHCN Services Program, or his or her designee, considers a provider's request for an exception to the 95-day claims filing deadline and the 120-day correction and resubmission deadline, if the delay is due to one of the following reasons and is received by the program within 18 months from the date of service:

- Damage to or destruction of the provider's business office or records by a catastrophic event or natural disaster; including, but not limited to fire, flood, or earthquake that substantially interferes with normal business operations of the provider. The request for an exception to the filing deadline must include:

  - An affidavit or statement from a person with personal knowledge of the facts detailing the requested exception.
  - The cause for the delay.
  - Verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's current employee or agent.
  - Any additional information requested by the CSHCN Services Program, including independent evidence of insurable loss; medical, accident or death records and a police or fire department report substantiating the damage or destruction.
- Damage or destruction of the provider's business office or records caused by intentional acts of an employee or agent of the provider, only if the employment or agency relationship was terminated and the provider filed criminal charges against the former employee or agent. The request for an exception to the filing deadline must include:
  - An affidavit or statement from a person with personal knowledge of the facts detailing the requested exception.
  - The cause for the delay.
  - Verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent.
  - Any additional information requested by the program, including a police or fire report substantiating the damage or destruction caused by the former employee or agent's criminal activity.
- Delay, error, or constraint imposed by the program in the eligibility determination of a client and/or in claims processing, or delay due to erroneous written information from the program, its designee, or another state agency. The request for an exception to the filing deadline must include:
  - An affidavit or statement from a person with personal knowledge of the facts detailing the requested exception.
  - The cause for the delay.
  - Verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent.
  - Any additional information requested by the program, including written documentation from the program, its designee, or another state agency containing the erroneous information or explanation of the delay, error, and/or constraint.
- Delay due to problems with the provider's electronic claims system or other documented and verifiable problems with claims submission. The request for an exception to the filing deadline must include:
  - An affidavit or statement from a person with personal knowledge of the facts detailing the requested exception.
  - The cause for the delay.
  - Verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent.
  - Any additional information requested by the CSHCN Services Program, including a written repair statement or invoice; a computer or modem-generated error report indicating attempts to transmit the data failed for reasons outside the control of the provider, or an explanation for the system implementation or other claim submission programs; a detailed, written statement by the person making the repairs or installing the system concerning the relationship and impact of the computer problem or system implementation to delayed claims submission; and the reason alternative billing procedures were not initiated after the problems became known.

The DSHS manager of the unit with responsibility for oversight of the CSHCN Services Program, or his or her designee(s), considers a provider's request for an exception to claims receipt deadlines due to delays caused by entities other than the provider and the program only if the following criteria are met:

- All claims that are to be considered for the same exception accompany the request (only the claims that are attached are considered).
- The exception request is received by the program within 18 months from the date of service.
- The exception request includes an affidavit or statement from a representative of an original payer, a third-party payer, or a person who has personal knowledge of the facts, stating the requested exception, documenting the cause for the delay, and providing verification that the delay was caused by another entity and not the neglect, indifference, or lack of diligence of the provider or the provider's employees or agents.

Send requests for exceptions to claim filing deadlines to:

CSHCN Services Program
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133

Note: *Correspondence greater than ten pages must be mailed.*

5.1.10 Fiscal Agent Payment Deadline

The CSHCN Services Program fiscal agent is required to finalize all claims, including appeals or adjustments, within 24 months.

- Provider claims—CSHCN Services Program payments cannot be made after 24 months from the date of service or discharge date on inpatient claims.
- Retroactive SSI eligibility claims—The payment deadline is derived from the client's eligibility add date to allow 24 months from the add date for the retroactive SSI-eligible client.

Payment deadlines should not be confused with the claims filing deadlines that are in place for claim submissions and appeals.

5.2 Third-Party Resource (TPR)

Federal and state laws require that the CSHCN Services Program use program funds for the payment of most medical services only after all reasonable measures were taken to use a client's TPR.

A TPR is a source of payment (other than payment from the CSHCN Services Program) for medical services. TPR includes payment from any of the following sources:

- Private health insurance
- Dental insurance plan
- Health maintenance organization (HMO)
- Home, automobile, or other liability insurance
- Preferred provider organization (PPO)
- Cause of action (lawsuit)
- Medicare
- Health-care plans of the U.S. Department of Defense or the U.S. Department of Veterans Affairs (also known as TRICARE)
- Employee welfare plan
- Union health plan
- Children's Health Insurance Program (CHIP)
- Prescription drug card
- Vision insurance plan

Even though Texas Medicaid is considered a non-TPR source, when the client is eligible for both the CSHCN Services Program and Texas Medicaid, Medicaid must be billed before billing the CSHCN Services Program. The CSHCN Services Program does not pay a provider for any services that could have been reimbursed by Texas Medicaid.

If Texas Medicaid denies or recoups a claim for client ineligibility, a copy of the Medicaid R&S Report must be submitted with the claim and received at TMHP within 95 days from the date of disposition.

A provider who furnishes services and is participating in the CSHCN Services Program must not refuse to furnish services to an eligible client because of a third party's potential liability for payment of the services.

Eligible clients must not be held responsible for billed charges in excess of the TPR payment for services that are a benefit of the CSHCN Services Program. When the TPR pays less than the program allowable amount for services that are a benefit, the provider may submit a claim to TMHP for any additional allowable amount. The program does not reimburse providers for copays or provider discounts deducted from TPR payments.

When the client has other third-party coverage, the CSHCN Services Program may pay the deductible or coinsurance for the client as long as the combination of insurance and program payment does not exceed CSHCN Services Programs fee schedule in use at the time of service.

Exception: *By law, the CSHCN Services Program cannot reimburse for CHIP deductibles or coinsurance.*

The CSHCN Services Program may pay for covered health-care benefits during CHIP or other health insurance enrollment waiting periods. During these periods, providers may file claims directly with the CSHCN Services Program without evidence of denial by the other insurer.

5.2.1 Health Maintenance Organization (HMO)

The CSHCN Services Program does not reimburse providers for client copays.

The CSHCN Services Program considers payment for services specifically excluded or limited by HMOs, but a benefit of the CSHCN Services Program. An explanation of benefits (EOB) is required from the HMO. Payment of those services must not exceed the CSHCN Services Programs maximum allowable fees for those services.

The CSHCN Services Program does not provide assistance for:

- Supplement of payment made by HMOs to their providers, unlike other insurance.
- Services that are available through an HMO and were not provided by an HMO approved provider.
- Authorization and payment for services available through an HMO.
- Copayments to providers for services available through an HMO.

Providers may collect copays for CSHCN Services Program clients with private insurance. The CSHCN Services Program reimburses clients for medication copays only. Clients should call the TMHP-CSHCN Services Program Contact Center Client Line at 1-877-888-2350, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time for additional information.

5.2.2 CSHCN Services Program Eligibility Form

Insurance coverage is indicated by the word "Insurance" below the date of birth in the CSHCN Services Program Eligibility forms case number block. Refer to Section 3.3.2, "CSHCN Services Program Eligibility Form Sample," on page 3-12 for a sample copy of the form. The information is obtained at the time of the application and must be verified at the time services are rendered.

If a provider is aware that a client has other health insurance but the word "Insurance" is not displayed on the CSHCN Services Program Eligibility Form, the provider must notify TMHP of the details concerning the type of policy and scope of benefits.

To report other insurance information, providers can call the TMHP Third-Party Resource (TPR) Unit at 1-800-846-7307, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time for additional information or write to the following address:

TMHP TPR Unit
PO Box 202948
Austin, TX 78720-2948

5.2.3 Claims Filing Involving a TPR

When a CSHCN Services Program client has other health insurance, that resource must be billed and providers must receive a disposition from the insurance company before submitting a claim for consideration of payment by the CSHCN Services Program. All claims for clients with other insurance coverage must reference the following information:

- Name of the other insurance resource
- Address of the other insurance resource
- Policy (identification) number and group number
- Policyholder
- Effective date, if available
- Date of disposition by other insurance resource
- Payment or specific denial information

Claims must be submitted on paper with the EOB attached.

Refer to: Claims Information section at the end of each chapter of this manual for more information.

5.2.4 Verbal Denials by a TPR

When a claim is denied by TMHP because of the client's other coverage, information identifying the TPR appears on the provider's R&S Report.

A statement from the client or family member indicating that they no longer have this resource is not sufficient documentation to reprocess the claim. Providers may call the third-party insurance resource and receive a verbal denial. In these situations, the provider must indicate the following information on the R&S Report:

- Date of the telephone call
- Name and telephone number of the insurance company
- Name of the person with whom they spoke
- Policyholder and group information
- Specific reason for the denial (include client's *type of coverage* to enhance the accuracy of claims processing; for example, a policy that covers only inpatient services or only physician services)

When a provider is advised by a TPR that benefits were paid to the client, the provider must include that information on the claim with the date and amount of payment made to the client, if available. If a denial was sent to the client, refer to the information listed in this section. This information enables TMHP to consider the claim for payment.

5.2.5 Filing Deadlines Involving a TPR

Any health insurance, including CHIP or Medicaid, that provides coverage to a CSHCN Services Program eligible client must be used before the program can consider the services for reimbursement. Claims must be received by the program or the payment contractor within 95 days of the date of the disposition by the other TPR and no later than 365 days from the date of service.

If the claim is denied, the provider may submit a claim for consideration to the program. The letter of denial must accompany the claim, or the provider must include the following information with the claim for consideration:

- Date the claim was filed with the insurance company
- Reason for the denial
- Name and telephone number of the insurance company
- Policy (identification) number
- Name of the policy holder and identification numbers for each policy covering the client
- Name of the insurance company contact who provided the denial information
- Date of the contact with the insurance company

Claims involving a TPR have the following deadlines applied:

- Claims with a valid disposition must be submitted to TMHP within 95 days from the disposition (payment or denial) date.
- In addition to the above, there is a 365-day filing deadline from the date of service. *This means that a fully documented claim must be received by TMHP within 365 days of the date of service.* However, when a TPR recoups a payment made in error on a claim, and that claim was never submitted to TMHP, the provider must send the claim for special handling to the attention of the Third-Party Resources Unit at TMHP within 95 days of the TPR action, if the 365-day filing period was exceeded.

Texas Medicaid & Healthcare Partnership
Third-Party Resources Unit
PO Box 202948
Austin, TX 78720-2948

Claims denied by the TPR on the basis of late filing are not considered for payment by the CSHCN Services Program.

TMHP does not have the authority to waive state or federal mandates, such as filing deadlines.

Note: *Providers may request an administrative review of any claim denied by the CSHCN Services Program payment contractor. Refer to Section 7.3.5, "Administrative Review for Claims," on page 7-6, for more information.*

5.2.6 Blue Cross Blue Shield (BCBS) Nonparticipating Physicians

BCBS currently has procedures in place to pay assigned claims directly to nonparticipating providers. A nonparticipating provider is eligible to receive direct reimbursement from BCBS, when assignment is accepted. However, only payment dispositions are sent to the provider. An EOB regarding denials is sent only to the client.

Be aware that by accepting assignment on a claim when the client also has the CSHCN Services Program coverage, providers are agreeing to accept payment made by insurance carriers and the CSHCN Services Program, when appropriate, as payment in full. *The CSHCN Services Program client must not be held liable for any balance related to CSHCN Services Program-covered services.*

Physicians who treat CSHCN Services Program clients with BCBS private insurance and who are nonparticipating with BCBS must follow the instructions and procedures as follows:

- Do not provide the CSHCN Services Program client with a bill or anything the client could use as a bill. An informational statement may be given. To avoid confusion, write "Information only" clearly on the copy of the statement.
- Bill BCBS directly, accepting assignment. When payment from BCBS is received, the claim may be filed with TMHP to seek additional payment up to the CSHCN Services Program allowable amount.

A claim must be filed with TMHP-CSHCN Services Program within 365 days of the date of service.

5.2.7 Refunds

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments that are a result of overpayment, duplicate payment, payment to incorrect providers, returned equipment, and overpayments due to overlapping payments by the CSHCN Services Program and another source. An overpayment must be refunded to the CSHCN Services Program.

Providers must reimburse the CSHCN Services Program refund account by lump sum payment. At the discretion of the Program, refunds may be made in monthly installments or out of current claims due to be paid the provider. To process refunds accurately, refund checks should be accompanied by a CSHCN Services Program Refund Information Form and include the following information:

- Refunding provider's name and provider identifier
- Client's name and client number
- The date on which the medical service was rendered
- A copy of the R&S Report that shows the claim to which the refund is being applied
- The specific reason for the refund
- Private insurance paid on the claim. The provider must refund the lower of the amount paid by the primary insurance or CSHCN Services Program. The provider should include the exact amount paid and the insurance company's name, address, policy number, and group number.

Refund requests must be submitted to:

Texas Medicaid & Healthcare Partnership
Financial Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

5.2.8 Refunds to TMHP Resulting From Other Insurance

If the CSHCN Services Program makes payment for a claim and payment is received from another resource for the same services, the provider must refund the CSHCN Services Program the lesser of the amount paid by the TPR or the amount paid by the program. These refunds must not be held until the end of an accounting year. Providers must accept assignment; therefore, they must accept the CSHCN Services Program payment as payment in full for services that are a benefit and must not use payment by another TPR to make up the difference between the amount billed and the CSHCN Services Program payment.

Providers must use the following guidelines to determine the amount to be refunded to the CSHCN Services Program:

- When the CSHCN Services Program pays more than the other resource pays, the amount of the other payment is due as a refund to the CSHCN Services Program. For example:

Total billed	$300
CSHCN Services Program payment	$200
Other resource payment	$150
Amount to be refunded to TMHP	$150

- When the CSHCN Services Program pays less than the other resource, the amount paid by the Program is due as a refund. For example:

Total billed	$300
CSHCN Services Program payment	$200
Other resource payment	$250
Amount to be refunded to TMHP	$200

5.2.9 Accident-Related Claims

TMHP monitors all accident claims to determine whether another resource may be liable for the medical expenses of the CSHCN Services Program clients. Providers are required to ask clients whether the medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers must indicate this information in the appropriate fields on the electronic claim form, in Block 10 of the CMS-1500 paper claim form, or Blocks 31 through 34 on the UB-04 CMS-1450 paper claim form.

If payment is available from a known third party, such as personal injury protection automobile insurance, that responsible party must be billed before the CSHCN Services Program. If the third-party payment is substantially delayed due to contested liability or unresolved legal action, a claim may be submitted to TMHP for consideration of payment. TMHP processes the liability-related claim and pursues reimbursement directly from the potentially liable party on a postpayment basis.

The following information must be included on these claims:

- Name and address of the TPR
- Description of the accident including location, date, time, and alleged cause
- Reason for delayed payment by the TPR

5.2.9.1 Accident Resources and Refunds Involving Claims for Accidents

Acting on behalf of the CSHCN Services Program, TMHP has the authority to recover payments from any settlement, court judgment, or other resources awarded to a CSHCN Services Program client. In most cases, TMHP works directly with the attorneys, courts, and insurance companies to seek reimbursement for program payments. If a provider receives a portion of a settlement for which the program has made payment, the provider must refund the CSHCN Services Program. Any provider filing a lien for the entire billed amount must contact the Third-Party Resources Unit at TMHP to coordinate program postpayment activities. Providers may contact the TMHP Tort Contact Center by calling 1-800-846-7307, which is available Monday through Friday, from 8 a.m. to 5 p.m., Central Time.

A provider who receives an attorney's request for an itemized statement, claim copies, or both, should contact the TMHP Third-Party Resources Unit, if the CSHCN Services Program was billed for any services relating to the request. The provider must furnish TMHP with the client's name and CSHCN Services Program ID number, dates of service involved, and the name and address of the attorney or casualty insurance company. This information enables TMHP to pursue reimbursement from any settlement.

5.2.9.2 Third-Party Liability for Claims Involving Accidents

DSHS contracts with TMHP to administer third-party liability cases. To ensure that the CSHCN Services Program is the payer of last resort, TMHP performs postpayment investigations of potential casualty and liability cases.

TMHP also identifies and recovers CSHCN Services Program expenditures in casualty cases involving CSHCN Services Program clients.

Investigations are a result of referrals from many sources, including attorneys, insurance companies, health-care providers, CSHCN Services Program clients, and state agencies.

Referrals should be submitted on the Tort Response Form to the following address:

TMHP Tort Department
PO Box 202948
Austin, TX, 78720-2948
Fax: 1-512-514-4225

TMHP releases CSHCN Services Program claims information when a Department of State Health Services Form to Release CSHCN Services Program Claims History is submitted. This form is available in both English and Spanish. The form must be signed by the CSHCN Services Program client, parent, or guardian. Referrals are processed within ten business days.

An attorney or other person who represents a CSHCN Services Program client in a third-party claim or action for damages for personal injuries must send written notice of representation to the TMHP Tort department at the address listed above. The written notice must be submitted within 45 days of the date on which the attorney or representative undertakes representation of the CSHCN Services Program client or from the date on which a potential third party is identified.

The following information must be included:

- The CSHCN Services Program client's name, address, and identifying information
- The name and address of any third party or third-party health insurer against whom a third-party claim is, or may be, filed for injuries to the CSHCN Services Program client
- The name and address of any health-care provider that has asserted a claim for payment for medical services provided to the CSHCN Services Program client for which a third party may be liable for payment, whether or not the claim was submitted to, or paid by, TMHP

Providers should indicate when information is unknown when the initial notice is filed. Revisions must be submitted when the information becomes available.

If the attorney or representative requests claim information about the CSHCN Services Program client, an authorization form must be included as part of the notice and must be signed by the CSHCN Services Program client, parent, or guardian. The Department of State Health Services Form to Release CSHCN Services Program Claims History must be used. This form is available in both English and Spanish.

DSHS must approve all trusts before any proceeds from a third party are placed into a trust.

For additional information, providers may contact the TMHP Tort Contact Center at 1-800-846-7307, which is available Monday through Friday, from 8 a.m. to 5 p.m., Central Time.

5.3 Multipage Claim Forms

Professional (CMS-1500)

The approved electronic professional claim format is designed to list 50 line items.

The total number of details allowed for a professional claim by the TMHP claims processing system (C21) is 28. If the services provided exceed 28 line items on an approved electronic claims format or 28 line items on paper claims, the provider must submit another claim for the additional line items.

The CMS-1500 paper claim form is designed to list six line items in Block 24. If more than six line items are billed, a provider may attach additional forms (pages) totaling no more than 28 line items. The first page of a multipage claim must contain all the required billing information. On subsequent pages of the multipage claim, the provider should identify the client's name, diagnosis, information required for services in Block 24, and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form and indicate "continued" in Block 28. The combined total charges for all pages should be listed on the last page in Block 28.

Institutional (UB-04 CMS-1450)

An approved electronic format of the UB-04 CMS-1450 is designed to list 61 lines in Block 43 or its electronic equivalent. C21 merges like revenue codes together to reduce the lines to 28 or less.

If the services exceed the 28 lines, the provider may submit another claim for the additional lines or merge codes. When splitting a claim, all pages must contain the required information. Usually, there are logical breaks to a claim. For example, the provider may submit the surgery charges in one claim and the subsequent recovery days in the next claim. Hospitals are required to submit all charges.

The UB-04 CMS-1450 paper claim form is designed to list 23 lines in Block 43. If services exceed the 23-line limitation, the provider may attach additional pages. The first page of a multipage claim must contain all required billing information. On subsequent pages, the provider identifies the client's name, diagnosis, all information required in Block 43, and the page number of the attachment (e.g., page 2 of 3) in the top right-hand corner of the form and indicate "continued" on Line 23 of Block 47. The combined total charges for all pages should be listed on the last page on Line 23 of Block 47.

The total number of details allowed for an institutional claim by the TMHP claims processing system (C21) is 28. C21 merges like revenue codes together to reduce the lines to 28 or less. If the C21 merge function is unable to reduce the lines to 28 or less, the claim will be denied, and the provider will need to reduce the number of details and resubmit the claim.

Note: *Revenue codes must be submitted on the UB-04 CMS-1450 institutional paper claim form or electronic equivalent in accordance with the National Uniform Billing Committee (NUBC) standards for all inpatient and outpatient institutional claims. Providers can refer to the NUBC website at www.nubc.org.*

Revenue Codes

Per the NUBC, revenue codes are defined as codes that identify specific accommodations, ancillary services, or unique billing calculations or arrangements. Revenue codes are four-digit codes that must be entered on claims as follows:

- Providers submitting claims through TexMedConnect will be required to enter four-digit revenue codes, including the leading zero (where appropriate) for inpatient and outpatient claim submissions.
- Providers submitting institutional claims in the 837I electronic format should continue to use four-digit revenue codes in Loop 2400, Segment SV201, to enter revenue codes.

Providers are required to adhere to national billing standards, including NUBC guidelines defining data submission requirements.

Providers may refer to the National Uniform Billing Committee website for further information.

Type of Bill

Type of bill (TOB) values must be submitted on the UB-04 CMS-1450 claim form or electronic equivalent in accordance with the National Uniform Billing Committee (NUBC).

Per NUBC, TOB is defined as a code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacement, voids, etc.), with the last digit defining the frequency of the bill.

Providers that submit institutional claims in the 837I electronic format may use Loop 2300, Segment CLM05-1 through CLM05-3 to enter TOBs.

5.4 Tips on Expediting Paper Claims

Use the following guidelines to enhance the accuracy and timeliness of paper claims processing.

5.4.1 General requirements

- Use original claim forms. Don't use copies of claim forms.
- Detach claims at perforated lines before mailing.
- Use 10 x 13 inch envelopes to mail claims. Don't fold claim forms, appeals, or correspondence.
- Don't use labels, stickers, or stamps on the claim form.
- Don't send duplicate copies of information.
- Use 8 ½ x 11 inch paper. Don't use paper smaller or larger than 8 ½ x 11 inches.
- Don't mail claims with correspondence for other departments.

5.4.2 Data Fields

- Print claim data within defined boxes on the claim form.
- Use black ink, but not a black marker. Don't use red ink or highlighters.
- Use all capital letters.
- Print using 12 point Courier font only. Don't use fonts smaller or larger than 12 points. No other font will be accepted.
- Use a laser printer for best results. Don't use a dot matrix printer, if possible.
- Use eight digits to indicate the date (e.g., 01012013). Don't use dashes or slashes in date fields.

5.4.3 Attachments

- Use paper clips on claims or appeals if they include attachments. Don't use glue, tape, or staples.
- Place the claim form on top when sending new claims, followed by any medical records or other attachments.
- Number the pages when sending when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
- Don't total the billed amount on each claim form when submitting multiple claims for the same client.
- Submit claim forms with R&S Reports.

5.5 Correction and Resubmission (Appeal) Time Limits

All correction and resubmission (appeals) of denied claims and requests for adjustments on paid claims must be received by TMHP within 120 days from the date of disposition of the claim (the date of the R&S Report on which the claim appears).

Refer to: 2014 Filing Deadline Calendar

2015 Filing Deadline Calendar

5.5.1 Claims with Incomplete Information

Claims lacking the information necessary for processing are listed on the R&S Report with an EOB code requesting the missing information. Providers must resubmit a signed, completed, and corrected claim with a copy of the R&S Report on which the claim appears to TMHP within 120 days from the date on the R&S Report to be considered for payment. Hospitals are not required to resubmit itemized inpatient charges if those charges were included with the original submission.

5.5.2 Other Insurance Appeals

Providers appealing a claim denial due to other insurance coverage must submit to TMHP the complete other-insurance information, including all EOBs with disposition dates. The disposition date is the date on which the other insurance company processed the payment or denial. If a provider submits other-insurance EOBs without disposition dates, the appeal will be denied.

5.5.3 Resubmission of TMHP EDI Rejections

Providers that receive TMHP EDI rejections may resubmit an electronic claim within 95 days of the DOS. A paper appeal may also be submitted with a copy of the rejection report within 120 days of the rejection report to meet the filing deadline. A copy of the rejection report with the EDI batch ID must accompany each corrected claim that is submitted on paper.

5.5.3.1 TMHP EDI Batch Numbers, Julian Dates

All electronic transactions are assigned an eight-character Batch ID immediately upon receipt by the TMHP Electronic Data Interchange (EDI) Gateway. The batch ID format allows electronic submitters to determine the exact day and year that a batch was received. The batch ID format is JJJYSSSS, where each character is defined as follows:

- JJJ—Julian date. The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where E = 0, F = 1, G = 2, and H = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date. For example, a Julian date of 143 would be F43.
- Y—Year. The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a "3" in this position indicates the year 2013.

- SSSS—The unique 4-character sequence number assigned by EDI to the claim filed.

Refer to: Section 7.3.1.3, "Electronic Rejections," on page 7-4 more information on electronic appeals.

5.6 Coding

5.6.1 Diagnosis Coding

The *only* diagnosis coding structure accepted by the CSHCN Services Program is the *International Classification of Diseases,* Ninth Revision, Clinical Modification (ICD-9-CM). The CSHCN Services Program requires providers to provide ICD-9-CM diagnosis codes on their claims. Diagnosis codes must correspond to the highest level of specificity available. A written description of the diagnosis is not required.

If the diagnosis code submitted is a valid three- or four-digit code, do not add zeroes to the code to make it five digits. Claims submitted with an invalid diagnosis code are denied.

Specific diagnosis codes related to program benefits are listed in chapters that follow. These listings are intended to provide helpful information, but should not be considered all-inclusive. From time to time, diagnosis codes are added, deleted, or revised.

5.6.2 Procedure Coding

5.6.2.1 Healthcare Common Procedure Coding System (HCPCS)

The procedure coding system used by the CSHCN Services Program is called the Healthcare Common Procedure Coding System (HCPCS). HCPCS is a common coding structure for determining reimbursement made available to health-care providers and third-party payers.

HCPCS is designed around a five-character numeric or alphanumeric base for all procedure codes. To ensure an up-to-date coding structure, HCPCS is updated annually using the latest edition of the *Current Procedural Terminology* (CPT) manual (i.e., Level I coding) and nationally established Centers for Medicare & Medicaid Services (CMS) codes (i.e., Level II coding). The coding systems comply with *Health Insurance Portability and Accountability Act* (HIPAA) requirements.

Refer to: "Level I," on page 5-18 and "Level II," on page 5-19 for additional information about the HCPCS level coding.

Most added procedure codes that are not directly replacing a discontinued procedure code must go through the Texas Medicaid rate hearing process, as required by Chapter 32 of the Human Resources Code, §32.0282, and Title 1 of the Texas Administrative Code, §355.201, which require public hearings to receive comments on Texas Medicaid payment rates.

Refer to: Section 5.6.2.5, "Determining Reimbursement Rates for New HCPCS Procedure Codes," on page 5-19 for additional information about the rate hearing process as well as claims filing and prior authorization requirements for affected procedure codes.

Specific procedure codes related to program benefits are listed in chapters that follow. These listings are intended to provide helpful information, but should not be considered all-inclusive. From time to time, procedure codes are added, deleted, or revised. Benefit and coding information is updated in the *CSHCN Services Program Provider Bulletin*.

The CSHCN Services Program does not reimburse for deleted procedure codes.

Authorization and prior authorization requests must be submitted to update HCPCS procedure codes for services.

5.6.2.2 National Correct Coding Initiative (NCCI) Guidelines

The *Patient Protection and Affordable Care Act* (PPACA) mandates that all claims submitted on or after October 1, 2010, must be filed in accordance with the NCCI guidelines. NCCI was developed by CMS to promote the correct coding of health-care services by providers. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported.

NCCI consists of two types of edits:

- NCCI procedure-to-procedure edits that define pairs of procedure codes that should not be reported together for a variety of reasons.
- MUE are units-of-service edits that define the number of units of service beyond which the reported number of units of service is unlikely to be correct.

Each NCCI code pair edit is associated with a policy as defined in the *National Correct Coding Initiative Policy Manual*. Effective dates apply to code pairs in NCCI and represent the date when CMS added the code pair combination to the NCCI edits. Code combinations are processed based on this effective date. Termination dates also apply to code pairs in NCCI. This date represents the date when CMS removed the code pair combination from the NCCI edits. Code combinations are refreshed quarterly.

NCCI edits are applied to services that are performed by the same provider on the same date of service only. Providers may refer to the CMS website at www.medicaid.gov /Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for the *NCCI Policy* and *Medicare Claims Processing* manuals that contain the NCCI rules, relationships, and general information.

Providers are encouraged to monitor CMS for updates to the NCCI rules and guidelines. A link to the CMS NCCI website is also available through the TMHP website at www.tmhp.com on the Code Updates - NCCI Compliance web page. In instances where the CSHCN Services Program implements exceptions to the NCCI relationships, providers will be informed through the standard provider notification process.

The HCPCS and CPT codes included in the *Children with Special Health Care Needs Services Program Provider Manual* and the *CSHCN Services Program Provider Bulletins* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. In instances when CSHCN Services Program medical policy is more restrictive than NCCI MUE guidance, CSHCN Services Program medical policy prevails.

NCCI Appeals

Claims or procedure codes that have been denied based on NCCI guidelines may be appealed with an appropriate modifier or documentation of medical necessity. If the submitted procedure code is denied because NCCI guidelines indicate the code is included in another procedure, the claim may be appealed with a modifier if applicable. If a modifier does not apply but medical necessity can be proven, the provider must submit documentation of medical necessity that indicates both services were necessary on the same date of service. For guideline exceptions that may be appealed, providers may refer to the CMS website at www.cms.gov/Outreach-and-Education /Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf. Providers must follow the current standard appeals process when appealing claims to TMHP.

Refer to: Section 7.3, "Claim Appeals," on page 7-3 for additional information about appealing claims.

5.6.2.3 Level I

The following is information about the American Medical Associations (AMA) physicians' CPT codes:

- The codes are *all numeric,* consisting of five digits
- CPT codes represent 80 percent of HCPCS
- Maintenance of CPT is the responsibility of the AMA (AMA updates on a yearly basis)
- Updates by the AMA are coordinated with CMS before distribution of modifications to third-party payers
- Anesthesia codes from CPT must be used

Note: *Claims for anesthesia must list the CPT anesthesia procedure codes. Use of narrative descriptions or CPT surgical codes result in claim denial.*

5.6.2.4 Level II

The following is information about CMS (HCPCS) codes:

- CMS (HCPCS) provides codes for both physician and nonphysician services that are not contained in CPT (such as ambulance, durable medical equipment (DME), prostheses, and some medical codes).
- Updating of HCPCS codes is the responsibility of the CMS Maintenance Task Force.
- The codes are all *alphanumeric*, consisting of a single alpha character (A–V) followed by four numeric digits.

The single alpha character signifies the following:

Character	Description
A	Supplies, ambulance, chiropractic
B	Enteral and parenteral therapy
D	Dental
E	DME and oxygen
H	Rehabilitation services
J	Drugs (administered other than orally)
K	ICD-9-CM surgery (informational only)
L	Orthotic and prosthetic procedures
M	Medical
P	Laboratory
Q	Temporary procedures
R	Radiology
T	Diapers
V	Vision and hearing services (nonphysician); speech/language pathology services (nonphysician)

HCPCS codes are used by all the CSHCN Services Program providers to identify the procedures they perform.

Exception: *Inpatient facility charges submitted on a UB-04 CMS-1450 paper claim form or equivalent electronic claim format must be billed using revenue codes.*

5.6.2.5 Determining Reimbursement Rates for New HCPCS Procedure Codes

The CSHCN Services Program adopts the new codes that are direct replacements of discontinued codes at the discontinued codes reimbursement rate. The new HCPCS procedure codes that are not directly replacing discontinued codes require a rate hearing to determine an appropriate Texas Medicaid reimbursement rate. The Health and Human Services Commission (HHSC) conducts public rate hearings to provide an opportunity for the provider community to comment on the Medicaid proposed payment rate. After the rate hearings are complete for each procedure code, the CSHCN Services Program makes the determination to adopt the Texas Medicaid rate established through the rate hearing process or to adopt the rate of a similar discontinued code.

As indicated in the *HCPCS Special Bulletin* that is published at the beginning of each year, claims for procedure codes that require a rate hearing must be submitted within the initial 95 day filing deadline. The most appropriate procedure code for the service provided must be submitted. Services provided are denied as pending a rate hearing (EOB 02008) until the applicable reimbursement rate is adopted.

Once the Medicaid reimbursement rate has been determined through the rate hearing process, the CSHCN Services Program will evaluate the proposed rate to determine whether alignment with the Medicaid rate is fiscally feasible. Once reimbursement rates are established in the rate

hearing, evaluated by the CSHCN Services Program, and applied, TMHP will reprocess the claim. No action on the part of the provider is necessary. Providers are notified of the implementation date and reprocessing efforts. The client cannot be billed for these services.

For those procedures that require authorization or prior authorization, providers must follow the processes detailed in Chapter 4, "Prior Authorizations and Authorizations" of the current *CSHCN Services Program Provider Manual*. Providers must not wait until new codes have completed the rate hearing process to request an authorization or prior authorization.

5.6.2.6 National Drug Codes (NDC)

All CSHCN Services Program providers must submit an NDC for professional or outpatient electronic and paper claims submitted with physician-administered prescription drug procedure codes.

N4 must be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

National Drug Unit of Measure: The submitted unit of measure should reflect the volume measurement administered. Refer to the NDC Package Measure column on the Texas NDC-to-HCPCS Crosswalk.

The valid units of measurement codes are:

- F2—International unit
- GR—Gram
- ME—Milligram
- ML—Milliliter
- UN—Unit

Note: *Unit quantities must be submitted, and are required.*

Paper Claim Submissions

Depending on the claim type, the NDC information must be submitted as indicated below for paper claims, or the equivalent electronic field:

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Block No.	Description	Guidelines
43	Revenue codes and description	This block should include the following elements in the following order: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231) • The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME. (e.g., GR) • The unit quantity with a floating decimal for fractional units (limited to 3 digits). (e.g., 0.025) **Example:** N400409231231GR0.025

CMS-1500

Block No.	Description	Guidelines
24A	Date(s) of service	In the shaded area, enter : • NDC qualifier N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medicaiton was administered. Do not enter spaces or hyphens within this number. (e.g., 00409231231) **Example:** N400409231231
24D	Procedures, services, or supplies	In the shaded area, enter NDC quantity of units administered (up to 12 digits including the decimal point). A decimal point must be used for fractions of a unit (e.g., 0.025).
24G	Days or units	In the shaded area, enter the NDC unit of measurement code (e.g., GR). There are 5 allowed values: F2, GR, ML, UN or ME.

2017 Claim Form

Block No.	Description	Guidelines
32A	Date(s) of service	In the shaded area, enter : • NDC qualifier N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medicaiton was administered. Do not enter spaces or hyphens within this number. (e.g., 00409231231) **Example:** N400409231231
32D	Procedures, services, or supplies Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Modifier	In the shaded area, enter the NDC quantity of units administered (up to 12 digits including the decimal point). A decimal point must be used for fractions of a unit (e.g., 0.025).
32F	Days or units	In the shaded area, enter the NDC unit of measurement code (e.g., GR). There are 5 allowed values: F2, GR, ML, UN or ME.

National Drug Unit: Claims will be edited for the value submitted in the NDC quantity field. In order to convert the HCPCS units submitted into the NDC quantity; use the Texas NDC-to-HCPCS Crosswalk to review the "HCPCS Description" and the "NDC Label" description to identify the quantity.

The Texas NDC-to-HCPCS Crosswalk identifies relationships between HCPCS codes and National Drug Codes (NDC). The Texas file is published at least quarterly. The Texas NDC-to-HCPCS Crosswalk can be found at www.txvendordrug.com/formulary/clinician-administered-drugs.shtml. Clinician-administered drugs that do not have an appropriate NDC to HCPCS combination for the procedure code that is submitted are not payable.

Texas Supplemental NDC File lists those physician-administered multiple-source drugs that the U.S. Secretary of Health and Human Services has determined to have the highest dollar volume of physician-administered drugs that are dispensed through Medicaid. The Texas supplemental NDC file is available on the NDC webpage under topics on the TMHP website at www.tmhp.com.

5.6.2.7 Drug Rebate Program

The CSHCN Services Program will reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the Centers for Medicare & Medicaid Services (CMS) Drug Rebate Program and that show as active on the CMS list for the date of service the drug is administered.

CMS maintains a list of participating manufacturers and their rebate-eligible drug products, which is updated quarterly on the CMS website. TMHP will republish this list quarterly in a more accessible format. Providers will be notified when the first formatted file from TMHP is available.

When providers submit claims for clinician-administered drug procedure codes, they must include the National Drug Code (NDC) of the administered drug as indicated on the drug packaging.

TMHP will deny claims for drug procedure codes under the following circumstances:

- The NDC submitted with the drug procedure code is not on the CMS drug rebate list that was current on the date of service.
- The NDC submitted with the drug procedure code has been terminated.
- The drug procedure code is submitted with a missing or invalid NDC.

To avoid claim denials, providers must speak with the pharmacy or wholesaler with whom they work to ensure the product purchased is on the current CMS list of participating manufacturers and their drugs.

Vitamins and minerals procedure codes will be listed on a separate tab of the supplemental file.

TMHP has created a Rebatable National Drug Codes web page to display the quarterly lists published by CMS. Every quarter, after CMS publishes an updated list of rebatable NDCs, TMHP will produce a formatted list with the unnecessary details removed and will add the new list to the web page.

Note: *CSHCN Services Program does not pay for drug wastage.*

5.6.2.8 Modifiers

Modifiers further describe and qualify services provided. A modifier is placed after the five-digit procedure code. Refer to the service-specific sections for additional modifier requirements. Providers must maintain documentation in the client's medical record that supports the medical necessity of the services that are billed using a modifier. Acceptable documentation includes, but is not limited to, progress notes, operative reports, laboratory reports, and hospital records. On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed. Modifiers and their descriptions are available in current issues of CPT and HCPCS coding resources.

Note: *Retrospective review may be performed to ensure that the submitted documentation supports the medical necessity of a service and any modifier used to bill the claim.*

5.6.2.9 Type of Services (TOS)

The TOS identifies the specific field or specialty of services provided. TOS codes are not required for billing, but they do appear on the provider's Remittance and Status (R&S) Reports.

For procedure codes that require a modifier to assign a TOS, providers can refer to the appropriate specific section for information on modifier requirements for claim submissions.

TOS	Description
0	Blood
1	Medical Services
2	Surgery
3	Consultations
4	Radiology (total component)
5	Laboratory (total component)

TOS	Description
6	Radiation Therapy (total component)
7	Anesthesia
8	Assistant surgery
9	Other (e.g., prosthetic eyewear, contacts, ambulance)
C	Home health services
E	Eyeglasses
F	Ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC)
G	Genetics
I	Professional component for radiology, laboratory, or radiation therapy
J	DME purchase new
L	DME rental
R	Hearing aid
T	Technical component for radiology, laboratory, or radiation therapy
W	Dental

5.6.2.10 Place of Service (POS) Coding

The POS identifies where services are performed. Indicate the POS by using the appropriate numeric code for each service listed on the claim. The following POS codes must be used:

Place of Service	Two-Digit Numeric Codes (Electronic Billers)	One-Digit Numeric Codes (Paper Billers)
Office	11, 15, 20, 49, 50, 60,65, 71, 72	1
Home	12	2
Inpatient hospital	21, 51, 52, 55, 56, 61	3
Outpatient hospital	22, 23, 24, 62	5
Other location	01, 03, 04, 05, 06, 07, 08, 16, 26, 34, 41, 42, 53, 57, 99	9
Independent lab	81	6
Destination of ambulance	Indicate destination using above codes	Indicate destination using above codes

5.6.3 Benefit Code

A benefit code is an additional data element used to identify state programs. Providers participating in the CSHCN Services Program must use benefit code CSN and DM3 when submitting claims and authorizations to TMHP. Additional codes may be added as necessary.

Benefit Code	Program
CSN	CSHCN Services Program
DM3	CSHCN Services Program home health DME services

Important: *The appropriate benefit code must be included on each CSHCN Services Program claim that is submitted to TMHP. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions about TexMedConnect to the TMHP EDI Help Desk at 1-888-863-3638.*

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)" on page 40-1 for more information about electronic billing.

5.7 Claims Filing Instructions

Providers must read the instructions in this section carefully and supply all the requested information on the claim form.

Claims must contain the billing provider's complete name, address, provider identifier, and signature of the provider or an authorized representative, or a "signature on file" statement. Claims prepared by computer billing services may have "Signature on File" printed in the signature block if the billing service retains a letter on file from the provider authorizing the service. A claim without the provider's complete name, address, provider identifier, signature, or "signature on file" statement cannot be processed. The Patient Protection and Affordable Care Act (PPACA) mandates that all claims submitted to TMHP must be filed in accordance with NCCI guidelines. The guidelines can be found in the NCCI Policy and *Medicare Claims Processing Manuals*, which are available on the CMS website.

5.7.1 Claim Details

The maximum number of units on a claim detail can not exceed 9,999 units. Providers who submit a claim with more than 9,999 units must bill 9,999 units on the first detail of the claim and any additional units on separate details.

5.7.2 Provider Types and Selection of Claim Forms

5.7.2.1 Providers and Services Billable on CMS-1500

Claims for the following provider types or services must be billed on a CMS-1500 paper claim form or approved electronic format when requesting payment for medical services and supplies under the CSHCN Services Program:

- Advanced practice registered nurse (APRN), such as pediatric nurse practitioner (PNP), clinical nurse specialist (CNS), and family nurse practitioner (FNP)
- Ambulance
- Anesthesiologist assistants
- Augmentative communication devices (ACDs)
- Certified respiratory care practitioner (CRCP)
- Certified registered nurse anesthetists (CRNA)
- Durable medical equipment (DME)
- Freestanding ambulatory surgery center
- Gastrostomy devices
- Genetic services
- Independent laboratory, radiology, and radiation therapy
- Medical foods
- Medical nutritional products and services
- Orthosis and prosthesis
- Outpatient behavioral health services
- Outpatient therapy (physical therapy [PT], occupational therapy [OT], and speech-language pathology [SLP])
- Pharmacy
- Physician (doctor of medicine [MD] and doctor of osteopathy [DO])
- Podiatry
- Total parenteral nutrition (TPN)
- Vision services

- Any other authorized provider of medical services and supplies not specifically required to use a different claim form when submitting claims to TMHP

Refer to: The Professional Paper Claim Form (CMS-1500) page of the CMS website at www.cms.gov for more information about the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

5.7.2.2 CMS-1500 Claim Form Provider Definitions

CMS-1500 Claim Form Provider Definitions

The following definitions apply to the provider terms used on the CMS-1500 Claim Form:

Referring Provider

The Referring Provider is the individual who directed the patient for care to the provider rendering the services being submitted on the claim form.

Examples include, but are not limited to, a primary care provider referring to a specialist; an orthodontist referring to an oral and maxillofacial surgeon; a physician referring to a physical therapist; and a provider referring to a home health agency.

Ordering Provider

The Ordering Provider is the individual who requested the services or items listed in Block D of the CMS-1500 claim form.

Examples include, but are not limited to, a provider ordering diagnostic tests and medical equipment or supplies.

Rendering Provider

The Rendering Provider is the individual who provided the care to the client. In the case where a substitute provider was used, that individual is considered the Rendering Provider.

An individual such as a lab technician or radiology technician who performs services in a support role is not considered a rendering provider.

Supervising Provider

The Supervising Provider is the individual who provided oversight of the Rendering Provider and the services listed on the CMS-1500 claim form.

An example would be the supervision of a resident physician.

Purchased Service Provider

A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis.

Examples of services include:

- Processing a laboratory specimen
- Grinding eyeglass lenses to the specifications of the Referring Provider
- Performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule.

In the case where a substitute provider is used, that individual is not considered a Purchased Service Provider.

5.7.2.3 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 claim forms with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/Pages/EDI/EDI_Home.aspx.

Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for more information about electronic billing. All CSHCN Services Program claims must be submitted with the appropriate benefit code.

Section 5.6.3, "Benefit Code," on page 5-23 of this chapter for information about using the appropriate benefit code to file CSHCN Services Program electronic claims.

5.7.2.4 CMS-1500 Paper Claim Form Instructions

The following instructions describe the information that must be entered in each of the block numbers of the CMS-1500 paper claim form. *Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.*

Refer to: The Professional Paper Claim Form (CMS-1500) page of the CMS website at www.cms.gov for more information about the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

Block No.	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the client's nine-digit CSHCN Services Program client number. For Other Property & Casualty Claims: Enter the Federal Tax ID or SSN of the insured person or entity.
2	Patient's name	Enter the client's last name, first name, and middle initial as printed on the CSHCN Services Program identification form. If the insured uses a last name suffix (e.g., Jr., Sr.) enter it after the last name and before the first name.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client's sex by checking the appropriate box. Only one box can be marked.
5	Patient's address	Enter the client's complete address as described (street, city, state, and ZIP+4 Code).
9	Other insured's name	For special situations, use this space to provide additional information such as: • If the client is deceased, enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.
10a 10b 10c	Is the patient's condition related to: a) Employment (current or previous)? b) Auto accident? c) Other accident?	Check the appropriate box. If other insurance is available, enter appropriate information in Blocks 11, 11a, and 11b.

Block No.	Description	Guidelines
11 11a 11b	Other health insurance coverage	• If another insurance resource has made payment or denied a claim, enter the name and information of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. • If the client is enrolled in Medicare attach a copy of the Medicare Remittance Notice to the claim form. • For Workers' Compensation and Other Property & Casualty Claims: Required if known. Enter Workers' Compensation or Property & Casualty Claim Number assigned by the payer.
11c	Insurance plan or program name	Enter the benefit code, if applicable, for the billing or performing provider.
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF," or legal signature. When legal signature is entered, enter the date signed in eight digit format (MMDDYYYY). TMHP will process the claim without the signature of the client.
14	Date of current	If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.
17 17b	Name of referring physician or other source	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered or supervised the service(s) or supplies on the claim. If multiple providers are involved, enter one provider using the following priority order: • Referring Provider • Ordering Provider • Supervising Provider Do not use periods or commas within the name. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. DN = Referring Provider DK = Ordering Provider DQ = Supervising Provider The NPI must be entered in block 17b. **Supervising Physician for Referring Physicians:** If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.

Block No.	Description	Guidelines
19	Additional claim information	**Ambulance transfers of multiple clients** If the claim is part of a multiple transfer, indicate the other client's complete name and CSHCN Services Program number, or indicate "Not a CSHCN Services Program client." **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility **Supervising Physician for Referring Physicians** If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.
20	Outside lab?	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the name and address or provider identifier of the facility that performed the service in Block 32. ***Note:*** *The CSHCN Services Program regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.*
21	Diagnosis or nature of illness or injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.
23	Prior authorization number	Enter the PAN issued by TMHP, if applicable. For Workers' Compensation and Other Property & Casualty Claims: Required when prior authorization, referral, concurrent review, or voluntary certification was received.
24	(Various)	General notes for Blocks 24a through 24j: • Unless otherwise specified, all required information should be entered in the unshaded portion. • If more than 6-line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim. • For multipage claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form.

Block No.	Description	Guidelines
24a	Date(s) of service	Enter the date of service for each procedure provided in a MM/DD/YYYY format. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24g. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. **National Drug Code (NDC)** In the shaded area, enter: • NDC qualifier N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medicaiton was administered. Do not enter spaces or hyphens within this number (e.g., 00409231231) ***Example:*** *N400409231231* **Refer to:** "National Drug Codes (NDC)," on page 5-20.
24b	Place of service	Select the appropriate POS code for each service from the table under "Place of Service (POS) Coding," on page 5-23.
24d	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. ***Note:*** *ASC providers should enter only one CPT procedure code for the inclusive global fee.* In the shaded area, enter an NDC quantity of units administered, up to 12 digits including the decimal point (e.g., 0.025). **Refer to:** "National Drug Codes (NDC)," on page 5-20.
24e	Diagnosis pointer	In 24 E, enter the diagnosis code reference letter (pointer) as shown in Form Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. Diagnosis codes must be entered in Form Field 21 only. Do not enter diagnosis codes in Form Field 24E.
24f	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.
24g	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). ***Note:*** *The maximum number of units per detail is 9,999.* In the shaded area, enter the NDC unit of measurement code (e.g., GR). There are 5 allowed values: F2, GR, ML, UN or ME. **Refer to:** "National Drug Codes (NDC)," on page 5-20. Enter the number of blood factor units provided.

Block No.	Description	Guidelines
24j	Rendering provider ID # (performing)	Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Do not enter the performing identifier in Block 33. Enter the TPI in the shaded area of the field. Enter the NPI in the unshaded area of the field.
26	Patient's account number	**Optional** Any alphanumeric characters (up to 15) in this block are referenced on the Remittance and Status (R&S) Report.
27	Accept assignment	**Required** All providers of the CSHCN Services Program Services must accept assignment to receive payment by checking Yes.
28	Total charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in Block 11. If the client makes a payment, the reason for the payment must be indicated in Block 11.
30	Balance due	If appropriate, subtract Block 29 from Block 28 and enter the balance.
31	Signature of physician or supplier	The physician, supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. **Refer to:** "Claims Filing Instructions," on page 5-24
32	Service facility location information	If services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP+4 Code of the facility where the service was provided.
32A	NPI	Enter the NPI of the service facility location.
33	Billing provider info & PH #	Enter the billing provider's name, street, city, state, ZIP+4 Code, and telephone number.
33A	NPI	Enter the NPI of the billing provider.
33B	Other ID #	Enter the TPI of the billing provider.

5.7.2.5 UB-04 CMS-1450 Paper Claim Form Instructions

The following services must be billed using the UB-04 CMS-1450 paper claim form or electronic claim format when requesting payment:

- Hospital ambulatory surgical center (HASC)
- Home health (skilled nursing service)
- Hospice services
- Inpatient hospital
- Inpatient rehabilitation

- Outpatient hospital
- Renal dialysis facility

Refer to: The Institutional paper claim form (CMS-1450) CMS website at www.cms.gov for more information about the CMS-1450 paper claim form. Providers can purchase CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

5.7.2.6 UB-04 CMS-1450 Electronic Billing

Electronic billers must submit UB-04 CMS-1450 claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837I 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, field locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for more information about electronic billing.

5.7.2.7 Instructions for Completing the UB-04 CMS-1450 Paper Claim Form

These instructions describe the information that must be entered in each of the block numbers of the UB-04 CMS-1450 paper claim form. *Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.*

Block No.	Description	Guidelines
1	Unlabeled	Enter the hospital name, street, city, state, ZIP+4 Code, and telephone number.
3a	Patient control number	**Optional** Any alphanumeric character (limit 16) entered in this block is referenced on the R&S Report.
3b	Medical record number	Enter the client's medical record number (limited to ten digits) assigned by the hospital.

Block No.	Description	Guidelines
4	Type of bill (TOB)	Enter a TOB code. First Digit—Type of Facility: 1 Hospital 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC]) 8 Special facility Second Digit—Bill Classification (except clinics and special facilities): 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) Third Digit—Frequency: 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim 5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim
6	Statement covers period	Enter the beginning and ending dates of service billed.
8a	Patient identifier	**Optional** Enter the client identification number if it is different than the Subscriber and insured's identification number.
8b	Patient name	Enter the client's last name, first name, and middle initial.
9a-9b	Patient address	Starting in 9a, enter the client's complete address as described (street, city, state, and ZIP+4 Code).
10	Birthdate	Enter the client's date of birth (MM/DD/YYYY).
11	Sex	Indicate the client's sex by entering an "M" or "F."
12	Admission date	Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims.
13	Admission hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.

Block No.	Description	Guidelines
14	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 15.) 5 Trauma center
15	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, 3, or 5: 1 Physician referral 2 Clinic referral 3 Health maintenance organization (HMO) referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility (SNF) 6 Transfer from another health-care facility 7 Emergency room 8 Court/law enforcement 9 Information not available For type of admission 4 (newborn): 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (client status of "30"), leave the block blank.
17	Patient Status	For inpatient claims, enter the appropriate two-digit code to indicate the client's status as of the statement "through" date. **Refer to:** Section 5.7.2.8, "Client Status (for block 17)," on page 5-39.
18-28	Condition codes	Enter the two-digit condition code "05" to indicate that a legal claim was filed for recovery of funds potentially due to a client.
29	ACDT state	**Optional** Accident state.
31-34	Occurrence codes and dates	Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61, 62, and 80 must also be completed as required. **Refer to:** Section 5.7.2.9, "Occurrence Codes (for blocks 31 through 34)," on page 5-40.
35-36	Occurrence span codes and dates	For inpatient claims, enter code "71" if this hospital admission is a readmission within 7 days of a previous stay. Enter the dates of the previous stay.

Block No.	Description	Guidelines
39-41	Value codes	Accident hour—For inpatient claims, if the client was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39-41 must equal the total days billed as reflected in Block 6.
42-43	Revenue codes and description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. **National Drug Code** Enter N4 Enter the 11-digit NDC number (number on package or container from which medication was administered). Do not enter hyphens or spaces within this number (e.g., 00409231231). The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) must also be submitted (e.g., 0.025). ***Example:*** *N400409231231GR0.025* **Refer to:** Section 5.6.2.6, "National Drug Codes (NDC)," on page 5-20.

Block No.	Description	Guidelines
44	HCPCS/rates	**Inpatient** Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. **Outpatient** Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. ***Note:*** *The UB-04 CMS-1450 claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e.* If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims. ***Note:*** *HASC providers should enter only one CPT procedure code for the inclusive global fee.*
45	Service date	Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.
45 (line 23)	Creation date	Enter the date the bill was submitted.
46	Serv. units	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation. Enter the number of blood factor units provided.
47	Total charges	Enter the total charges for each service provided.
47 (line 23)	Totals	Enter the total charges for the entire claim. ***Note:*** *For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
48	Noncovered charges	Enter the amount of the total noncovered charges.
50	Payer Name	Enter the health plan name.
51	Health Plan ID	Enter the health plan identification number.

Block No.	Description	Guidelines
54	Prior payments	Enter amounts paid by any TPR, and complete Blocks 31, 61, 62, and 80 as required.
56	NPI	Enter the NPI of the billing provider. HASC facilities should use the HASC provider identifier for scheduled outpatient day surgeries. Claims for emergency, unscheduled outpatient surgical procedures should be using the hospital's outpatient provider identifier.
57	Other identification (ID) number	Enter the CSHCN Services Program TPI number (non-NPI number) of the billing provider.
58	Insured's name	If other health insurance is involved, enter the insured's name.
60	Insured's Unique ID	Enter the client's nine-digit CSHCN Services Program identification number.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number if one was issued.
65	Employer name	Enter the name of the client's employer if health care might be provided.
66	Diagnosis/Procedure Code Qualifier	Enter the applicable ICD indicator to identify which version of ICD codes is being reported: 9 = ICD-9-CM 0 = ICD-10-CM
67	Principal diagnosis (DX) code and present on admission (POA) indicator	Enter the ICD-9-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. **Required** POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. HASC providers are not required to enter a diagnosis code. **Refer to:** Section 5.7.2.10, "POA Indicators (for blocks 67 and 72)," on page 5-40.

Block No.	Description	Guidelines
67A-67Q	Other DX codes and POA indicator	Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. A diagnosis is not required for clinical laboratory services provided for nonpatients (TOB "141"). ***Exception:*** *A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein.* ***Note:*** *ICD-9-CM diagnosis codes entered in 67K-67Q are not required for systematic claims processing.* **Required** POA indicator-Enter the applicable POA indicator in the shaded area for inpatient claims. **Refer to:** Section 5.7.2.10, "POA Indicators (for blocks 67 and 72)," on page 5-40.
69	Admit DX code	Enter the ICD-9-CM diagnosis code indicating the cause of admission or include a narrative. ***Note:*** *The admitting diagnosis is only for inpatient claims.*
70a-70c	Patient's reason DX	**Optional** New block indicating the client's reason for visit on unscheduled outpatient claims.
71	Prospective Payment System (PPS) code	**Optional** The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a-72c	External cause of injury (ECI) and POA indicator	**Required** Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. **Refer to:** Section 5.7.2.10, "POA Indicators (for blocks 67 and 72)," on page 5-40.
74	Principal procedure code and date	Enter the HCPCS procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed. ***Note:*** *HASC providers enter only one CPT procedure code for the inclusive global fee.*
74a-74e	Other procedure codes and dates	Enter the HCPCS procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.

Block No.	Description	Guidelines
76	Attending provider	Enter the attending provider name and identifiers. NPI number of the attending provider. For inpatient claims enter the NPI of the provider who perform the service or procedure or is responsible for the treatment and plan of care (POC). For outpatient claims enter the NPI of the physician who referred the client to the hospital.
77	Operating	Enter name (last name and first name) and NPI number of the operating provider (the individual with the primary responsibility for performing the surgical procedures). Required when a surgical procedure codes is listed on the claim.
78-79	Other provider	Other provider's name (last name and first name) and NPI. Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. Designated physician—For a limited client when the physician performed or authorized nonemergency care. Rendering provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure. ***Note:*** *If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.*

Block No.	Description	Guidelines
80	Remarks	This block is used to explain special situations such as the following: • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. • If a client stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician. • If services are the result of an accident, the cause and location of the accident must be entered in this block. The time must be entered in Block 39. • If laboratory work is sent out, the name and address or the provider identifier of the facility where the work was forwarded must be entered in this block. • If the services resulted from a family planning provider's referral, write "family planning referral." • If services were provided at another facility, indicate the name and address of the facility where the services were rendered.
81A-81D	Code code (CC)	**Optional** Area to capture additional information necessary to adjudicate the claims. Required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere on the claim data set.

5.7.2.8 Client Status (for block 17)

Code	Description
1	Routine discharge
2	Discharged to another short-term general hospital
3	Discharged to SNF
4	Discharged to intermediate care facility (ICF)
5	Discharged to another type of institution
6	Discharged to care of home health service organization
7	Left against medical advice
8	Discharged or transferred to home under care of a Home IV provider
9	Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)
20	Expired
30	Still client (To be used only when the client has been in the facility for 30 consecutive days and payment is based on diagnosis-related group [DRG])
40	Expired at home (hospice use only)
41	Expired in a medical facility (hospice use only)
42	Expired - place unknown (hospice use only)

Code	Description
43	Discharged or transferred to a federal hospital (such as a Veterans Administration [VA] hospital)
50	Hospice-Home
51	Hospice-Medical facility
61	Discharged or transferred within this institution to a hospital-based Medicare approved swing bed
62	Discharged or transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare-certified long-term care hospital (LTCH)
64	Discharged or transferred to a nursing facility certified under Medicaid, but not certified under Medicare
65	Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged or transferred to a critical access hospital (CAH)
71	Discharged to another institution of outpatient (OP) services
72	Discharged to another institution

5.7.2.9 Occurrence Codes (for blocks 31 through 34)

Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of occurrence codes.

5.7.2.10 POA Indicators (for blocks 67 and 72)

Code	Description	Guidelines
Y	Yes	Present at the time of inpatient admission.
N	No	Not present at the time of inpatient admission.
U	Unknown	Documentation is insufficient to determine if condition is present at time of inpatient admission.
W	Clinically undetermined	Provider is unable to clinically determine whether condition was present at time of inpatient admission or not.
1	Unreported/Not used	Exempt from POA reporting.

5.7.2.11 Dental Claim Filing

Dental and orthodontia services must be billed using the 2012 American Dental Association (ADA) Dental Paper Claim Form or equivalent electronic format when requesting payment.

Providers are responsible for obtaining these forms from a supplier of their choice.

Refer to: The ADA website at www.ada.org for a sample of the ADA Dental Claim Form.

5.7.2.12 2012 ADA Dental Claim Electronic Billing

Electronic billers must submit dental claims using TexMedConnect or an approved vendor software that uses the ANSI ASC X12 837D 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software

package is different, block locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for more information about electronic billing.

5.7.2.13 Instructions for Completing the Paper ADA Dental Claim Form

The instructions describe the information that must be entered in each of the block numbers of the paper 2012 ADA Dental Claim Form. Thoroughly complete the dental claim form according to the instructions below to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

Block No.	ADA Description	Instructions
1	Type of Transaction (Mark all applicable boxes)	For the CSHCN Services Program, check Statement of Actual Services Box. The other two boxes are not applicable.
2	Predetermination/Preauthorization Number	Enter PAN if assigned by the CSHCN Services Program.
3	Company/Plan Name, Address, City, State, ZIP Code	Enter name and address of CSHCN Services Program Contractor payer where the claim is to be sent.
4	Other Dental or Medical Coverage	Check "No" if no other dental or medical coverage (skip blocks 5-11). Check "Yes" if dental or medical coverage is available other than CSHCN Services Program coverage, and complete Blocks 5-11.
5	Name of Policyholder/Subscriber in #4	This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
6	Date of Birth (MM/DD/CCYY)	Enter insureds eight-digit date of birth (MM/DD/CCYY). This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
7	Gender	Check insureds correct gender. This line refers to the insured and is not necessarily the client. May be parent or legal guardian of client receiving treatment.
8	Policyholder/Subscriber ID (SSN or ID#)	Enter insureds subscriber identifier. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
9	Plan/Group Number	Enter insureds plan/group number. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
10	Client's Relationship to Person Named in #5	Enter insureds relationship to primary subscriber. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	Information on other insurance carrier, if applicable.

Block No.	ADA Description	Instructions
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Enter client's last name, first name, and middle initial exactly as written on the CSHCN Services Program Eligibility Form.
13	Date of Birth (MM/DD/CCYY)	Enter client's eight-digit date of birth (MM/DD/CCYY).
14	Gender	Check client's gender.
15	Policyholder/Subscriber ID (SSN or ID#)	Enter client's CSHCN Services Program number.
16	Plan/Group Number	Enter the benefit code, if applicable, of the billing or performing provider.
17	Employer Name	Not applicable for the CSHCN Services Program.
18	Relationship to Policyholder/Subscriber in #12 Above	Not applicable for the CSHCN Services Program.
19	Reserved for Local Use	Leave blank and skip to Item 20. (Field was previously used to report "Student Status".)
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Must put client name information, same as in Block 12.
21	Date of Birth (MM/DD/CCYY)	Must put client's eight-digit date of birth information, same as in Block 13.
22	Gender	Must put client gender information, same as in Block 14.
23	Client ID/Account # (Assigned by Dentist)	**Optional**—Used by dental office to identify internal client account number. This block is not required to process the claim.
24	Procedure Date (MM/DD/CCYY)	Enter eight-digit date of service (MM/DD/CCYY).
25	Area of Oral Cavity	Not applicable for the CSHCN Services Program.
26	Tooth System	Not applicable for the CSHCN Services Program.
27	Tooth Number(s) or Letter(s)	Enter the Tooth ID as required for procedure code. Select the appropriate tooth number for permanent teeth (01–32 or the appropriate letter for primary teeth 0A through 0T).
28	Tooth Surface	Enter the Surface ID as required for procedure code using M (Mesial); F (Facial); B (Buccal or Labial); O (Occlusal); L (Lingual or Cingulum); D (Distal); and/or I (Incisal).
29	Procedure Code	Use appropriate *Current Dental Terminology* (CDT) procedure code.
29a	Diagnosis Code Pointer	Enter the letter(s) from Box 34 that identified the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.
29b	Procedure Quantity	Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in item 24. The default value is "01."
30	Description	Provide a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature). Field length reduced by 8 characters to provide space for added items 29a and 29b.

Block No.	ADA Description	Instructions
31	Fee	Enter usual and customary charges for each line of service used. Charges must not be higher than the fees charged to private pay clients.
31a	Other Fee(s)	When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies. Identify the source of each payment date in Block 11. If the client makes a payment, the reason for the payment must be identified in Block 11. Field number changed to enable addition of added items 34 and 34a.
32	Total Fee	Enter the sum of all fees in Block 31. For multipage claims, enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. **Note:** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.* Field number change to enable addition of added items 34 and 34a.
33	Missing Teeth Information	Mark an "X" on the number of the missing tooth. (For identifying missing permanent detention only.) Report missing teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant services procedures on a particular claim. Field number changed to enable addition of added items 34 and 34a. Field size shortened to indicate the reporting of missing teeth is now limited to permanent detention.
34	Diagnosis Code List Qualifier	Enter the appropriate code to identify the diagnosis code source: B= International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (for dates of service on or before September 30, 2015) AB= ICD-10 (for dates of service on or after October 1, 2015)
34a	Diagnosis Code(s)	Enter up to four applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter "A".
35	Remarks	Use the Remarks space for local orthodontia codes, a narrative explanation for exception to periodicity (Block 19), a facility name, address, and NPI if the place of treatment (Block 38) is not a provider's office, an emergency narrative (Block 45), or additional information, such as reports for 999 codes or multiple supernumerary teeth, or remarks codes.
36	Client/Guardian signature	Not applicable for the CSHCN Services Program.
37	Subscriber signature	Not applicable for the CSHCN Services Program.

Block No.	ADA Description	Instructions
38	Place of Treatment	Enter the 2-digit place of service (POS) code for professional claims, which is a Health Insurance Portability and Accountability Act (HIPAA) standard. Frequently used POS codes include the following: • 11=Office • 12=Home • 21=Inpatient hospital • 22= Outpatient hospital • 31=Skilled nursing facility • 32= Nursing facility Field was changed to enable more accurate location identification using the HIPAA standard code set for place of service. ***Note:*** *All current POS codes are available online from the Centers for Medicare & Medicaid Services (CMS).*
39	Enclosures	Enter a "Y" or "N" to indicate whether there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models). Field changed to report Yes/No instead of types and quantities of enclosures.
40	Is Treatment For Orthodontics?	Check **Yes** or **No** as appropriate.
41	Date Appliance Placed (MM/DD/CCYY)	Not applicable for the CSHCN Services Program.
42	Months of Treatment Remaining	Not applicable for the CSHCN Services Program.
43	Replacement of Prosthesis?	Not applicable for the CSHCN Services Program.
44	Date Prior Placement (MM/DD/CCYY)	Not applicable for the CSHCN Services Program.
45	Treatment Resulting from	Providers are required to check Other Accident box for emergency claim reimbursement. If Other Accident box is checked, information about the emergency must be provided in Block 35.
46	Date of Accident (MM/DD/CCYY)	Not applicable for the CSHCN Services Program.
47	Auto Accident State	Not applicable for the CSHCN Services Program.
48	Name, Address, City, State, ZIP Code	Name and address of the billing group or individual provider (not the name and address of a provider employed within a group).
49	NPI	Enter required billing dentist's NPI for a group or an individual (not the NPI for a provider employed within a group).
50	License Number	Not applicable for the CSHCN Services Program.
51	SSN or TIN	Not applicable for the CSHCN Services Program.
52	Telephone Number	Enter area code and telephone number of billing group or individual (*not* the telephone number of a provider employed within a group).

Block No.	ADA Description	Instructions
52A	Additional Provider ID	Enter the TPI assigned to the billing dentist or dental entity (not the CSHCN Services Program employed within a group).
53	Signed (Treating Dentist)	Required signature of treating dentist or authorized personnel.
54	NPI	Enter the performing dentist's (provider who treated the client).
55	License Number	Not applicable for the CSHCN Services Program.
56	Address, City, State, ZIP Code	Not applicable for the CSHCN Services Program.
56A	Provider Speciality Code	This block is optional.
57	Telephone Number	Not applicable for the CSHCN Services Program.
58	Additional Provider ID	Required information—must enter nine-character TPI for the performing dentist (provider who treated the client) TPI.

5.7.2.14 Electronic Claims Submission

TMHP uses the HIPAA-compliant ANSI ASC X12 5010 file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security.

Claims may be submitted electronically to TMHP through TexMedConnect on the TMHP website at www.tmhp.com or through billing agents who interface directly with the TMHP Electronic Data Interchange (EDI) Gateway. Files that are submitted using EDI version 5010 are limited to a maximum of 5,000 transactions per file. Files that have more than 5,000 transactions will be rejected.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for more information about electronic claims submission.

5.7.2.15 Taxonomy Codes

Billing providers that are not associated with a group are required to submit a taxonomy code on all electronic claims. TMHP will reject claims for non-group billing providers (individuals and facilities) that are submitted without a taxonomy code.

Group billing providers are no longer required to submit the taxonomy code on electronic claims. Group billing providers can submit the taxonomy code to assist with the NPI crosswalk.

5.7.2.16 Dates on Claims

All dates (such as date of birth and date of service) entered on the claim (electronic and paper) must be eight digits in MMDDYYYY format.

Example: *August 6, 2013, is entered as 08062013.*

5.7.2.17 Span Dates

Providers currently submitting paper claims and that have provided services on consecutive days may bill multiple consecutive days per claim detail as long as the dates are in the same month and year. Providers must indicate (in the quantity billed) the number of dates they are billing.

Example: *Services were provided each day from August 6, 2013, to August 16, 2013. When submitting the paper claim, enter the from date of service as 08062013 and the to date of service as 08162013. The quantity is 11.*

Note: *Claims submitted with a quantity billed not equal to the number of days indicated in the date of service blocks are denied. When the claim is processed, the system creates multiple details consisting of four consecutive days each so that the claim appears on the provider's R&S Report with one detail for each 4 days billed. Using the example above, there are three details as illustrated below.*
If the number of details created during this process is greater than 28, the claim is denied for exceeding the maximum details per claim, and the provider must resubmit the claim, dividing the dates of service into multiple claims, to convey complete billing information.

Detail	From DOS	To DOS	Qty Billed
1	08062013	08092013	4
2	08102013	08132013	4
3	08142013	08162013	3

5.7.2.18 Hospital Billing

Hospitals submitting inpatient claims on paper may submit up to 61 service lines per claim. When the claim is submitted, the system performs a merge function that combines like revenue codes to reduce the number of service lines to 28 or less. Because of the merge function, it is important to understand that when the claim appears on the R&S Report the provider does not see the 61 service lines submitted, but rather the results of merged details. If the merge function is unable to merge the number of service lines to 28, the claim is denied for exceeding the maximum details per claim, and the claim needs to be subdivided and resubmitted as multiple claims.

For more information on electronic claim submission, contact the TMHP EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

5.7.2.19 Group Billing

Providers billing as a group must give the provider identifier of the individual rendering the services on their claims as well as the group provider identifier. To be eligible for reimbursement, both the group and the performing provider must be enrolled in the CSHCN Services Program.

5.7.3 Supervising Physician Provider Number Required on Some Claims

The supervising physician provider number will be required on some claims for services that are ordered or referred by one provider at the direction of or under the supervision of another provider, and the referral or order is based on the supervised provider's evaluation of the client.

If a referral or order for services is based on a client evaluation that was performed by the supervised provider, the claim from the performing provider must include the names and National Provider Identifiers (NPIs) of both the ordering provider and the supervising provider for Children with Special Health Care Needs (CSHCN) Services Program clients. The performing provider will need to obtain all of the required information from the ordering or referring provider before submitting the claim to TMHP.

Note: *Pharmacy claims are currently excluded from this requirement.*

5.7.4 Ordering/Referring Provider NPI

All CSHCN Services Program claims for services that require a physician order or referral must include the ordering or referring provider's NPI:

- If the ordering or referring provider is enrolled in the CSHCN Services Program as a billing or performing provider, the billing or performing provider NPI can be used.
- If the ordering or referring provider is not currently enrolled in the CSHCN Services Program as a billing or performing provider, the provider can enroll to receive an ordering or referring-only Texas Provider Identifier (TPI). The provider will receive one TPI that can be used for orders and referrals for both Texas Medicaid clients and CSHCN Services Program clients.

Note: *The billing provider will be responsible for confirming that the ordering or referring provider is enrolled as an ordering or referring-only provider.*

Claims that are submitted without the ordering or referring provider's NPI may be subject to retrospective review and denial if the NPI is not included on the claim.

5.8 Reimbursement

CSHCN Services Program reimbursements are available to all actively enrolled providers either by check or electronic funds transfer (EFT). Through EFT, TMHP deposits reimbursements directly into a provider's bank account. Active providers do not have any type of payment holds on their enrollment status.

The CSHCN Services Program reimburses hospitals, physicians, and other suppliers of service. Each section of this manual gives more detail concerning the methods used to reimburse each provider specialty for claims processed by TMHP. The following information is provided as an overview of the CSHCN Services Program reimbursement methodology.

The CSHCN Services Program implemented rate reductions for certain services. The Online Fee Lookup (OFL) includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at 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.*

5.8.1 Electronic Funds Transfer (EFT)

EFT is a method for directly depositing funds into a designated bank account. When providers enroll, TMHP deposits funds from their approved claims directly into their designated bank account. Transactions transmitted through EFT contain descriptive information to help providers reconcile their bank accounts.

5.8.1.1 Advantages of EFT

The advantages of EFT are:

- Stop payments are no longer necessary because no paper is involved in the transaction process.
- Payment theft is less likely to occur because the process is handled electronically rather than by paper.
- Deposited funds are available for withdrawal within a few days after completion of the TMHP financial cycle.
- Upon deposit, the bank considers the transaction immediately collected. No float is attached to EFT deposits for CSHCN Services Program funds.
- TMHP includes provider and R&S Report numbers with each transaction submitted. If the banks processing software captures and displays the information, both numbers would appear on the banking statement.

5.8.1.2 Enrollment Procedures

Providers are strongly encouraged to participate in EFT. EFT does not require special software, and providers can enroll immediately. To enroll in EFT, complete the Electronic Funds Transfer (EFT) Notification. Complete the EFT form, include a deposit slip or canceled check, and mail or fax the items to:

Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78720–0765
Fax: 1-512-514-4214

The EFT form allows the entry of up to eight TPI numbers. Additional EFT forms may be submitted when a provider needs to list more than eight TPI numbers. Each form must include a provider signature.

TMHP issues a prenotification transaction during the next cycle directly to the provider's bank account. This transaction serves as a checkpoint to verify EFT is working correctly.

If the bank returns the prenotification without errors, the provider begins to receive EFT transactions with the third cycle following the enrollment form processing. The provider continues to receive paper checks until they begin to receive EFT transactions.

If the provider changes bank accounts, the provider must submit a new EFT Agreement to the TMHP Provider Enrollment department. The prenotification process is repeated and, once completed, the EFT transaction is deposited to the new bank account.

5.8.1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe 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.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Chapter 24, Hospital "Payment Window Reimbursement Guidelines," on page 24-13 for additional information about the payment window reimbursement guidelines for inpatient admission.

5.8.2 Texas Medicaid Reimbursement Methodology (TMRM)

The CSHCN Services Program reimburses physicians based on the TMRM. This methodology is used to reimburse the following services and tests:

- Physician services
- Services incidental to physician's services
- Diagnostic tests (other than clinical laboratory)
- Radiology services

TMRM is based on Medicare's resource-based relative value scale (RBRVS) with Medicaid modifications.

Refer to individual provider chapters for specific information about reimbursement.

5.8.3 Maximum Allowable Fee Schedule

Physicians/supplier services that are not reimbursed according to TMRM or reasonable charge may be reimbursed according to a maximum fee schedule. Maximum fee schedules are determined by state and federal regulations.

5.8.4 Manual Pricing

Certain procedure codes do not have an established fee and must be priced manually by the TMHP-CSHCN Services Program medical staff. The medical staff determines the reimbursement amount by comparing the services to other services that require a similar amount of skill and resources. If an item requires manual pricing, providers must submit with the prior authorization request or the claim, the appropriate procedure codes and documentation of one of the following, as applicable:

- The manufacturer's suggested retail price (MSRP) or average wholesale price (AWP)

- The provider's documented invoice cost if a published MSRP or AWP is not available

Note: *The AWP is for nutritional products only. For appropriate processing and payment, providers should bill the applicable MSRP or AWP rate instead of the calculated manual pricing rate. The calculated rate or the Pay Price that is indicated on the authorization letter for prior authorized services should not be billed on the claim.*

5.8.5 Physician Services in Hospital Outpatient Setting

Section 104 of the *Tax Equity and Fiscal Responsibility Act* of 1982 (TEFRA) requires the CSHCN Services Program to limit reimbursement of physician services furnished in a hospital outpatient setting that are also ordinarily furnished in a physician's office. The limit for each service is determined by establishing a charge base for each professional service and multiplying the charge base by 0.60. The charge base for a service is the TMRM fee for similar services furnished in the office.

This provision applies to those procedures performed in the outpatient department of the hospital, such as in clinics and emergency departments. When the eligible client is seen in the outpatient department of the hospital in an emergency situation, the condition that created the emergency must be documented on the claim form.

The following services are excluded from this limitation:

- Surgical services that are covered by ambulatory surgical center (ASC) services
- Anesthesiology and radiology services
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention may be reasonably expected to result in one of the following outcomes:
  - Serious jeopardy to the client's health
  - Serious impairment to bodily functions
  - Serious dysfunction of any body organ or part

5.8.6 Inpatient Hospital Reimbursement

The reimbursement methodology for many CSHCN Services Program facilities that are reimbursed based on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) has changed to the prospective payment methodology based on All Patient Refined Diagnosis Related Groups (APR-DRG) payment system.

Hospitals that are enrolled in the CSHCN Services program must first be enrolled in Texas Medicaid. The CSHCN Services Program reimbursement methodology has changed from TEFRA to APR-DRG. The reimbursement methodology for hospitals that are reimbursed by Texas Medicaid using APR-DRG also applies for the CSHCN Services Program. This reimbursement methodology applies to all hospitals except for state-owned teaching hospitals and inpatient psychiatric facilities.

The reimbursement method will not affect inpatient benefits and limitations. Inpatient admissions will continue to require prior authorization.

Note: *The 20-percent payment reduction that is currently applied to inpatient claims by the CSHCN Services Program will remain in effect.*

Refer to: "Hospital Reimbursement," on page 24-11 for more information about hospital reimbursement.

Prospective Payment Methodology

The prospective payment methodology is based on a DRG payment system. Reimbursement based on DRG includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. Claims may not be submitted for technical services.

The CSHCN Services Program does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, providers may submit only one claim for each inpatient stay. The claim must include appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 paper claim form or electronic equivalent, to be considered for payment.

The number of days of care charged for a client for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to- midnight method is to be used in counting days of care for reporting purposes even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a client returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a client begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (January 1 through December 31) for clients who are 21 years of age and older. Claims may be subject to retrospective review, which may result in recoupment.

5.8.7 Fees

Providers can now access the online fee lookup (OFL) function on the TMHP website at www.tmhp.com and do the following:

- Retrieve fee schedule information in real time
- Search for procedure code reimbursement rates individually, in a list, or in a range
- Search and review their contracted rates
- Retrieve up to 24 months of history for a procedure code by searching for specific dates of service within that 2-year period
- Perform an online, interactive search of benefit information that has been published within the past 18 months for up to ten procedure codes.

5.8.7.1 Provider-Specific Rates for Procedure Codes with Modifiers and Age-Range Criteria

Providers with contracted rates may also use the OFL on the TMHP website to view provider-specific rates for procedure codes that have modifiers and age range criteria.

Providers may view their provider-specific rates for procedure codes with modifiers and age range criteria by completing the following steps:

1) Access the secure portion of the TMHP website at www.tmhp.com
2) Click **Fee Schedules**
3) Click **Fee Search**
4) Click **Contracted Rate Search**
5) Select or Enter the following:

   a. NPA/API/Taxonomy/Address/ZIP+4/ Benefit Code

   b. Program Code

   c. Procedure Code

   d. Date of Service

   e. Modifier 1 (if applicable)

   f. Modifier 2 (if applicable)

g. Modifier 3 (if applicable)

h. Modifier 4 (if applicable)

i. From Age, in years (if applicable)

j. To Age, in years (if applicable)

6) Click **Submit**

The Contracted Rate Search results page features a display of contracted rate search criteria and additional columns and rows to display search results. The Contracted Rate Search results page displays the following:

- Rate Type
- Rate
- Start Date
- End Date (if end-dated)
- Modifiers (if applicable)
- Client From and To Age (if applicable)

5.8.8 CSHCN Services Program Reimbursement Information for Clients

The CSHCN Services Program may reimburse clients for drug copays and transportation of remains when there is an accompanying parent or other responsible person.

Clients may call TMHP at 1-877-888-2350, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for additional information.

Clients may also receive reimbursement for insurance premiums through the Insurance Premium Payment Assistance (IPPA) program. For additional information, clients may call the TMHP-IPPA toll-free client help line at 1-800-440-0493, Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

5.9 CSHCN Services Program Accounts Receivables (Using Medicaid Funds to Satisfy the AR)

A service that is rendered to a CSHCN Services Program client who receives retroactive Medicaid eligibility may be reimbursed by the CSHCN Services Program or by Medicaid, but not by both.

The CSHCN Services Program is the payer of last resort. The CSHCN Services Program does not supplement a client's Medicaid benefits. However, services that are not a benefit of Medicaid may be covered by the CSHCN Services Program. If dual Medicaid and CSHCN Services Program eligibility is determined, claims that have already been paid by the CSHCN Services Program will be reprocessed under the appropriate program.

An accounts receivable (AR) is created for each CSHCN Services Program claim that is reprocessed and subsequently reimbursed under Medicaid so that the amount the CSHCN Services Program originally reimbursed can be returned to the CSHCN Services Program.

If the CSHCN Services Program payout during the week's financial cycle in which the claim was reprocessed is not sufficient to satisfy the AR, the provider's Medicaid claim payouts will be used to satisfy the CSHCN Services Program AR.

Note: *The deduction from Medicaid claim payouts will not exceed the amount Medicaid reimbursed the provider when the CSHCN Services Program claim was reprocessed.*

If the CSHCN Services Program AR is not satisfied within 45 days, TMHP will send the provider a notice that requests repayment to the CSHCN Services Program for the remaining AR balance.

5.10 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.

Chapter

6

Remittance and Status (R&S) Reports

6.1 R&S Report Information

The R&S Report provides information on pending, paid, denied, adjusted, and incomplete claims. TMHP provides R&S Reports to give providers detailed information about the status of claims submitted to TMHP. The R&S Report also identifies receivables resulting from inappropriate payments. These receivables are recouped from payments of subsequent claim submissions.

Providers receive an R&S Report for each 9-digit provider identifier with claim activity.

Providers can determine the program associated with the R&S Report by looking at the top center of the R&S Report. The line below Texas Medicaid & Healthcare Partnership identifies the program associated with the R&S Report.

Online R&S Reports are available as a PDF every Monday morning at 6 a.m., Central Time, following the claims processing cycle. Providers must have a provider administrator account on the TMHP website at www.tmhp.com to receive online R&S Reports.

Refer to: Section 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1, for information about electronic billing.

Providers must retain copies of all R&S Reports for a minimum of 5 years. Do not send original R&S Reports back to TMHP; instead, submit copies of the R&S Reports when submitting a corrected claim or when resubmitting a previously incomplete claim.

Samples of the R&S Report are provided at the end of this chapter. The R&S Report provides information using the following general formatting guidelines:

- Information is displayed in rows rather than columns
- Incomplete claims appear in the "Claims — Paid or Denied" section
- Explanation of benefits (EOB) and explanation of pending status (EOPS) codes are five characters in length (up to four messages can be displayed at the claim level and up to five at the detail level)
- Descriptions of EOBs and EOPS are in an appendix at the end of the R&S Report
- Financial transactions appear in one of the following categories: accounts receivable, Internal Revenue Service (IRS) levies, claim refunds, payouts (system and manual), claim reissues, and claim voids
- The internal control number (ICN) is 24 digits
- The primary diagnosis submitted on the claim appears with the claim header information

6.1.1 Electronic Remittance and Status (ER&S) Reports

Using *Health Information Portability and Accountability Act* (HIPAA)-compliant Electronic Data Interchange (EDI) standards, the ER&S Report can be downloaded through the TMHP-EDI Gateway using TexMedConnect or third-party software. ER&S Reports contain the same information as a paper R&S Report and can be downloaded in any format.

ER&S Reports are available on the Monday following the weekly claims processing cycle. To obtain an ER&S Report, providers must complete and submit an ER&S Agreement. The ER&S Agreement is located in the Forms section of the EDI page on the TMHP Provider home page at www.tmhp.com and can be submitted to the TMHP-EDI help desk by mail or by fax to 1-512-514-4228.

Additional information about ER&S Reports can be accessed via the EDI companion guide ANSI ASC X12N 835. Companion guides are available in the Technical Information section of the EDI Provider home page on the TMHP website.

6.1.2 Banner Pages

Banner pages are used to inform providers of changes in policies, claims, and procedures. The title pages include the following information:

- TMHP address for submitting paper copies of corrected and resubmitted claims
- Provider's name, address, and telephone number

- Unique R&S Report number specific to each report
- Provider identifiers
- Report sequence number (a cumulative number of R&S Reports the provider has received for the calendar year)
- Date of the week reported on the R&S Report
- Federal tax identification number
- Page number (the R&S Report begins with page 1)
- Automated Inquiry System (AIS) telephone number for AIS inquiry calls
- Taxonomy code
- Benefit code

6.1.3 Explanation of R&S Report Row Headings

Row Heading/Section	Explanation
Patient name	Lists the client's last name and first name as indicated on the provider's claim. This field is truncated to display 13 characters.
Claim number	The 24-digit ICN assigned by TMHP for a specific claim. The format for the TMHP claim number is **PPPCCCMMMYYYYJJJBBBBBSSS.** **PPP**: *COMPASS21* Program 400: CSHCN Services Program Code **CCC**: Claim Type 020: Physician supplier/Genetics 021: Dental 023: Outpatient hospital/Home Health Agency (HHA) 040: Inpatient hospital 060: Medical Transportation Program **MMM**: Media Source (Region) 010: Paper 011: Paper adjustment 020: TDHconnect 021: TDHconnect adjustment 030: Electronic (including TexMedConnect) 031: Electronic adjustment (including TexMedConnect) 041: AIS adjustment 051: Mass adjustment 071: Retroactive eligibility adjustment 080: State action request 081: State action request adjustment 110: Postal mail 990: Default media type 991: Default/summary for all adjustments 999: Default/summary for all media regions **YYYY**: Year in which the claim was received **JJJ**: Julian date on which the claim was received **BBBBB**: TMHP internal batch number **SSS:** TMHP internal claim sequence within the batch
Benefit code	These codes are submitted by the provider to identify state programs.
CSHCN number	The client's CSHCN Services Program number.
Medical record number	If a medical record number is used on the provider's claim, that number appears here.

Row Heading/Section	Explanation
EOB	Any EOB code that applies to the entire claim (header level) prints here. Up to four EOB codes display at the header level.
Diagnosis	The primary diagnosis listed on the provider's claim.
Patient account number	If a client's account number is used on the provider's claim, that number appears here.
Service dates	Format MMDDYYYY (month, day, year) in *From* and *To* dates of service.
Type of Service (TOS)/Procedure/Accommodation Code	Indicates by code the specific service provided to the client. The two-digit TOS appears first, followed by a Healthcare Common Procedure Coding System (HCPCS) procedure code. A three-digit code represents a hospital accommodation or ancillary revenue code.
Billed quantity	Indicates the quantity billed per claim detail.
Billed charge	Indicates the charge billed per claim detail.
Allowed quantity	Indicates the quantity allowed per claim detail.
Allowed charge	Indicates the charges allowed per claim detail.
Place of service (POS) column	Includes the POS to the left of the Paid Amount. A two-digit numeric code identifying the POS is indicated in this field.
Paid amount	The final amount allowed for payment per claim detail. Also appearing in this field is the amount paid by another insurance resource. The other insurance (OI) amount is preceded by a minus (-) symbol, and this amount is subtracted from the total of the paid amounts appearing in this field. The total paid amount for the claim appears on the claim total line.
EOB codes	These codes explain the payment or denial of the provider's claim. EOB codes are printed next to and directly below the claim. An explanation of all EOBs appearing on the R&S Report are printed in the appendix at the end of the R&S Report.
EOPS code	The EOPS codes appear only in the "Claims In Process" section of the R&S Report. The codes explain the status of pending claims and are not an actual denial or final disposition.
MOD	Modifiers describe and qualify the services that were provided. For dental services, two modifiers are printed. The first is the tooth identification (TID) and the second is the surface identification (SID).

6.1.4 Explanation of R&S Report Section Headings

6.1.4.1 Claims—Paid or Denied

The title, "Claims — Paid or Denied," is centered on the top of each page in this section. Claims in this section are finalized the week before preparation of the R&S Report. The claims are listed by claim status, claim type, and in client name order. The reported status of each claim does not change unless the provider, CSHCN Services Program, or TMHP initiates further action. TMHP *cannot* process incomplete claims.

Only paper claims are denied as incomplete. Incomplete claims may be submitted as original claims only if the resubmission is received by TMHP within the original filing deadline. Otherwise, the claim must be received within 120 days of the date on the R&S Report.

If a provider determines that a claim cannot be appealed electronically or through the Automated Inquiry System (AIS), the claim may be appealed on paper by completing the following steps:

- Submit a copy of the R&S Report page on which the claim is paid or denied. A copy of any other official notification from TMHP may also be submitted.
- Submit one copy of the R&S Report for each claim appealed.

- Circle only one claim per R&S Report page.
- Identify the reason for the appeal.
- If applicable, indicate the incorrect information and provide the correct information that should be used to appeal the claim.
- Attach a copy of any supporting medical documentation that is required or has been requested by TMHP. Supporting documentation must be on a separate page and not copied on the opposite side of the R&S Report.

Refer to: Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1.

Chapter 7, "Appeals and Administrative Review," on page 7-1.

Claims filed electronically without required information are *rejected*. Users are required to retrieve the response file to determine the reason for rejections. Providers receiving TMHP EDI rejections may resubmit an electronic claim within 95 days from the date of service.

A paper appeal may also be submitted with a copy of the rejection report. Appeals must be received by TMHP within 120 days of the rejection report date to be considered. A copy of the rejection report must accompany each corrected claim submitted on paper.

6.1.4.2 Adjustments to Claims

The title, "Adjustments to Claims," is centered at the top of each page in this section. Adjustments are listed by claim type, client name, and CSHCN Services Program client number. Media types 011, 021, 031, 041, 051, 071, and 081 appear in this section. An adjustment is printed in the same format as a paid or denied claim.

The adjusted claim is listed first on the R&S Report. EOB 00123, "This is an adjustment to previous claim XXXXXXXXXXXXXXXXXXXXXXXX which appears on R&S Report dated XX/XX/XX" follows this claim. The dollar amounts on the original claim are followed by a minus (-) symbol indicating the original payment is voided.

The net adjustment amount is the difference between the claim total for the original claim and the claim total for the adjusted claim. If the total amount of money to be recouped is not available on the current R&S Report, it is taken from future payments.

EOB 00601 prints the following message below the claim indicating the amount is to be recouped later: "A receivable has been established in the amount of the original payment: $_____. Future payments will be withheld or reduced until such amount is paid in full."

When an adjustment is set up (EOB 00601) and enough money is available on the next R&S Report, EOB 00097 prints, "Payment adjusted on following client." The original ICN and R&S Report date appears. The dollar amount to be recouped is listed in the Original Amount column. The amount changes until all money is recouped.

In the "Adjustments to Claims" section, the amount identifying the *net difference* (difference between the original claim payment and the adjusted claim payment) appears below the prior claim payment. If the net difference is a positive amount, the amount is added to the amount of the current check. If the net difference is a negative amount, a minus sign appears before the dollar amount, and that amount is deducted from the amount of the current check.

6.1.4.3 Financial Transactions

All accounts receivables, IRS levies, payouts, refunds, reissues, and voids appear in this section of the R&S Report. The financial transactions section does not use the R&S Report form column headings. Additional subheadings are printed to identify the financial transactions. References to fiscal year end (FYE) represent the provider's FYE based on cost report information and does not apply to all providers. The following are descriptions of the six types of financial transactions.

Accounts Receivable

Accounts receivable identifies money that was subtracted from the provider's current payment because it is owed to the CSHCN Services Program. Specific claim data is not given on the R&S Report unless the accounts receivable setup is claim-specific. An accounts receivable control number is provided that should be referenced when corresponding with TMHP. If the withholding

amount is related to a specific claim and not an EOB 00601 described in Section 6.1.4.2, "Adjustments to Claims," on page 6-5, a separate letter with this information is sent to the provider. Accounts receivable appears on the R&S Report in the following format:

Row Heading/Section	Explanation
Control number	A control number that should be referenced when corresponding with TMHP.
Recoupment rate	The percentage of the provider's payment withheld each week unless the provider elects to have a specific amount withheld each week.
Maximum periodic recoupment amount	The amount to be withheld each week or month. This field is blank if the provider elects to have a percentage withheld each week or month.
Original date	The date the financial transaction was originally processed.
Original amount	The total amount owed to the CSHCN Services Program.
Prior date	The date the last transaction on the accounts receivable occurred.
Prior balance	The amount owed from a previous R&S Report.
Applied amount	The amount subtracted from the current R&S Report.
FYE	The fiscal year end for cost reports.
EOB	The EOB code that corresponds to the reason code for the accounts receivable.
Patient name	If the accounts receivable is claim specific, the name of the client listed on the claim.
Claim number	If the accounts receivable is claim specific, the ICN of the original claim.
Balance	Indicates the total outstanding accounts receivable (AR) balance that remains due.

IRS Levies

If TMHP receives a notice from the IRS of a levy against a provider, payments will be withheld from the provider's payment. These are displayed in the IRS Levies section of the R&S Report. Payments are withheld until the levy is satisfied or released. Although the current payment amount is lowered by the amount of the levy payment, the provider's 1099 earnings are not lowered. IRS levies are reported in the following format:

Row Heading/Section	Explanation
Control number	Control number to reference when corresponding with TMHP.
Maximum recoupment rate	The percentage of the provider's payment withheld each week unless the provider elects to have a specific amount withheld each week.
Maximum recoupment amount	The amount to be withheld on a periodic basis. This field is blank if the provider elects to have a percentage withheld each week.
Original date	The date the levy was originally set up.
Original amount	The total amount owed to the CSHCN Services Program.
Prior balance	The amount owed from a previous R&S Report.
Prior update	The date the last transaction on the levy occurred.
Current amount	The amount subtracted from the current R&S Report.
Remaining balance	The amount still owed on the levy (this amount becomes the previous balance on the next R&S Report).

Payouts

Payouts are dollar amounts owed to the provider. TMHP processes two types of payouts: system payouts that increase the weekly payment amount and manual payouts or refunds that result in a separate payment issued to the provider. Specific claim data is not given on the R&S Report for payouts. If the payout is claim-related, a separate letter with this information is sent to the provider. A control number is given that should be referenced when corresponding with TMHP.

Payouts appear on the R&S Report in the following format:

Row Heading/Section	Explanation
Payout control number	Control number to reference when corresponding with TMHP.
Payout amount	Amount of the payout.
FYE	The fiscal year for which this refund is applicable.
EOB	The EOB code that corresponds to the reason code assigned.
Refund check number	The number of the refund check issued by TMHP.
Refund check amount	The amount of the refund check mailed to the provider.
Patient name	The name of the client (if available).
PCN	The CSHCN Services Program number of the client (if available).
DOS	The date of service (if available).

Claim Reissues

Claim reissues are identified by EOB 00122, "This claim is a reissue of a previous claim." For example, EOB 00122 is used if a check is lost in the mail and must be reissued to the provider. The message follows each claim that was reissued. Every claim paid on the original check is reprinted in the financial section. The claims appear on the R&S Report in the following format:

Row Heading/Section	Explanation
Check number	The number of the original check.
Check amount	The amount of the original check.
R&S number	The number of the original R&S Report.
R&S date	The date of the original R&S Report.

Claim Voids

Claim voids are identified by EOB 00134, "Voided claims – this amount has been credited to your net IRS liability." This occurs when the TMHP check has been returned and voided. Claims originally paid on the check are listed and the amounts credited to the provider's 1099. Claim voids are printed in the same format as claim reissues.

Claim Refunds

Claim refunds are identified by EOB 00124, "Thank you for your refund; your 1099 liability has been credited." This message verifies that money refunded to the CSHCN Services Program for incorrect payments was received and posted. The provider's check number and the date of the check are printed on the R&S Report. Claim refunds appear on the R&S Report in the following format:

Row Heading/Section	Explanation
ICN	The claim number of the claim to which the refund was applied this cycle.
Patient name	The client's first name, middle initial, and last name on the applicable claim.
CSHCN number	The client's CSHCN Services Program number.
Date of service	The format MMDDYYYY (month, day, year) in *From* date of service.

Row Heading/Section	Explanation
Total billed	The total billed amount of the refunded claim.
Amount applied this cycle	The refund amount applied to the claim.
EOB	The EOB code that corresponds to the reason code assigned.

6.1.4.4 Financial Transactions/Void and Stop—"Stale-Dated Checks"

Stale-dated checks (i.e., checks older than 180 days) that have not been cashed are voided and applied to any outstanding accounts receivable. If the balance on a stale-dated check after it has been applied to accounts receivable is over $5,000, written notification is sent to the provider 60 days before the void occurs. Once a check has been voided, the associated claims may not be payable, and the transaction is considered final. The CSHCN Services Program encourages providers to receive payment via electronic funds transfer (EFT) to eliminate stale-dating issues. EFT ensures that providers receive payments via direct deposit in a bank account of their designation. To enroll in EFT, use the Electronic Funds Transfer (EFT) Notification or call the TMHP Contact Center at 1-800-568-2413, Monday through Friday from 7 a.m. to 7 p.m., Central Time, and select Option 2.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1.

6.1.5 Claims Payment Summary

This section summarizes payments, adjustments, and financial transactions listed on the R&S Report. The section has two categories: one for the current weeks totals and one for the year-to-date totals.

Example: *If the provider is receiving a payment on this particular R&S Report, the following information is given: "Payment summary for check number (check #) or (directly deposited by EFT) in the amount of ($amount). Note that items marked with an asterisk (*) do not affect your 1099 earnings." The check number is also printed on the check that accompanies the R&S Report.*

The Claims Payment Summary appears on the R&S Report in the following format:

Heading	Explanation
Claims paid	The number of claims processed for the week, as well as the year-to-date total.
System payouts	The total amount of system payouts issued to the provider by TMHP.
Manual payouts	The total amount of manual payouts issued to the provider by TMHP (remitted by a separate check or EFT).
Amount paid to IRS for levies	The amount remitted to the IRS and withheld from the provider's payment due to an IRS levy.
Amounts paid to IRS for backup withholding	The amount paid to the IRS for backup withholding.
Accounts receivable recoupment	The total amount withheld from the provider's payment for accounts receivable.
Amounts stopped or voided	The total amount of the payment that was voided or stopped with no reissuance of payment.
System reissues	The amount of the reissued payment.

Heading	Explanation
Claims related refunds	The net amount allowed for the week's payment. If there are no adjustments recouping money showing negative paid amounts, the claim's amount is the total of all paid amounts on the individual claims. If there are adjustments showing negative paid amounts, the claim's amount is the total paid amount minus the total amount of claim-related refunds applied during the weekly cycle.
Nonclaim-related refunds	The total amount of nonclaim-related refunds applied during the weekly cycle.
Amount affecting 1099 earnings	The amount added for this week to the provider's earnings. This figure is the claim's amount minus any withheld or credit amounts. This column also shows weekly and year-to-date totals. The year-to-date IRS amount is the net total of reportable payments for tax purposes.
Held amount	The total amount withheld from the provider's payment.
Payment amount	Amount of the payout
Pending claims	The total amount billed for claims in process beginning with the cutoff date for the report.

6.1.5.1 Claims In Process

Claims that are in process appear in the section titled "The Following Claims are Being Processed." The R&S Report may list up to five EOPS messages per claim. The claims listed in this section are in process and *cannot* be resubmitted for any reason until they appear in either the "Claims - Paid or Denied," or "Adjustments - Paid or Denied" sections of the R&S Report. TMHP lists the pending status of these claims only for informational purposes. The pending messages should not be interpreted as a final claim disposition.

All claims and claims resubmitted for reconsideration that TMHP has in process are listed on the R&S report weekly. TMHP provides the following information on the R&S Report:

- Client name
- Claim number
- EOPS
- *International Classification of Diseases,* Ninth Revision, Clinical Modification (ICD-9-CM) number
- Initial date of service
- Billed charge (total billed)

6.1.5.2 EOB and EOPS Codes Section

The "Explanation of Benefits Codes Messages" section lists the descriptions of all EOBs and EOPS that appeared on the R&S Report. EOBs and EOPS appear in numerical order.

Electronic Data Interchange ANSI X12 5010 835 files will display the appropriate Claims Adjustment Reason Code (CARC), Claims Adjustment Group Code (CAGC), and Remittance Advice Remarks Code (RARC) explanation codes that are associated with EOB denials.

The 835 file will include the CARC, CAGC, and RARC explanation codes that are associated with the highest priority detail EOB to provide a clearer explanation for the denial.

6.1.6 R&S Report Examples

The following pages provide examples of R&S Reports.

6.1.6.1 Physician R&S Report Example: Banner Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code: CSN
Report Seq. Number: 35
R&S Number: 2460000

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BANNER PAGE

39 (03/25/11 THROUGH 04/15/11) *****ATTENTION ALL CSHCN SERVICES PROGRAM PROVIDERS*****

EFFECTIVE FOR DATES OF SERVICE ON OR AFTER MAY 1, 2011, NONSURGICAL VISION SERVICES PROCEDURES BENEFIT CRITERIA WILL CHANGE FOR THE CHILDREN WITH
SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM. DETAILS OF THESE CHANGES ARE AVAILABLE ON THE TMHP WEBSITE AT WWW.TMHP.COM.

FOR MORE INFORMATION, CALL THE TMHP-CSHCN SERVICES PROGRAM CONTACT CENTER AT 1-800-568-2413.

40 (03/25/11 THROUGH 04/15/11) *****ATTENTION ALL CSHCN SERVICES PROGRAM PROVIDERS*****

EFFECTIVE FOR DATES OF SERVICE ON OR AFTER MAY 1, 2011, THE REIMBURSEMENT RATES FOR SOME PHYSICIAN-ADMINISTERED DRUG PROCEDURE CODES WILL CHANGE FOR THE CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM. DETAILS ARE AVAILABLE ON THE TMHP WEBSITE.

FOR MORE INFORMATION, CALL THE TMHP-CSHCN SERVICES PROGRAM CONTACT CENTER AT 1-800-568-2413.

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

YOUR AIS NUMBER IS 0000000-01
FOR AIS INQUIRY CALL TOLL FREE 1-(800) 568-2413
THE PROVIDER MANUAL PROVIDES DETAILS.
PHYSICAL ADDRESS ON RECORD:
TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234

(214) 555-4141

6.1.6.2 Physician R&S Report Example: Blank Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code: CSN
Report Seq. Number: 35
R&S Number: 2460000

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6.1.6.3 Physician R&S Report Example: Claims – Paid or Denied

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code: CSN
Report Seq. Number: 35
R&S Number: 2460000

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PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	BENEFIT	CSHCN #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
---SERVICE DATES---		-----BILLED-----		-----ALLOWED-----						

FROM	TO	TOS	PROC	QTY	CHARGE	QTY	CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB	EOB	MOD	MOD
********** CLAIMS - PAID OR DENIED **********																
DOE, JANE 400020010200704400000000 000123456789			CSN 999999900						01147							25000
03/22/2011	03/22/2011	1	92004	1.0	225.00	1.0	105.11	1	103.01	00475	01196					
03/22/2011	03/22/2011	1	92015	1.0	35.00	1.0	22.91	1	22.45	00475	01196					
					$260.00		$128.02		$125.46	CLAIM TOTAL						
PAID CLAIM TOTALS					$260.00		$128.02		$125.46							

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

6.1.6.4 Physician R&S Report Example: Blank Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code: CSN
Report Seq. Number: 35
R&S Number: 2460000

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6.1.6.5 Physician R&S Report Example: Payment Summary Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code: CSN
Report Seq. Number: 35
R&S Number: 2460000

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PAYMENT SUMMARY FOR CSHCN FOR TAX ID 987654321

	*** AFFECTING PAYMENT THIS CYCLE *** AMOUNT	COUNT	*** AMOUNT AFFECTING 1099 EARNINGS *** THIS CYCLE	YEAR TO DATE
CLAIMS PAID	125.46	1	125.46	333.49
SYSTEM PAYOUTS				
MANUAL PAYOUTS (REMITTED BY SEPARATE CHECK OR EFT)				
AMOUNT PAID TO IRS FOR LEVIES				
AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING				
ACCOUNTS RECEIVABLE RECOUPMENTS				
AMOUNTS STOPPED/VOIDED				
SYSTEM REISSUES				
CLAIM RELATED REFUNDS				
NON-CLAIM RELATED REFUNDS				
HELD AMOUNT				
PAYMENT AMOUNT	125.46		125.46	333.49

PENDING CLAIMS

**********PAYMENT TOTAL FOR CHECK 000000012345678 IN THE AMOUNT OF 125.46**********

6.1.6.6 Physician R&S Report Example: Explanation of Benefits (EOB) Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code: CSN
Report Seq. Number: 35
R&S Number: 2460000

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EXPLANATION OF BENEFITS CODES MESSAGES

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00475	PAID ACCORDING TO THE TEXAS MEDICAID REIMBURSEMENT METHODOLOGY-TMRM (RELATIVE VALUE UNIT TIMES STATEWIDE CONVERSION FACTOR)
01147	PLEASE REFER TO OTHER EOB MESSAGES ASSIGNED TO THIS CLAIM FOR PAYMENT/DENIAL INFORMATION.
01196	THIS PAYMENT WAS REDUCED BY 2% IN ACCORDANCE WITH THE STATE'S SPENDING REDUCTION PLAN FOR CLAIMS WITH A DATE OF SERVICE ON OR AFTER FEBRUARY 1, 2011. PCS SERVICES ARE REDUCED BY 1%.

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOP CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

6.1.6.7 Ambulatory Surgical Center (ASC) R&S Report Example: Banner Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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39 (03/25/11 THROUGH 04/15/11) *****ATTENTION ALL CSHCN SERVICES PROGRAM PROVIDERS*****

EFFECTIVE FOR DATES OF SERVICE ON OR AFTER MAY 1, 2011, NONSURGICAL VISION SERVICES PROCEDURES BENEFIT CRITERIA WILL CHANGE FOR THE CHILDREN WITH
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EFFECTIVE FOR DATES OF SERVICE ON OR AFTER MAY 1, 2011, THE REIMBURSEMENT RATES FOR SOME PHYSICIAN-ADMINISTERED DRUG PROCEDURE CODES WILL CHANGE FOR THE CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM. DETAILS ARE AVAILABLE ON THE TMHP WEBSITE.

FOR MORE INFORMATION, CALL THE TMHP-CSHCN SERVICES PROGRAM CONTACT CENTER AT 1-800-568-2413.

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

YOUR AIS NUMBER IS 0000000-01
FOR AIS INQUIRY CALL TOLL FREE 1-(800) 568-2413
THE PROVIDER MANUAL PROVIDES DETAILS.
PHYSICAL ADDRESS ON RECORD:
TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234

(214) 555-5555

6.1.6.8 ASC R&S Report Example: Adjustments R&S Report

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	BENEFIT	CSHCN #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
---SERVICE DATES---		-----BILLED-----		-----ALLOWED-----						
FROM / TO	TOS	PROC	QTY	CHARGE	QTY	CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB	EOB	MOD	MOD
********** ADJUSTMENTS - PAID OR DENIED **********															
DOE, JANE	40002303020110600000000		111111111	2222222				01147							71537
0000000000															
02/18/2011	02/18/2011	F	28755	1.0	10,192.39	1.0	444.95	5	436.05	00325	00058		01196		TA
					$10,192.39		$444.95		$436.05	CLAIM TOTAL					
SMITH, JOHN	40002303020110620000000		111111111	2222222				01147							75732
0000000000															
02/24/2011	02/24/2011	F	17108	1.0	6,334.31	1.0	235.23	5	230.53	00325	00058		01196		
					$6,334.31		$235.23		$230.53	CLAIM TOTAL					
PAID CLAIM TOTALS					$16,526.70		$680.18		$666.56						

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

6.1.6.9 ASC R&S Report Example: Blank Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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6.1.6.10 ASC R&S Report Example: Adjustments R&S Report

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	BENEFIT	CSHCN #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
---SERVICE DATES--- FROM / TO	TOS	PROC	-----BILLED----- QTY / CHARGE	-----ALLOWED----- QTY / CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB	EOB	MOD	MOD
********** CLAIMS - PAID OR DENIED **********													
ADJUSTMENT CLAIM:													
DOE, JANE 0000000000	40002303120110770000000	CSN	111111111	2222222		01147							59654
12/22/2010	12/22/2010	F	51798	1.0	1,430.00	.0	.00	5	.00	00572	00129	00954	
					$1,430.00		$.00		$.00	ADJUSTMENT CLAIM TOTAL			
00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 400023030201100612312345													
ORIGINAL CLAIM:													
DOE, JOHN 0000000000	40002301020110690000000	CSN	111111111	2222222		01147							59654
12/22/2010	12/22/2010	F	51798	1.0	1,430.00	.0	.00	5	.00	00572			
					$1,430.00		$.00		$.00	ORIGINAL CLAIM TOTAL			
ADJUSTMENT CLAIM:													
DOE, JAMES 0000000000	40002303120110740000000	CSN	111111111	2222222		01147							52100
01/14/2011	01/14/2011	F	41899	1.0	6,211.15	1.0	504.00	5	498.96	00325	00149	01170	U3
					$6,211.15		$504.00		$498.96	ADJUSTMENT CLAIM TOTAL			

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

6.1.6.11 ASC R&S Report Example: Adjustments R&S Report

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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PATIENT NAME CLAIM NUMBER BENEFIT CSHCN # MEDICAL RECORD # MEDICARE # EOB EOB EOB EOB DIAGNOSIS
PATIENT ACCT #
---SERVICE DATES--- -----BILLED----- -----ALLOWED-----
FROM TO TOS PROC QTY CHARGE QTY CHARGE POS PAID AMT EOB EOB EOB EOB EOB MOD MOD

********** ADJUSTMENTS - PAID OR DENIED **********

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 40002303020110061231234 5

ORIGINAL CLAIM:
DOE, JANNET 40002303120110460000000 0 CSN 111111111 2222222 01147 52100
0000000000
01/14/2011 01/14/2011 F 41899 1.0 6,211.15 .0 .00 5 .00 0164 00R01 SG

$6,211.15 $.00 $.00 ORIGINAL CLAIM TOTAL

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 40002303020110061231234 5

ADJUSTMENT CLAIM:
DOE, JOHNNY 40002301020110760000000 0 CSN 111111111 2222222 01147 52100
0000000000
02/18/2011 02/18/2011 F 41899 1.0 6,156.53 1.0 504.00 5 493.92 00325 00149 01196 U3

$6,156.53 $504.00 $493.92 ADJUSTMENT CLAIM TOTAL

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 40002303020110061231234 5
ORIGINAL CLAIM:
DOE, JAMMIE 40002303120110550000000 0 CSN 111111111 2222222 01147 52100
0000000000
02/18/2011 02/18/2011 F 41899 1.0 6,156.53 .0 .00 5 .00 00958 00572 01170 EP

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

6.1.6.12 ASC R&S Report Example: Adjustments R&S Report

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	BENEFIT	CSHCN #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
---SERVICE DATES---		-----BILLED-----		-----ALLOWED-----						
FROM TO	TOS	PROC	QTY	CHARGE	QTY	CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB	EOB	MOD	MOD

********** ADJUSTMENTS - PAID OR DENIED **********

CONTINUED FROM PREVIOUS PAGE

DOE, JAMMIE 40002303120110550000000 CSN 111111111
0000000000

	$6,156.53	$.00	$.00	ORIGINAL CLAIM TOTAL
PAID CLAIM TOTALS	$13,797.68	$1,008.00	$992.88	

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

6.1.6.13 ASC R&S Report Example: Blank Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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6.1.6.14 ASC R&S Report Example: Claims in Process R&S Report

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	BENEFIT	CSHCN #	MEDICAL RECORD #	MEDICARE #	EOPS	EOPS	EOPS	EOPS	DIAGNOSIS
---SERVICE DATES--- FROM	TO	TOS	PROC	-----BILLED----- QTY	CHARGE	-----ALLOWED----- QTY	CHARGE	POS	PAID AMT	EOPS	EOPS	EOPS	EOPS	EOPS	MOD	MOD
DOE, JAKE	40002303020110730000000			111111111	2222222											47410
0000000000																
03/07/2011	03/07/2011	F	42820	1.0	6,878.36				00I03							
					$6,878.36											
DOE, JOE	40002303020110730000000			111111111	2222222											73390
0000000000																
02/11/2011	02/11/2011	F	29891	1.0	10,421.30				00I03						RT	
					$10,421.30											
DOE, DAVE	40002303020110760000000			111111111	2222222											7840
0000000000																
03/11/2011	03/11/2011	F	62270	1.0	7,690.00				00I03							
					$7,690.00											

********** THE FOLLOWING CLAIMS ARE BEING PROCESSED **********

THE EXPLANATION OF PENDING STATUS (EOPS) CODES LISTED ARE NOT FINAL CLAIM DENIALS OR PAYMENT DISPOSITIONS. THE EOPS CODES IDENTIFY THE REASONS WHY A CLAIM IS IN PROCESS. BECAUSE THESE CLAIMS ARE CURRENTLY IN PROCESS, NEW INFORMATION CANNOT BE ACCEPTED TO MODIFY THE CLAIM UNTIL THE CLAIM FINALIZES AND APPEARS AS FINALIZED ON YOUR R&S REPORT. PLEASE REFER TO THE LAST SECTION OF THIS REPORT FOR THE MESSAGES THAT CORRESPOND TO THE EOPS CODES USED ON THIS REPORT.

****

IF YOUR CLAIM HAS NOT APPEARED ON ANY R&S REPORT AS PAID, DENIED OR PENDING WITHIN 30 DAYS OF SUBMISSION TO TMHP, PLEASE CONTACT TELEPHONE INQUIRY AT 1-800-925-9126 AND/OR SEE CLAIMS FILING INSTRUCTIONS IN YOUR PROVIDER MANUAL.

6.1.6.15 ASC R&S Report Example: Claims in Process R&S Report

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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PATIENT NAME	CLAIM NUMBER	BENEFIT	CSHCN #	MEDICAL RECORD #	MEDICARE #	EOPS	EOPS	EOPS	EOPS	DIAGNOSIS
PATIENT ACCT #										

---SERVICE DATES---				-----BILLED-----		-----ALLOWED-----										
FROM	TO	TOS	PROC	QTY	CHARGE	QTY	CHARGE	POS	PAID AMT	EOPS	EOPS	EOPS	EOPS	EOPS	MOD	MOD

********** THE FOLLOWING CLAIMS ARE BEING PROCESSED **********

THE EXPLANATION OF PENDING STATUS (EOPS) CODES LISTED ARE NOT FINAL CLAIM DENIALS OR PAYMENT DISPOSITIONS. THE EOPS CODES IDENTIFY THE REASONS WHY A CLAIM IS IN PROCESS. BECAUSE THESE CLAIMS ARE CURRENTLY IN PROCESS, NEW INFORMATION CANNOT BE ACCEPTED TO MODIFY THE CLAIM UNTIL THE CLAIM FINALIZES AND APPEARS AS FINALIZED ON YOUR R&S REPORT. PLEASE REFER TO THE LAST SECTION OF THIS REPORT FOR THE MESSAGES THAT CORRESPOND TO THE EOPS CODES USED ON THIS REPORT.

PENDING CLAIM TOTALS $24,989.66

****

IF YOUR CLAIM HAS NOT APPEARED ON ANY R&S REPORT AS PAID, DENIED OR PENDING WITHIN 30 DAYS OF SUBMISSION TO TMHP, PLEASE CONTACT TELEPHONE INQUIRY AT 1-800-925-9126 AND/OR SEE CLAIMS FILING INSTRUCTIONS IN YOUR PROVIDER MANUAL.

6.1.6.16 ASC R&S Report Example: Payment Summary Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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PAYMENT SUMMARY FOR CSHCN FOR TAX ID 987654321

	*** AFFECTING PAYMENT THIS CYCLE *** AMOUNT	COUNT	*** AMOUNT AFFECTING 1099 EARNINGS *** THIS CYCLE	YEAR TO DATE
CLAIMS PAID	1,659.46	5	1,659.46	10,718.85
SYSTEM PAYOUTS				
MANUAL PAYOUTS (REMITTED BY SEPARATE CHECK OR EFT)				
AMOUNT PAID TO IRS FOR LEVIES				
AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING				
ACCOUNTS RECEIVABLE RECOUPMENTS				
AMOUNTS STOPPED/VOIDED				
SYSTEM REISSUES				
CLAIM RELATED REFUNDS				
NON-CLAIM RELATED REFUNDS				
HELD AMOUNT				
PAYMENT AMOUNT	1,659.46		1,659.46	10,718.85

PENDING CLAIMS 24,989.66

**********PAYMENT TOTAL FOR CHECK 000000012345678 IN THE AMOUNT OF 1,659.46**********

6.1.6.17 ASC R&S Report Example: Explanation of Benefits (EOB) Page

Texas Medicaid & Healthcare Partnership
CSHCN Remittance and Status Report
Date: 04/08/2011

Mail original claim to:
CSHCN / Texas Medicaid & Healthcare Partnership
P.O. Box 200855
Austin, Texas 78720-0855

TEXAS ASC PROVIDER
PO BOX 959595
HOUSTON, TX 75999-1234
(214) 555-5555

Mail all other correspondence to:
CSHCN / Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 568-2413

TPI: 7654321-02
NPI/API: 0987654321
Taxonomy: 111100000X
Benefit Code: CSN
Report Seq. Number: 13
R&S Number: 1230000

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EXPLANATION OF BENEFITS CODES MESSAGES

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00058	PROCEDURE PAYMENT DETERMINED BY PROGRAM/BENEFIT PLAN, LOCALITY/SPECIALTY, DATE OF SERVICE AND BILLED AMOUNT.
00129	PAYMENT REDUCED BY MEDICAL REVIEWER.
00149	PROCEDURE PAYMENT BASED ON PROGRAM/BENEFIT PLAN, DATE OF SERVICE, AND A MAXIMUM PAYMENT AMOUNT SET BY HCFA OR TDH.
00164	THESE SERVICES ARE NOT IN ACCORDANCE WITH MEDICAL POLICY.
00325	FOR INPATIENT SERVICES, PAID AMOUNT REDUCED BY 20% EFF 9/1/94. FOR OUT PATIENT SVCS, PAID AMOUNT REDUCED BY 17.3% EFF 9/1/99 OR 20% EFF 9/1/94-8/31/99.
00572	IT IS MANDATORY THAT AUTHORIZATION BE OBTAINED. DUE TO LACK OF APPROVAL, THE SERVICE IS NON-PAYABLE.
00954	THE AUTHORIZATION NUMBER USED ON THIS CLAIM IS NOT VALID FOR THE DATE OF SERVICE.
00958	THIS IS NOT A VALID PROCEDURE CODE AND OR MODIFIER FOR THIS DATE OF SERVICE. RESUBMIT WITH A VALID PROCEDURE CODE AND OR MODIFIER.
01147	PLEASE REFER TO OTHER EOB MESSAGES ASSIGNED TO THIS CLAIM FOR PAYMENT/DENIAL INFORMATION.
01170	THIS PAYMENT WAS REDUCED BY 1% IN ACCORDANCE WITH THE STATE'S SPENDING REDUCTION PLAN FOR CLAIMS WITH A DATE OF SERVICE ON OR AFTER SEPTEMBER 1, 2010.
01196	THIS PAYMENT WAS REDUCED BY 2% IN ACCORDANCE WITH THE STATE'S SPENDING REDUCTION PLAN FOR CLAIMS WITH A DATE OF SERVICE ON OR AFTER FEBRUARY 1, 2011. PCS SERVICES ARE REDUCED BY 1%.

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOP CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00I03	OUR FILES INDICATE AN AUTHORIZATION INFORMATION MISMATCH.
00R01	THIS CLAIM IS SUSPENDED FOR POSSIBLE CUTBACK OR MANUAL PRICING REVIEW.

6.2 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.

Chapter

7

Appeals and Administrative Review

7.1 Appeals

An appeal is a request for reconsideration of a previous denial.

Providers may request an appeal if a denial is received for any of the following:

- Authorization or prior authorizations
- Claims
- Provider enrollment

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for additional information regarding the appeals process for authorization and prior authorization denials.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for additional information.

Section 2.1.4, "Provider Enrollment Determinations," on page 2-5 for additional information.

7.2 Authorization and Prior Authorization Denials

Authorization or prior authorization requests that do not contain all of the information necessary for the program to make a determination are denied.

Refer to: Section 4.6, "Authorization and Prior Authorization Denials," on page 4-12 for information about reasons for denials.

7.2.1 Administrative Review for Authorization or Prior Authorization Denials

A provider or client who has received a denied authorization or prior authorization may submit a request for an administrative review to the CSHCN Services Program if they are dissatisfied with TMHP's decision to deny the authorization or prior authorization.

All providers and clients must submit requests for an administrative review within 30 days of the date TMHP denied the authorization or prior authorization. Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program–Administrative Review
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133

Additional information requested by the CSHCN Services Program must be returned to the Program within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case is closed.

7.2.2 Fair Hearing Requests for Authorizations or Prior Authorizations

After an administrative review, providers or clients may request a fair hearing if they are dissatisfied with the CSHCN Services Program's decision and the supporting reason.

The fair hearing is the final appeal process and is described in the *Texas Administrative Code* (TAC) Title 25, Part 1, Chapter 1, Subchapter C (www.sos.state.tx.us). The fair hearing process is conducted by the Office of General Counsel at DSHS.

Providers or clients may choose to represent themselves, or have legal counsel or another spokesperson, at the hearing. If providers or clients are unable to attend the hearing in person, they may request arrangements to attend by teleconference.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons.

Providers and clients who fail to request a fair hearing within the 20-day period are presumed to have waived their right to request a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program-Fair Hearing
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133 or 1-512-776-7162 (in Austin)

7.3 Claim Appeals

Providers may use three methods to appeal claims to TMHP:

- Automated Inquiry System (AIS)
- Electronic
- Paper

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days of the date of disposition of the Remittance and Status (R&S) Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline is extended to the next business day.

Refer to: 2014 Filing deadline calendar
2015 Filing Deadline Calendar

All appeals must be sent to TMHP as a first-level appeal. A first-level appeal is a provider's initial appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all required information to be considered.

7.3.1 Electronic Appeal Submission

Providers can use TexMedConnect or vendor software to submit files directly to TMHP or they may use a billing agent (i.e., billing companies or clearinghouses) that submits files on the provider's behalf.

TMHP Electronic Data Interchange (EDI) accepts the *Health Insurance Portability and Accountability Act* (HIPAA) standard American National Standards Institute (ANSI) ASC X12 837 format.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for additional information regarding electronic transactions.

Zero-paid claims that appear in the "Claims - Paid or Denied" section of the R&S Report and the allowed charge and the paid amount are $0, may be resubmitted as electronic appeals. Zero-paid claims that are still within the 95-day filing deadline should be submitted as new day claims, which process faster than appeals.

For more information, contact the TMHP EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

7.3.1.1 Advantages of Electronic Appeal Submission

- Increased accuracy potentially improves cash flow
- Audit trails can be maintained through print and download capabilities
- Appeal submission fields can be automatically filled in with Electronic Remittance and Status (ER&S) Report information, reducing data entry time
- Acceptance or rejection reports received for appeals submissions

7.3.1.2 Disallowed Electronic Appeals

The following claims may not be appealed electronically, and providers must appeal these denials on paper:

- Claims that require supporting documentation (e.g., operative report, medical records)
- Claims listed as *pending* or in *process* with explanation of pending status (EOPS) messages
- Claims denied as past *filing deadline*, except when retroactive eligibility deadlines apply
- Claims denied as past the *payment deadline*
- Inpatient Hospital claims that require supporting documentation
- Third-party resource (TPR) and other insurance
- Claims billed for additional days or units not included in the original claim

7.3.1.3 Electronic Rejections

TMHP EDI transactions that fail HIPAA edits are rejected, and the submitter receives a 277CA claim response file which replaced the TMHP EDI Rejected Transaction Report. The 277CA claims response file lists activity by submitter, provider, and payer.

The 277CA claims response file includes member identifier, patient last name and first initial, patient control number (PCN), type of bill or place of service, charge, transaction from and to dates, receipt date, rejection code, and rejection description.

Providers must send the batch ID, PCN, date of service, transaction from and to dates, receipt date, and rejection codes from the 277CA claims response file to TMHP when appealing denied claims.

The batch ID is located in the file name of the returned 277CA claims response, and not within the file. Providers must include the batch ID in all electronic response files submitted to TMHP for appeals to denied claims. Handwritten batch IDs are not acceptable for submission to TMHP. Providers who cannot identify or retrieve the batch ID from the 277CA claims response file name should contact the clearinghouse or vendor to have the filename included in the response document. If not, the provider must request a copy of the response file that contains the filename from the clearinghouse.

Providers who receive a rejection on the 277CA claims response file may resubmit an electronic claim within 95 days of the date of service.

A paper appeal may also be submitted with a copy of the response document within 120 days of the 277CA claims response file rejection to meet the filing deadline. A copy of the electronic response file rejection to include the batch ID must accompany each corrected claim that is submitted on paper.

7.3.2 AIS Claim Correction and Resubmission (Appeals)

Telephone resubmissions or appeals may be entered through AIS using the keypad of a touch tone telephone. Providers may submit up to 3 field corrections per claim and 15 appeals per call. If invalid information is entered three times during any step, the call is transferred to a contact center representative for assistance.

For more information about how to correct and resubmit claims using AIS, providers may obtain a CSHCN Services Program AIS User Guide online at www.tmhp.com or by calling 1-800-568-2413.

Providers may submit appeals through AIS to correct claims that were denied for the following:

- Beginning date of service
- Billing, performing, or referring provider identification numbers
- Client number
- Date of birth
- Date of onset
- Ending date of service
- Place of service (POS)

- Prior authorization number (PAN)
- Quantity billed
- X-ray date
- Type of service (TOS)

The following may *not* be appealed through AIS, and providers must appeal these denied claims on paper:

- Incomplete claims listed on the R&S Report in the "Claims - Paid or Denied" section
- Claims listed on the R&S Report with $0 allowed and $0 paid
- Claims that require supporting documentation (e.g., operative report, medical records)
- Procedure code, modifier, or diagnosis code
- Claims listed as *pending* or *in process* with Explanation of Pending Status (EOPS) messages
- Claims denied as *past filing deadline* except when retroactive eligibility deadlines apply
- Claims denied as *past the payment deadline*
- Inpatient hospital claims that require supporting documentation
- Third-Party Liability (TPL) and other insurance

7.3.3 Paper Appeals

If a claim cannot be appealed electronically or by using AIS, providers may appeal the claim on paper by completing the following:

1) Submit a copy of the R&S page on which the claim is paid or denied or other official notification from TMHP (i.e., TMHP letters attached to returned claims).
2) Submit one copy of the R&S Report page for each claim appealed.
3) Circle only one claim per R&S page.
4) Indicate the reason for the appeal.
5) If applicable, indicate the incorrect information and provide the correct information that should be used to appeal the claim.
6) Attach a copy of any supporting documentation that is necessary or requested by TMHP. Supporting documentation must be on a separate page.

Note: *Completed claim forms are not required to be submitted with paper appeals. Providers who submit paper appeals must clearly document on the R&S Report what information is being appealed and must identify the claim being appealed.*

Reminder: *Do not copy supporting documentation on the opposite side of the R&S Report.*

Paper appeals must be submitted to the following address:

Texas Medicaid & Healthcare Partnership
Attn: CSHCN Services Program Appeals, MC-A11
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

Providers may not request reconsideration or appeal of the following:

- Claims appearing in the "Pending Claims" section of the R&S Report. Providers cannot resubmit or appeal a claim that has not appeared as a paid or denied claim.
- Incomplete claims appearing in the "Claims - Paid or Denied" section of the R&S Report. Incomplete claims appear with one or more EOB code(s). Providers must correct the information and submit a new claim with the R&S Report within 120 days of the date on the R&S Report.

Important: *It is strongly recommended that providers who submit paper appeals retain a copy of the documentation they send. It also is recommended that paper documentation be sent by certified mail with a return receipt requested. This documentation and a detailed list of the claims that were enclosed provides proof that the claims were received by TMHP. This is particularly important if it is necessary to*

prove that the 120-day appeals deadline has been met. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed list. The provider may need to keep such proof for all claims submissions, if their CSHCN Services Program provider identifier is pending.

7.3.3.1 Total Billed Amount Changes

Appeals must be submitted on paper if the total billed amount is changed. Electronic appeals of this kind will be denied for timely filing if it is submitted more than 95 days after the original date of service.

To resubmit a claim with a new total billed amount, the claim may be submitted electronically as a new day claim. The new day claim must be within 95 days of the filing deadline. If a claim is submitted after the 95-day filing deadline, it will be denied for timely filing.

7.3.4 Appeals Submitted Incorrectly

If an incomplete appeal is received, it is returned to the sender with further appeal instructions and a request for more information. Documentation (either by letter or fax) that does not clearly indicate the reason for submission is returned to the sender for clarification.

If TMHP identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.

The provider may also initiate contact with a provider relations representative for assistance.

Refer to: Section 1.1.5, "TMHP Regional Representatives," on page 1-3 for contact information.

7.3.5 Administrative Review for Claims

To complete the TMHP appeals process:

a) The claim must have been denied or adjusted by TMHP, and

b) The claim must have been appealed as a first-level appeal to TMHP, and

c) The first level appeal must have been denied again for the same reasons by TMHP.

After the TMHP appeals process has been exhausted, the provider must submit a request for administrative review within 30 days of the date TMHP denied the appeal in order for the claim to be considered for payment.

Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program–Administrative Review
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133
or 1-512-776-7162

TMHP may be required to gather information related to the original claim and the first-level appeal. The CSHCN Services Program is the sole adjudicator of the administrative review.

Refer to: Section 4.6.2, "Administrative Review for Authorization and Prior Authorization Denials," on page 4-13.

7.3.5.1 Administrative Review Requirements

An administrative review is a request for a review as defined in 25 TAC §38.10 and §38.13.

An administrative review must be:

- Submitted in writing to CSHCN Services Program Administrative Review by the provider who delivered the service or received claim reimbursement or claim denial for the service.
- Received by CSHCN Services Program Administrative Review after the appeals process with TMHP has been exhausted, and must contain evidence of appeal dispositions from TMHP:

  - All correspondence and documentation from the provider to TMHP, including copies of supporting documentation that was submitted during the appeal process.
  - All correspondence from TMHP to the provider.
- Received by CSHCN Services Program within 30 days of the date of disposition by TMHP as evidenced by the R&S sent to provider.
- Complete and contain all of the information necessary for consideration and determination by CSHCN Services Program Administrative Review, including:
  - A written explanation that specifies the reason for the request for review.
  - Supporting documentation for the request.
  - All R&S Reports that identify the claims and services in question.
  - Identification of the incorrect information and the corrected information used to appeal the claim.
  - A copy of the original claim, if it is available. Claim copies are helpful when the administrative review involves medical policy or procedure coding issues.
  - A corrected, signed claim.
  - A copy of supporting medical documentation requested by TMHP.
  - Provider's internal notes and logs, when pertinent (cannot be used as proof of timely filing).
  - Memos from the state or TMHP indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the review.
  - Other documents, such as receipts (e.g., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, etc., if relevant. Receipts can be helpful when late filing is an issue.

Providers that have submitted their claims electronically can provide proof of timely filing by submitting a copy of an electronic claims report that includes the following information:

- Client name or Medicaid identification number (patient control number [PCN])
- DOS
- Total charges
- Batch identification number (Batch ID) (in correct format)

Note: *Only reports that were accepted or rejected by TMHP will be honored. The claim filed (client name or PCN, DOS, and total charges) should match the information on the batch report.*

Providers must adhere to all filing and appeal deadlines for an administrative review to be considered by the CSHCN Services Program. The filing and appeal deadlines are described in 25 TAC §38.10 and §38.13 and in this manual.

Refer to: Section 5.1.8, "Claims Filing Deadlines," on page 5-5 for additional information.

Additional information requested by the CSHCN Services Program must be returned to the Program within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case is closed.

7.3.6 Fair Hearing for Claims

After an administrative review, providers may request a fair hearing if they are dissatisfied with the CSHCN Services Program's decision and the supporting reason.

The fair hearing is the final appeal process and is described in the 25 TAC, Part 1, Chapter 1, Subchapter C (www.sos.state.tx.us). The fair hearing process is conducted by the Office of General Counsel at DSHS.

Providers may choose to represent themselves or have legal counsel or another spokesperson at the hearing. If providers are unable to attend the hearing in person, they may request arrangements to attend by teleconference.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 calendar days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived their right to a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program–Fair Hearing
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133 or 1-512-776-7162 (in Austin)

Note: *Weekends and holidays must be included in the count to determine the 20-day deadline.*

7.3.7 National Correct Coding Initiative (NCCI) Claims Appeals

Claims or procedure codes that have been denied based on NCCI guidelines may be appealed with an appropriate modifier or documentation of medical necessity. If the submitted procedure code is denied because NCCI guidelines indicate the code is included in another procedure, the claim may be appealed with a modifier if applicable. If a modifier does not apply but medical necessity can be proven, the provider must submit documentation of medical necessity that indicates both services were necessary on the same date of service. For guideline exceptions that may be appealed, providers may refer to the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf. Providers must follow the current standard appeals process when appealing claims to TMHP.

7.4 Provider Enrollment Appeals

The CSHCN Services Program may deny, modify, suspend, or terminate a provider's approval to participate for the reasons listed in the CSHCN Services Program Rules in 25 TAC §38.6(b)(1) through (2) at www.sos.state.tx.us/tac.

Before taking action to deny, modify, suspend, or terminate the approval of a provider, the CSHCN Services Program shall give the provider written notice of an opportunity to request an administrative review of the proposed action.

The administrative review process is outlined in the notice sent to the provider. A written request for an administrative review must be received within 30 calendar days of the date of the notice. If a written request for an administrative review is not received by the CSHCN Services Program by this date, the program's decision is final and cannot be appealed.

Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program -Administrative Review
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133 or 1-512-776-7162

In addition, a fair hearing is available to any provider for the resolution of conflict between the CSHCN Services Program and the provider.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived their right to a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program–Fair Hearing
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133 or 1-512-776-7162 (in Austin)

7.5 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.

7.6 Authorization and Filing Deadline Calendars

Refer to: 2014 Filing deadline calendar
2015 Filing Deadline Calendar

Chapter

8

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

8.1 Enrollment

To enroll in the CSHCN Services Program, an advanced practice registered nurse (APRN) (e.g., nurse practitioner [NP], clinical nurse specialist [CNS]) must be actively enrolled in Texas Medicaid, licensed as a registered nurse, and recognized as an APRN by the Texas Board of Nursing (BON). APRNs may enroll as a CSHCN Services Program provider by completing the provider enrollment application available through the TMHP-CSHCN Services Program. Out-of-state APRNs must meet all these conditions and be located in the United States within 50 miles of the Texas state border.

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

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

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

Refer to: Section 2.1,"Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program enrollment procedures.

Certified registered nurse anesthetists (CRNAs) should refer to Chapter 12, "Certified Registered Nurse Anesthetist (CRNA)," on page 12-1 for information specific to their practice.

8.2 Benefits, Limitations, and Authorization Requirements

Services provided by APRNs are benefits if the services are:

- Within the scope of practice for APRNs, as defined by Texas state law.
- Consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Benefits of the CSHCN Services Program when provided by a licensed physician (doctor of medicine [MD] or doctor of osteopathy [DO]).
- Reasonable and medically necessary as determined by DSHS or its designee.

APRNs who are employed or paid by a physician, hospital, facility, or other provider must not bill the CSHCN Services Program for their services, if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician's own provider identifier for services provided by an APRN must submit modifier SA on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

All limitations applicable to physicians for the same service will also be applied to the APRN.

8.2.1 Authorization Requirements

Authorization and prior authorization requirements are listed in individual sections of this manual. Authorization requirements applied to services provided by physicians (MD or DO) also apply to services provided by APRNs.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for detailed information about authorization and prior authorization requirements.

Section 31.2.13,"Clinician-Directed Care Coordination Services," on page 31-26 for information and prior authorization requirements for clinician-directed care coordination services.

8.3 Claims Information

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

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

The 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement,"on page 5-1 for general information about claims filing.

Section 5.7.2.4,"CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

8.4 Reimbursement

APRNs may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician. Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an APRN if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. Exceptions to the 92 percent reimbursement methodology for APRNs and physicians include injections, laboratory services, radiology services, and immunizations.

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.*

8.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 isavailable 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.

Chapter

9

Ambulance

9.1 Enrollment

To enroll in the CSHCN Services Program, ambulance 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 laws and requirements. Providers may enroll online or download enrollment forms at www.tmhp.com.

A hospital-operated ambulance provider must enroll as an ambulance provider and submit claims using the ambulance provider identifier, not the hospital provider identifier.

Out-of-state ambulance and air ambulance providers must meet all these conditions and be located in the United States within 50 miles of the Texas state border.

Ambulance and air ambulance providers must submit a copy of their permit or license from 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 25 Texas Administrative Code *(TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.*

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

9.2 General Information

The CSHCN Services Program may reimburse emergency and non-emergency ambulance transports (ground, air, or specialized emergency medical services vehicle) when the client meets the definition of emergency medical condition or meets the requirements for non-emergency transport.

The following ambulance services procedure codes are a benefit of the CSHCN Services Program:

Procedure Codes					
A0382	A0398	A0420	A0422	A0424	A0425
A0426	A0427	A0428	A0429	A0430	A0431
A0433	A0434	A0435	A0436	A0999	

Procedure codes A0398, A0433, A0434 and A0999 may be reimbursed as emergency or nonemergency services.

- Claims for emergency services must be submitted with the ET modifier.
- Nonemergency services must be prior authorized.

Transport mileage charges (procedure code A0425) cannot be included in the transport charge or in any other charge on the claim.

Mileage charges (procedure code A0425) cannot be considered for reimbursement unless a transport procedure code is included on the claim.

The inpatient hospital stay benefit includes medically necessary emergency and non-emergency ambulance transportation of the client during an inpatient hospital stay.

Ambulance transport during a client's inpatient hospital stay will not be reimbursed to the ambulance provider. One time ambulance transports that occur immediately after the client's discharge may be considered for reimbursement.

9.2.1 Origin and Destination Modifiers

The following are the origin and destination codes accepted by the CSHCN Services Program:

Origin and Destination Code	Description
D	Diagnostic or therapeutic site, or freestanding facility (e.g., radiation therapy center) other than H or P
E	Residential, domiciliary, or custodial facility (unskilled facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital (inpatient or outpatient)
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Nonhospital-based dialysis facility
N	Skilled nursing facility
P	Physician's office
R	Residence (client's home or any residence)
S	Scene of accident or acute event
X	Intermediate stop at physician's office en route to the hospital (destination code only)

All ambulance claims must include the origin and destination modifiers on each procedure code submitted. Any procedure code submitted without the origin and destination modifiers will be denied.

9.2.2 Place of Service

All claims submitted must include a Place of Service (POS) code in block 24b of the CMS-1500 paper claim form.

The POS identifies where services are performed. Indicate the POS by using the appropriate numeric code for each service listed on the claim. The following POS codes must be used:

Place of Service	Two-Digit Numeric Codes (Electronic Billers)	One-Digit Numeric Codes (Paper Billers)
Office	11, 65, 71, 72	1
Home	12	2
Inpatient hospital	21, 51, 52, 55, 56, 61	3
Outpatient hospital	22, 23, 24, 62	5
Other location	26, 34, 53, 99	9
Independent lab	81	6
Destination of ambulance	Indicate destination using above codes	Indicate destination using above codes

9.2.3 Diagnosis Coding

Medical necessity and coverage of ambulance transport services are not based solely on the presence of a specific diagnosis. The CSHCN Services Program reimbursement for ambulance transports may be made only for those clients whose condition at the time of transport is such that ambulance transport is medically necessary. For example, it is insufficient that a client merely has a diagnosis such as pneumonia, stroke, or fracture to justify ambulance transport. In each of those instances, the condition of the client must be such that transport by any other means is medically contraindicated. In the case of ambulance transport, the condition necessitating transport is often that an accident or injury has occurred that gives rise to a clinical suspicion that a specific condition exists (for instance, fractures may be strongly suspected based on clinical examination and history of a specific injury).

It is the requesting provider's (facility, physician, or ambulance) responsibility to supply the CSHCN Services Program contract administrator with information that describes the condition of the client that necessitated the ambulance transport. Because many ambulance personnel have only a limited ability to establish a diagnosis, the CSHCN Services Program recognizes that coding of a client's condition using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes by ambulance transport services may be less specific than those determined by other health-care providers.

Ambulance services providers who submit ICD-9-CM diagnosis codes should choose the code that best describes the client's condition at the time of transport. When a diagnosis is not confirmed, it is better to use a symptom, finding, or injury code. Providers of ambulance services should avoid using ICD-9-CM codes to report "rule out" or "suspected" diagnoses.

When there are two responders to an emergency, the company that transports the client will be reimbursed for their services. The CSHCN Services Program does not reimburse for the return trip of an empty ambulance.

The ambulance provider does not have to submit the run sheet with the claim. This documentation may be requested upon retrospective review. A Medicare ambulance claim that has been denied must go through the appropriate Medicare claims appeal process with a decision by the administrative law judge before TMHP will process the ambulance claim.

9.2.4 General Documentation Requirements

Supporting documentation is required to be maintained by both the ambulance provider and the requesting provider, including a physician, health-care provider, or other responsible party.

An ambulance provider is required to maintain documentation that represents the client's medical conditions and other clinical information to substantiate medical necessity and the level of service and mode of transportation requested. This supporting documentation is limited to documents that are developed or maintained by the ambulance provider.

Physicians, health-care providers, or other responsible parties who request ambulance transport are required to maintain physician orders and the Nonemergency Ambulance Prior Authorization Request form in the client's medical record. Requesting providers must also maintain documentation of medical necessity for the ambulance transport.

9.3 Emergency Ambulance Transports

Emergency transports are to be to the nearest medical facility. An appropriate facility includes the equipment, personnel, and capability to provide the services necessary to support the required medical care. When an emergency transport is made to a facility other than the nearest appropriate facility and the type of transport is medically necessary, reimbursement for mileage is limited to the amount that would be reimbursed to transport to the nearest appropriate facility.

Facility-to-facility transports may be considered an emergency if the emergency treatment is not available at the first facility. All other facility-to-facility transports are considered nonemergent and prior authorization will be required.

The CSHCN Services Program coverage for emergency air ambulance transport services is limited to instances in which the client's pickup point is inaccessible by ground transport or when great distance interferes with the immediate admission to a medical treatment facility appropriate for their condition.

Claims for emergency transport services, must include the following:

- ET modifier for each procedure code.
- One or more emergency medical condition codes in the Emergency Medical Condition Code table below.

Claims for emergency ambulance transport services that are submitted without an emergency medical condition code may be appealed with documentation of medical necessity that supports the definition of an emergency medical condition.

An emergency ambulance transport that is denied will not be accepted on appeal as a nonemergency transport.

9.3.1 Emergency Prior Authorization

Emergency transports within the state of Texas do not require authorization. Transports within 50 miles of the Texas state border do not require authorization.

The inpatient hospital stay benefit includes medically necessary emergency and non-emergency ambulance transport of the client during an inpatient hospital stay. Ambulance transports during an inpatient hospital stay will not be authorized unless the transport is immediately after the client's discharge from the hospital.

Out-of-state (air, ground, and water) emergency transports require authorization. All out-of-state emergency transport requests will be reviewed by the CSHCN Services Program Medical Director.

9.3.2 Levels of Service

Ambulance services for basic life support and advanced life support are benefits of the CSHCN Services Program. The following CMS and the Texas Health and Safety Code definitions apply for basic and advanced levels of service:

- Basic life support (BLS) is emergency care that uses noninvasive medical acts, and if allowed by the licensing jurisdiction, may include the establishment of a peripheral intravenous (IV) line.
- Advanced life support, level 1 (ALS 1) is emergency care that uses invasive medical acts that include an ALS assessment or at least one ALS intervention.
- Advanced life support, level 2 (ALS 2) is emergency care that uses invasive medical acts including one of the following:
  - At least three separate administrations of one or more medications (excluding crystalloid fluids) by intravenous push/bolus or by continuous infusion
  - At least one of the ALS 2 procedures: manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, or intraosseous line.

9.3.3 Emergency Medical Conditions

An emergency is defined as a medical condition that manifests acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one of the following:

- Placing the client's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An emergency behavioral health condition is defined as any condition that, in the opinion of a prudent layperson with an average knowledge of health and medicine, requires immediate intervention or medical attention regardless of the nature, without which the client would present an immediate danger to themselves or others or that renders the client incapable of controlling, knowing, or understanding the consequences of their actions.

The following table includes the valid emergency medical condition codes for emergency ambulance services:

Emergency Medical Condition Codes							
0010	0011	0019	0020	0021	0022	0023	0029
0051	0200	0201	0202	0203	0204	0205	0208
0209	0210	0211	0212	0213	0218	0219	0220
0221	0222	0223	0228	0229	0320	0321	0322
0323	03281	03282	03283	03284	03285	03289	0329
0369	03812	0389	04041	04042	0470	0471	0478
0479	0500	0501	0502	0509	0600	0601	0609
061	0650	0651	0652	0653	0654	0658	0659
071	080	0810	0811	0812	0819	0840	0841
0842	0843	0844	0845	0846	0847	0848	0849
0930	0931	09320	09321	09322	09389	0939	24910
24911	24930	24931	24960	24961	25002	25003	2910
2913	29181	2920	29281	29282	29283	29284	29289
2929	29382	2989	3009	30300	30301	30302	30303
30500	33701	33921	3449	34500	34501	3452	34510
34511	3453	34540	34541	34550	34551	34560	34561
34570	34571	34580	34581	34590	34591	36811	36812
36816	3699	37990	37991	41512	4233	4260	42611
42613	4263	4264	42650	42653	4266	4270	4271
4272	42731	42732	42741	42742	4275	42760	42761
42769	42781	42789	4279	436	4379	449	4589
4590	51181	5128	53550	5362	5693	5780	5781
5789	5967	5968	59971	6238	6269	6920	6921
6922	6923	6924	6925	6926	69270	69271	69272
69273	69274	69275	69276	69277	69279	69281	69282
69283	69289	6929	6930	6931	6938	6939	69550
69551	69552	69553	69554	69555	69556	69557	69558
69559	6959	6989	7089	7242	7245	7249	7262
78001	78002	78003	78009	7802	78031	78039	7804
78065	78079	7808	78096	78097	7810	7812	7813
7814	78194	78199	7820	7821	7825	78261	7843
7847	78499	7850	7851	78550	78551	78552	78559
7859	78602	78603	78604	78605	78609	78650	78651

Emergency Medical Condition Codes							
78652	78659	7868	78701	78702	78703	78720	78729
79791	78900	78901	78902	78903	78904	78905	78906
78907	78909	78940	78941	78942	78943	78944	78945
78946	78947	78949	78960	78961	78962	78963	78964
78965	78966	78967	78969	79021	79022	7962	7963
7964	7991	80000	80001	80002	80003	80004	80005
80006	80009	80010	80011	80012	80013	80014	80015
80016	80019	80020	80021	80022	80023	80024	80025
80026	80029	80030	80031	80032	80033	80034	80035
80036	80039	80040	80041	80042	80043	80044	80045
80046	80049	80050	80051	80052	80053	80054	80055
80056	80059	80060	80061	80062	80063	80064	80065
80066	80069	80070	80071	80072	80073	80074	80075
80076	80079	80080	80081	80082	80083	80084	80085
80086	80089	80090	80091	80092	80093	80094	80095
80096	80099	80100	80101	80102	80103	80104	80105
80106	80109	80110	80111	80112	80113	80114	80115
80116	80119	80120	80121	80122	80123	80124	80125
80126	80129	80130	80131	80132	80133	80134	80135
80136	80139	80140	80141	80142	80143	80144	80145
80146	80149	80150	80151	80152	80153	80154	80155
80156	80159	80160	80161	80162	80163	80164	80165
80166	80169	80170	80171	80172	80173	80174	80175
80176	80179	80180	80181	80182	80183	80184	80185
80186	80189	80190	80191	80192	80193	80194	80195
80196	80199	8020	8021	80220	80221	80222	80223
80224	80225	80226	80227	80228	80229	80230	80231
80232	80233	80234	80235	80236	80237	80238	80239
8024	8025	8026	8027	8028	8029	80300	80301
80302	80303	80304	80305	80306	80309	80310	80311
80312	80313	80314	80315	80316	80319	80320	80321
80322	80323	80324	80325	80326	80329	80330	80331
80332	80333	80334	80335	80336	80339	80340	80341
80342	80343	80344	80345	80346	80349	80350	80351
80352	80353	80354	80355	80356	80359	80360	80361
80362	80363	80364	80365	80366	80369	80370	80371
80372	80373	80374	80375	80376	80379	80380	80381
80382	80383	80384	80385	80386	80389	80390	80391
80392	80393	80394	80395	80396	80399	80400	80401
80402	80403	80404	80405	80406	80409	80410	80411
80412	80413	80414	80415	80416	80419	80420	80421

Emergency Medical Condition Codes							
80422	80423	80424	80425	80426	80429	80430	80431
80432	80433	80434	80435	80436	80439	80440	80441
80442	80443	80444	80445	80446	80449	80450	80451
80452	80453	80454	80455	80456	80459	80460	80461
80462	80463	80464	80465	80466	80469	80470	80471
80472	80473	80474	80475	80476	80479	80480	80481
80482	80483	80484	80485	80486	80489	80490	80491
80492	80493	80494	80495	80496	80499	80500	8074
8076	8088	8089	81000	81100	81101	81102	81103
81109	81110	81111	81112	81113	81119	81200	81201
81202	81203	81209	81210	81211	81212	81213	81219
81220	81221	81230	81231	81240	81241	81242	81243
81244	81249	81250	81251	81252	81253	81254	81259
81300	81301	81302	81303	81304	81305	81306	81307
81308	81310	81311	81312	81313	81314	81315	81316
81317	81318	81320	81321	81323	81330	81331	81332
81333	81340	81341	81342	81343	81344	81345	81350
81351	81352	81353	81354	81380	81381	81382	81383
81390	81391	81392	81393	81400	81401	81402	81403
81404	81405	81406	81407	81408	81409	81410	81411
81412	81413	81414	81415	81416	81417	81418	81419
81500	81501	81502	81503	81504	81509	81510	81511
81512	81513	81514	81519	81600	81601	81602	81603
81610	81611	81612	81613	8170	8171	8180	8181
8190	8191	82000	82001	82002	82003	82009	82010
82011	82012	82013	82019	82020	82021	82022	82030
82031	82032	8208	8209	82100	82101	82110	82111
82120	82121	82122	82123	82129	82130	82131	82132
82133	82139	82300	82301	82302	82310	82312	82320
82321	82322	82330	82331	82332	82340	82341	82342
82380	82381	82382	82390	82391	82392	8290	8291
8471	8472	85100	85101	85102	85103	85104	85105
85106	85109	85110	85111	85112	85113	85114	85115
85116	85119	85120	85121	85122	85123	85124	85125
85126	85129	85130	85131	85132	85133	85134	85135
85136	85139	85140	85141	85142	85143	85144	85145
85146	85149	85150	85151	85152	85153	85154	85155
85156	85159	85160	85161	85162	85163	85164	85165
85166	85169	85170	85171	85172	85173	85174	85175
85176	85179	85180	85181	85182	85183	85184	85185
85186	85189	85190	85191	85192	85193	85194	85195

Emergency Medical Condition Codes							
85196	85199	85200	85201	85202	85203	85204	85205
85206	85209	85210	85211	85212	85213	85214	85215
85216	85219	85220	85221	85222	85223	85224	85225
85226	85229	85230	85231	85232	85233	85234	85235
85236	85239	85240	85241	85242	85243	85244	85245
85246	85249	85250	85251	85252	85253	85254	85255
85256	85259	85300	85301	85302	85303	85304	85305
85306	85309	85310	85311	85312	85313	85314	85315
85316	85319	85400	85402	85403	85404	85405	85406
85409	85410	85411	85412	85413	85414	85415	85416
85419	8600	8601	8602	8603	8604	8605	86100
86101	86102	86103	86110	86111	86112	86113	86120
86121	86122	86130	86131	86132	8620	8621	86221
86222	86229	86231	86232	86239	8628	8629	8630
8631	86320	86321	86329	86330	86331	86339	86340
86341	86342	86343	86344	86345	86346	86349	86350
86351	86352	86353	86354	86355	86356	86359	86380
86381	86382	86383	86384	86385	86389	86390	86391
86392	86393	86394	86395	86399	86400	86401	86402
86403	86404	86405	86409	86410	86411	86412	86413
86414	86415	86419	86500	86501	86502	86503	86504
86509	86510	86511	86512	86513	86514	86519	86600
86601	86602	86603	86610	86611	86612	86613	8690
8691	8700	8701	8702	8703	8704	8708	8709
8710	8711	8712	8713	8714	8715	8716	8717
8719	87200	87201	87202	87210	87212	87261	87262
87263	87264	87269	87271	87272	87273	87274	87279
8728	8729	8730	8731	87320	87321	87322	87323
87329	87330	87331	87332	87333	87339	87340	87341
87342	87343	87344	87349	87350	87351	87352	87353
87354	87359	87360	87361	87362	87363	87364	87365
87369	87370	87371	87372	87373	87374	87375	87379
8738	8739	87400	87401	87402	87410	87411	87412
8742	8743	8744	8745	8748	8749	8750	8751
8760	8761	8770	8771	8780	8781	8782	8783
8784	8785	8786	8787	8788	8789	8790	8791
8792	8793	8794	8795	8796	8797	8798	8799
88000	88001	88002	88003	88009	88010	88011	88012
88013	88019	88020	88021	88022	88023	88029	88100
88101	88102	88110	88111	88112	88120	88121	88122
8820	8821	8822	8830	8831	8832	8840	8841

Emergency Medical Condition Codes							
8842	8850	8851	8860	8861	8870	8871	8872
8873	8874	8875	8876	8877	8900	8901	8902
8910	8911	8912	8920	8921	8922	8930	8931
8932	8940	8941	8942	8950	8951	8960	8961
8962	8963	8970	8971	8972	8973	8974	8975
8976	8977	90000	90001	90002	90003	9001	90081
90082	90089	9009	9010	9011	9012	9013	90140
90141	90181	90182	90183	90189	9019	9020	90210
90211	90219	90220	90221	90222	90223	90224	90225
90226	90227	90229	90231	90232	90233	90234	90239
90240	90241	90242	90249	90250	90251	90252	90253
90254	90255	90256	90259	90281	90282	90287	90289
9029	90300	90301	90302	9031	9032	9033	9034
9035	9038	9039	9040	9041	9042	9043	90440
90441	90442	90450	90451	90452	90453	90454	9046
9047	9048	9049	9210	9211	9212	9219	9278
9330	9331	94120	94121	94122	94123	94124	94125
94126	94127	94128	94129	94130	94131	94132	94133
94134	94135	94136	94137	94138	94139	94220	94221
94222	94223	94224	94225	94229	94230	94231	94232
94233	94234	94235	94239	94320	94321	94322	94323
94324	94325	94326	94329	94330	94331	94332	94333
94334	94335	94336	94339	94420	94421	94422	94423
94424	94425	94426	94427	94428	94430	94431	94432
94433	94434	94435	94436	94437	94438	94520	94521
94522	94523	94524	94525	94526	94529	94530	94531
94532	94533	94534	94535	94536	94539	9492	9493
9582	95901	9598	9600	9601	9602	9603	9604
9605	9606	9607	9608	9609	9610	9611	9612
9613	9614	9615	9616	9617	9618	9619	9620
9621	9622	9623	9624	9625	9626	9627	9628
9629	9630	9631	9632	9633	9634	9635	9638
9639	9640	9641	9642	9643	9644	9645	9646
9647	9648	9649	96500	96501	96502	96509	9651
9654	9655	96561	96569	9657	9658	9659	9660
9661	9662	9663	9664	9670	9671	9672	9673
9674	9675	9676	9678	9679	9680	9681	9682
9683	9684	9685	9686	9687	9689	9691	9692
9693	9694	9695	9696	9698	9699	9700	9701
9709	9710	9711	9712	9713	9719	9720	9721
9722	9723	9724	9725	9726	9727	9729	9730

Emergency Medical Condition Codes							
9731	9732	9733	9734	9735	9736	9738	9739
9740	9741	9742	9743	9744	9745	9746	9747
9750	9751	9752	9753	9754	9755	9756	9757
9758	9760	9761	9762	9763	9764	9765	9766
9767	9768	9769	9770	9771	9772	9773	9774
9778	9779	9780	9781	9782	9783	9784	9785
9786	9788	9789	9790	9791	9792	9793	9794
9795	9796	9797	9799	981	9820	9821	9822
9823	9824	9828	9830	9831	9832	9839	9840
9841	9848	9849	9850	9851	9852	9853	9854
9855	9856	9858	9859	986	9870	9871	9872
9873	9874	9875	9876	9877	9878	9879	9891
9892	9893	9894	9895	9896	9897	9899	990
9910	9911	9912	9913	9914	9916	9919	9920
9921	9922	9923	9924	9925	9926	9927	9928
9929	9940	9941	9948	9950	9951	99520	9953
9954	99553	99560	99561	99562	99563	99564	99565
99566	99567	99568	99569	9957	99580	99583	99600
99601	99602	99604	99609	9961	9962	99630	99631
99640	99641	99642	99643	99644	99645	99646	99647
99649	99659	99769	99811	99831	99832	99833	9982
9989	99941	99942	99949	99981	99982	99988	99989
V715	V8701	V8709	V8711	V8712	V8719	V872	V8739

9.4 Non-Emergency Ambulance Transports

Nonemergency transports are provided by an ambulance provider for a client to or from a scheduled medical appointment, to or from another licensed facility for treatment, or to the client's home after discharge from a hospital. Nonemergency ambulance transports may be considered a benefit of CSHCN Services Program when alternate means of transport is contraindicated due to the client's medical or mental health condition.

Note: *In this circumstance, contraindicated means that the client cannot be transported by any other means from the origin to the destination without endangering the individual's health.*

Medical necessity must be established through prior authorization for all nonemergency ambulance transports. .

A round-trip transport from the client's home to a scheduled medical appointment (for example, an outpatient or freestanding dialysis or radiation facility) is a benefit when the client meets medical necessity requirements for nonemergency transport.

Nonemergency transports of clients with conditions that do not meet medical necessity criteria are not a benefit of the CSHCN Services Program. Transports must be limited to trips in which the client not only meets the medical necessity requirements, but the transport of the client is the least costly service available.

A provider that is denied payment for services rendered because of failure to obtain prior authorization or because a request for prior authorization was denied is entitled to appeal the denial.

A provider that is denied payment for rendered ambulance transport services is entitled to payment from the health-care provider or other responsible party that requested the services if:

- Payment is denied because the requesting provider did not obtain prior authorization.
- The performing provider submits a copy of the bill for which payment was denied to the health-care provider or other responsible party for payment.

Nonemergency ambulance transport requests that do not meet the medical necessity requirements may be provided through the Medical Transportation Program (MTP). MTP may be contacted toll free at 1-877-633-8747 to request transportation services.

9.4.1 Nonemergency Prior Authorizations

Prior authorization will be required for all nonemergency ambulance transports, regardless of the type of transport (e.g., air or specialized emergency medical services vehicle). To obtain prior authorization, a completed Nonemergency Ambulance Prior Authorization Request must be submitted. The Nonemergency Ambulance Prior Authorization Request must not be modified (i.e., changing of the sequence). If altered in any way, the request may be denied.

The following nonemergency transports require prior authorization:

- Hospital to hospital
- Hospital to outpatient facilities
- Round-trip transport from the client's home to a scheduled medical appointment

A physician, health-care provider, or facility must obtain prior authorization from the TMHP/CSHCN Services Program Ambulance Department or a person authorized to act on behalf of the prior authorization department on the same day or the next business day following the day of transport when an ambulance is used to transport a client in circumstances not involving an emergency, and the request is for the authorization of the provision of transportation for only one day. If transportation occurs over the weekend or a holiday, the responsible party must obtain authorization on the following business day.

If the request is for the provision of transportation for more than one day, the prior authorization department shall require a physician, health-care provider, or other responsible party to obtain a single prior authorization before an ambulance is used to transport a client in circumstances that do not involve an emergency. The Nonemergency Ambulance Prior Authorization Request must be filled out by the facility or the physician's staff that is most familiar with the client's condition. The ambulance provider must not assist in completing any portion of this form. The following rules apply to all nonemergency transports:

- Authorization must be evaluated based on the client's medical needs and may be granted for a length of time appropriate to the client's medical condition.
- A response to a request for authorization will be made no later than 48 hours after receipt of the request.
- A request for authorization will be immediately granted and will be effective for a period of not more than 60 days from the date of issuance if the request includes a written statement from a physician that includes both of the following:
  - A statement that alternative means of transporting the client are contraindicated.
  - A submission date that is no earlier than 60 days before the requested date of service.

Authorization can be obtained by telephone at 1-800-540-0694 for hospital-to-hospital or hospital-to-outpatient-facilities transports. Telephone requests will be accepted only from the transferring facility. Hospital-to-hospital or hospital-to-outpatient-facilities transport information

and prior authorization requests may also be faxed or mailed. The requesting hospital should fax or mail supporting documentation to the TMHP/CSHCN Ambulance Unit when requested, to assist in determining medical necessity. Requests may be faxed or mailed to:

Texas Medicaid & Healthcare Partnership
Ambulance Prior Authorizations
P.O. Box 200735
Austin, TX 78727-0735
Fax: 1-512-514-4205

The requesting provider must select from the following prior authorization periods on the Nonemergency Ambulance Prior Authorization Request:

- **One-time, nonrepeating (1 day)**. One-time requests are for those clients who require only a one-time transport.
  - The request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or discharge planner with knowledge of the client's condition. Stamped or computerized signatures and dates are not accepted. Without a signature and date, the form will be considered incomplete..
- **Recurring (up to 60 days)**. Prior authorization requests are reserved for recurring transports are for those clients whose transportation needs are anticipated to last as long as 60 days.
  - The request must be signed and dated by a physician, PA, NP, or CNS. Stamped or computerized signatures and dates are not accepted. Without a signature and date, the form will be considered incomplete.
  - The request must include the approximate number of visits needed for the repetitive transport (i.e. dialysis, radiation therapy).
  - If a prior authorization request has been approved and additional procedure codes are needed because the client's condition has deteriorated or the need for equipment has changed, the requesting provider must submit a new Nonemergency Ambulance Prior Authorization Request form.

The TMHP Ambulance Unit no longer issues nonemergency long-term (61-180 day) approvals effective February 15, 2013. Existing prior authorization approvals by the CSHCN Services Program are not affected by this change.

Long-term prior authorization requests submitted after February 15, 2013 are still processed; however, the approval criteria is issued for only up to 60 days if the client meets the criteria.

The prior authorization department will render a decision within 48 hours for prior authorization requests that are 60 days duration or less. If for any reason, the client's condition deteriorates or the need for equipment changes requiring additional procedure codes to be submitted for the transport after a previous prior authorization request has been approved, the requesting provider must submit a new Nonemergency Ambulance Prior Authorization Request.

9.4.2 Nonemergency Ambulance Exception Request

Clients whose physician has documented a debilitating condition and require recurring trips that will extend longer than 60 days may qualify for an exception to the 60 day prior authorization request.

To request an exception, the provider must submit all the following documentation:

- A completed Nonemergency Ambulance Exception form that is signed and dated by a physician.

Note: *Stamped or computerized signatures and dates are not accepted. Without a physician's signature and date, the form is considered incomplete.*

- A completed Nonemergency Ambulance Prior Authorization Request
- Medical records that support the client's debilitating condition which may include, but not limited to:

- Discharge information
- Diagonstic images (i.e. MRI, CT, X-rays)
- Care Plan

Note: *Documentation submitted with the statement "client has a debilitating condition" is insufficient.*

9.4.3 Documentation of Medical Necessity

Providers may be asked to supply additional documentation to support the client's condition. Retrospective review may be performed to ensure documentation supports the medical necessity of the transport.

Providers must document whether the client is currently an inpatient in a hospital when requesting prior authorization. Prior authorization will not be approved if the provider indicates the client is currently an inpatient in a hospital except for one time transports immediately after the client's discharge from the hospital.

The requesting provider which may include a physician, healthcare provider, or other responsible party is required to maintain the supporting documentation, physician's orders, the Nonemergency Ambulance Prior Authorization Request form and, if applicable, the Nonemergency Ambulance Exception form.

Documentation supporting medical necessity must include either:

- The client is bed-confined before, during and after the trip and alternate means of transport is medically contraindicated and would endanger the client's health (i.e. injury, surgery, or use of respiratory equipment); or
- The client's functional physical and/or mental limitations that have rendered him/her bed-confined must be documented.

Note: *Bed-confined is defined as a client who is unable to stand, ambulate, and sit in a chair or wheelchair.*

- The client's medical or mental health condition is such that alternate means of the transport is medically contraindicated and would endanger the client's health (i.e., injury, surgery, or the use of respiratory equipment); or
- The client is a direct threat to his/her self or others requiring the use of restraints (chemical or physical) or trained medical personnel during transport for client and staff safety (i.e. suicidal)

When physical restraints are needed, documentation must include, but not limited to:

- Type of restraint
- Time frame of use of the restraint
- Client’s condition

Note: *The standard straps used in ambulance transport are not considered a restraint.*

9.4.3.1 Run Sheets

The run sheet is used as a medical record for ambulance services and may serve as a legal document to verify the care provided, if necessary. The ambulance provider does not have to submit the run sheet with the claim.

The ambulance provider must have documentation to support the claim. Without documentation that would establish the medical necessity of a non-emergency ambulance transport, the transport may not be covered by the CSHCN Services Program.

It is the responsibility of the ambulance provider to maintain (and to furnish to the CSHCN Services Program upon request) concise and accurate documentation. The run sheet must include the client's physical assessment that explains why the client requires ambulance transportation and cannot be safely transported by an alternate mode of transport.

Coverage will not be allowed if the trip record contains an insufficient description of the client's condition at the time of transfer for the CSHCN Services Program to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the client's condition is limited to statements and/or opinions, such as the following:

- "Patient is non-ambulatory."
- "Patient moved by drawsheet."
- "Patient could only be moved by stretcher."
- "Patient is bed-confined."
- "Patient is unable to sit, stand, or walk."

The run sheet should detail the client's condition and must be consistent with documentation found in other supporting medical record documentation (including the nonemergency prior authorization request).

Note: *The ambulance provider may decline the transport if the client's medical or mental health condition does not meet the medical necessity requirements.*

9.5 Types of Transport

9.5.1 Multiple Client Transport

Multiple client transports are those in which more than one client is transported in the same vehicle at the same time. Claims for CSHCN Services Program clients must be submitted with the transport procedure code and the mileage procedure code with the GM modifier that indicates multiple client transport. Claims must include the names and CSHCN Services Program numbers of other CSHCN Services Program clients who shared the transfer or must indicate "Not a CSHCN Services Program client."

Payment for multiple client transports are adjusted to 80-percent reimbursement of the allowable base rate for the transport for each claim and mileage is divided equally among the clients who share the ambulance.

9.5.2 Specialty Care Transport

Specialty care transport (SCT) is the interfacility transportation of a critically injured or ill client by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the emergency medical technician (EMT) paramedic. SCT is necessary when a client's condition requires ongoing care that must be furnished by one or more health-care professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

9.5.3 Air or Water Specialized Medical Services Vehicle Transport

Helicopter, fixed-wing aircraft, or specialized emergency medical services vehicle ambulance transport services (procedure codes A0430, A0431, A0435, A0436, and A0999) will be reviewed by the CSHCN Services Program Medical Director and may be reimbursed if one or more of the following conditions are met:

- The client's medical condition requires immediate and rapid ambulance transport that could not have been provided by ground ambulance.
- The point of client pick-up is inaccessible by ground vehicle.
- Great distance or other obstacles are involved in transporting the client to the nearest appropriate facility.

Emergency air or specialized emergency medical services vehicle transports that do not meet the emergency air criteria, but do meet the ground criteria, will be reimbursed at the appropriate ground rate.

Prior authorization is required for all non-emergency ambulance transports, regardless of the type of transport (e.g., air or specialized emergency medical services vehicle). All ambulance transport services that include helicopter, fixed-wing aircraft, or specialized emergency medical services vehicles will be reviewed by the Medical Director. Claims for specialized emergency medical services vehicles (i.e., boat or airboat) must be submitted using procedure code A0999.

All air ambulance transports (procedure codes A0430 and A0431) must be billed with the corresponding air mileage procedure code A0435 or A0436.

9.5.4 Out-of- Locality Transport

Out-of-locality transports may be reimbursed if a local facility is not adequately equipped to treat the condition. "Out-of-locality" refers to one-way transfers of 50 or more miles from point of pickup to point of destination.9.6 Other Ambulance Services.

9.5.5 Extra Attendant

The use of an additional attendant must be related to extraordinary circumstances that prevent the basic crew from transporting a client safely. The extra attendant must be certified by the Department of State Health Services (DSHS) to provide emergency medical services.

Reasons an extra attendant may be required beyond the basic crew include, but are not limited to the following:

- Necessity of additional special medical equipment or treatment en route to destination (Providers must describe what special treatment and equipment is required and why it requires an attendant.)
- Client behavior that may be a danger to the client or ambulance crew or requires or may require restraints
- Extreme obesity (Providers must specify the client's weight and functional limitations.)

The CSHCN Services Program does not reimburse for an extra attendant based solely on an ambulance provider's internal policy.

The use of an extra attendant for air transport is not a benefit of the CSHCN Services Program. Reimbursement for an extra attendant (procedure code A0424) will be denied if billed with air transport (procedure codes A0430 or A0431).

9.5.5.1 Extra Attendant - Emergency Ambulance Transports

Emergency transports that use an extra attendant do not require prior authorization.

The billing provider's medical documentation must clearly indicate the services the attendant performed along with rationale for the services to indicate medical necessity of the attendant. The information that supports medical necessity must be kept in the billing provider's medical record and is subject to retrospective review.

When more than one client is transported at the same time in the same vehicle, the use of an extra attendant may be required when each client being transported requires medical attention and close monitoring.

9.5.5.2 Extra Attendant - Nonemergency Ambulance Transports

Prior authorization is required when an extra attendant is needed for any nonemergency transport. When an extra attendant is needed for subsequent transports, the prior authorization must be updated.

The requesting provider must prove medical necessity on the prior authorization request by identifying attendant services that could not be provided by the basic crew. The information that supports medical necessity must be kept in the requesting provider's medical record and is subject to retrospective review.

9.5.6 Oxygen

Reimbursement for oxygen (procedure code A0422) is limited to one procedure code per transport.

9.5.7 Ambulance Disposable Supplies

Ambulance disposable supplies are included in the global fee for SCT transports and must not be billed separately.

Reimbursement for BLS and ALS disposable supplies (procedure codes A0382 or A0398) is separate from the established fee for BLS and ALS ambulance transports and is limited to one billable procedure code per transport.

Claims submitted for BLS or ALS supplies will be denied unless a corresponding ALS or BLS transport is billed on the same claim.

9.5.8 Mileage

The CSHCN Services Program does not reimburse air or ground mileage when the client is not on board the ambulance.

Providers must calculate the number of miles traveled by using the ambulance vehicle odometer reading or an internet mapping tool. Mileage reported on the claim must be the actual number of miles traveled.

Claims for ground ambulance transports procedure codes A0426, A0427, A0428, A0429, A0433, A0434 and A0999 must be submitted with mileage procedure code A0425.

A transport and mileage procedure code must be billed on the same claim to be considered for reimbursement. Transport and mileage procedure codes should never be reported as stand-alone services.

Note: *Ambulance transport claims with a billed mileage amount of $0.00 may be reimbursed. To qualify for reimbursement, the transport claim must include a mileage quantity that is greater than zero.*

Providers may not include a mileage charge as part of the transport charge or in any other charges on the claim.

9.5.9 Waiting Time

Waiting time (procedure code A0420) is reimbursed up to one hour and may be submitted when it is the general billing practice of local ambulance companies to charge for unusual waiting time (over 30 minutes) based on the following:

- Separate charges must be billed for unusual wait times.
- The circumstances that necessitate a wait time and the exact time involved must be documented.

The amount charged for waiting time must not exceed the charge for a one-way transfer.

9.6 Relation of Service to Time of Death

The CSHCN Services Program may reimburse an ambulance provider in the following circumstances related to a deceased client:

- The client dies in the ambulance while en route to the destination.
- The ambulance services to the point of pickup for the client who is pronounced dead by the physician after the ambulance is called.

9.7 Ambulance Transport Services That Are Not Benefits

The CSHCN Services Program does not reimburse providers for the following:

- Services that do not result in a transport to a facility, regardless of any medical care rendered. Transport is only a benefit when the client is on board the ambulance.
- An extra charge for a night call.
- Ambulance services performed in the skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility settings.

9.8 Claims Filing and Reimbursement

9.8.1 Claims Filing

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

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

Ambulance claims 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.

Run sheets, medical records, or emergency room records are not required to be submitted with the claim submission. If, however, documentation is submitted with the claim, an emergency medical technicians signature is required on all of the documents.

Note: *Providers must maintain any documentation that substantiates the medical need for the transport and must ensure that the documentation is available to the CSHCN Services Program or its designee upon request.*

The ambulance provider is responsible for the integrity of the information about the client's condition necessitating the transport and the medical necessity of the transport. The ambulance provider may be sanctioned, including exclusion from the CSHCN Services Program, for completing or signing a claim form that includes a false or misleading representation of the client's condition or of the medical necessity of the transport.

Refer to: Chapter 40, "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.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

All claims submitted on paper or electronically must include the 2-letter origin and destination codes on every line detail. The origin is the first letter, and the destination is the second letter. For example, modifiers HR would indicate a hospital origin with a residence destination.

Providers must not bill CSHCN Services Program clients for ambulance services.

9.8.1.1 Emergency Ambulance Claims

Emergency air ambulance claims must include the appropriate procedure code(s) and all of the following additional information to be considered for reimbursement:

- Distance of transport
- Time of transport
- Acuity of client, origin or destination modifier, and relevant vital signs

Ambulance providers must use an appropriate ICD-9-CM diagnosis code in Block 21 of the CMS-1500 paper claim form or electronic equivalent to document the client's condition and the reason for the transport. If a diagnosis is not known at the time of the transport, providers must use the diagnosis code that most closely represents the client's physical signs and symptoms at the time of the transport. If the above documentation does not indicate an emergency, the claim is denied.

Providers billing electronically can enter the data supporting the necessity for the emergency transport in the Comments field or the Purpose of Stretcher field of the electronic claim. Providers using the CMS-1500 paper claim form can enter relevant vital signs and detailed narrative in Block 19 or 21 of the claim form. For ambulance transfers where the destination is a hospital, enter the name and address of the facility in Block 32.

9.8.1.2 Non-emergency Ambulance Claims

All nonemergency ambulance claims must include the appropriate procedure codes and all of the following additional information to be considered for reimbursement:

- Detailed description of the client's medical condition necessitating the transport
- Distance of transport
- Time of transport
- Acuity of client, origin and destination modifier, and relevant vital signs

Providers billing electronically can enter the data supporting the necessity for the nonemergency transport in the Comments field or the Purpose of Stretcher field of the electronic claim. Providers using the CMS-1500 paper claim form can enter relevant vital signs and detailed narrative in Block 19 or 21 of the claim form. For ambulance transfers where the destination is a hospital, enter the name and address of the facility in Block 32. For transfers from hospital-to-hospital, indicate in Block 19 the services needed at the second facility that were unavailable at the first facility.

9.8.1.3 Billing Mileage with $0.00

If the appropriate transport procedure code is submitted for reimbursement, claims with a billed mileage amount of $0.00 may be reimbursed. To qualify for reimbursement, the transport claim must include a mileage quantity that is greater than zero.

9.8.1.4 National Correct Coding Initiative (NCCI) Guidelines

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

9.8.2 Reimbursement

Ambulance procedure codes are reimbursed at a reasonable charge, which is the lesser of the billed amount or the amount allowed by Texas Medicaid.

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.*

9.8.2.1 One-day Payment Window Reimbursement Guidelines

The one-day payment window reimbursement guidelines do not apply for ambulance services.

Refer to: "Payment Window Reimbursement Guidelines," on page 24-13, for additional information about the one-day payment window reimbursement guidelines for services related to an inpatient hospital stay.

9.9 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.

Chapter

10

Augmentative Communication Devices (ACDs)

10.1 Enrollment

To enroll in the CSHCN Services Program, ACD providers must be actively enrolled in Texas Medicaid, have a valid CSHCN Services Program Provider Agreement, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state ACD providers may enroll and must meet all these conditions and be approved by the Department of State Health Services (DSHS).

ACD providers may enroll as a CSHCN Services Program provider by completing the provider enrollment application available through the TMHP website at www.tmhp.com.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 3.1.4, "Services Provided Outside of Texas," on page 3-3, for more detailed information.

10.2 Benefits, Limitations, and Authorization Requirements

An ACD system is also known as an augmentative and alternative communication (AAC) device system. Benefits are limited to the purchase, rental, replacement, modification, and repair of ACDs that function independently of any other technology (i.e., may not rely on a computer in any way) for program-eligible clients when a documented need exists.

The following procedure codes must be used to request prior authorization or file claims for the purchase or rental of ACDs:

Procedure Codes				
E2500	E2502	E2504	E2506	E2508
E2510	E2512	E2599		

Claims for the purchase of a carrying case (procedure code E2599) must be submitted with modifier U1. The prior authorization request for a carrying case must include the make, model, and purchase date of the ACD system.

Items that are included in the reimbursement for an ACD system and are not reimbursed separately include, but are not limited to, the following:

- Applicable software (except for software purchased specifically to enable a client-owned computer or a personal digital assistant [PDA] to function as an ACD system)
- Batteries
- Battery charger
- Power supplies

- Interface cables
- Interconnects
- Sensors
- Moisture guard
- A/C or other electrical adapters
- Adequate memory to allow for system expansion within a 3-year time frame
- Access device when necessary
- Mounting device when necessary
- All training necessary to instruct the client, family, and caregivers in the use of the ACD system
- Any extended warranty

Prior authorization is mandatory for:

- All ACD rentals or purchases.
- ACD modifications.
- All accessories, including a carrying case.
- Replacement of ACDs or components.
- Repairs.

ACDs may be prior-authorized if the following criteria are met:

- They are prescribed by the client's treating physician.
- Clinical documentation supports medical necessity and appropriateness (refer to individual sections in this chapter for specific documentation requirements).

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

The CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs) form.

10.2.1 Purchases or Rentals

Requests for ACD purchases should take into account all projected changes in the client's communication abilities for a minimum of 2 years. An ACD is not approved for purchase unless the client has used the requested ACD for a trial period of at least 30 days but not more than 60 days. Prior authorization may be obtained for rental (if feasible) during the trial period. If an ACD is unavailable for rental, a waiver may be granted with supporting documentation. All components, accessories, and switches, including mounting devices and lap trays necessary for use, must be used during the trial period before a decision to purchase can be approved. ACD systems and equipment that have been purchased are anticipated to last a minimum of 3 years.

Refer to: Chapter 36, "Speech-Language Pathology (SLP) Services," on page 36-1 for procedure codes related to therapy or training for use of an ACD during the trial period.

Requests for accessories that were unavailable at the time of the initial prescription may be considered once every 2 years with adequate supporting documentation. ACDs may be replaced every 3 years when one of the following occurs:

- They are lost or irreparably damaged.
- Three years have passed since the initial prescription and the ACD is no longer functional.
- Documentation supports medical necessity and appropriateness for replacing the current ACD.

10.2.1.1 Prior Authorization Requirements for Purchase or Rental

Prior authorization requests must include all of the following information or documentation:

- The medical diagnosis and how it relates to the client's communication needs
- Any significant medical information pertinent to the use of the ACD

- The limitations of the client's current communication abilities, system, and devices
- A statement as to why the prescribed ACD is the most effective, with a comparison of benefits versus alternative options
- A complete description of the ACD with all accessories, components, mounting devices, and modifications necessary for client use (must include the manufacturer's name, model number, and retail price)
- Documentation that the client is mentally, emotionally, and physically capable of operating and using the requested ACD
- A professional assessment must be conducted by a licensed speech-language pathologist in conjunction with other disciplines, such as physical or occupational therapy. This assessment must be completed before the ACD is prescribed by the physician. The prescribing physician should base the prescription on the professional assessment. The professional assessment by a licensed speech-language pathologist must include the following information:
  - Communication status and limitations
  - Speech and language skills assessment, including prognosis for speech or written communication
  - A description of the client's cognitive readiness
  - A description of the client's interactional, behavioral, or social abilities
  - A description of the client's capabilities, including intellectual, postural, physical, and sensory (visual and auditory)
  - A description of the client's motivation to communicate
  - A description of the client's residential, vocational, and educational setting
  - A description of how the ACD will be implemented or integrated into environments
  - A description of alternative ACDs considered, including a comparison of capabilities
  - A description of the ability of the ACD to meet the projected communication needs and growth potential of the client and how long the ACD will meet the client's needs
  - A detailing of any anticipated changes, modifications, or upgrades and projected time frames (short and long term)
  - A detailed training plan (who, what, when, and where)
- Specifications of the ACD, all of the component accessories that are necessary for the proper use of the ACD, and documentation of all necessary therapies and training

It is recommended that the preliminary evaluation for an ACD include the involvement of an occupational or physical therapist to assess the client's seating and postural needs and the motor skills required to use the ACD

10.2.2 Modifications

Modifications may be prior authorized with adequate supporting documentation of medical necessity and appropriateness when one of the following occurs:

- The client's needs have changed.
- A capability of or potential for communication develops that could not have been anticipated.

ACD modifications and requests for accessories that were unavailable at the time of the initial prescription may be considered once every 2 years with adequate supporting documentation.

10.2.2.1 Prior Authorization Requirements for Modifications

Documentation required for modifications of ACDs must include:

- A reevaluation by a licensed speech-language pathologist.
- A prescription from the treating physician.

- Documentation that significant changes have occurred in the client's environment, physical abilities, or linguistic abilities and that such changes impair or affect the client's ability to benefit from the ACD currently in use.
- Documentation that the prescribed modification provides the client with the potential for an increased level of functional communication with significant reduction of disability.

10.2.3 Repairs

All repairs require prior authorization. Nonwarranty repairs of an ACD system may be considered for prior authorization with documentation from the manufacturer explaining why the repair is not covered by warranty and with documentation of medical necessity.

Providers must use procedure code K0739 when billing nonwarranty repairs.

The CSHCN Services Program does not pay shipping and handling charges.

10.2.3.1 Prior Authorization Requirements for ACD Repairs

Documentation required for repairs of ACDs must include:

- A prescription from the treating physician.
- A statement that describes the needed repair.
- Justification of medical necessity.
- The estimated cost of repairs.

10.2.4 Replacement

Replacement of ACDs or components is considered in the following circumstances:

- When loss or irreparable damage has occurred
- It has been 3 years since the initial prescription, and the ACD is no longer functional
- Documentation supports medical necessity or appropriateness of replacing the current ACD

10.2.4.1 Prior Authorization Requirements for Replacement

Prior authorization requests must include a joint statement from the prescribing physician and a licensed speech-language pathologist that includes:

- The cause of loss or damage and what measures have been taken to prevent reoccurrences.
- Information stating the client's abilities or communication needs are unchanged, or no other ACDs currently available are better suited to the client's needs.
- A new evaluation or assessment if requesting a different ACD from one that has been lost or damaged.

10.2.5 Excluded Items

Excluded items that are not related to the ACD system and software components that are not necessary to operate the system are not a benefit of the CSHCN Services Program. Excluded items include, but are not limited to:

- Printers.
- Wireless internet access devices.
- Voice prosthetics or artificial larynxes.
- Speech generating software programs for personal computers or PDAs (procedure code E2511).

10.3 Claims Information

The CSHCN Services Program Documentation of Receipt form is required and must be completed before reimbursement can be made for any equipment delivered to a client. The certification form is available in both English and Spanish, and must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. Documentation of delivery must include one of the following:

- A delivery slip or invoice signed and dated by client or caregiver. The delivery slip or invoice must contain the client's full name, the address to which the supplies were delivered, the item description, and the numerical quantities that were delivered to the client.
- A dated carrier tracking document with shipping date and delivery date. The dated carrier tracking document must be attached to the delivery slip or invoice. The dated delivery slip or invoice must include an itemized list of goods that includes the descriptions and numerical quantities of the supplies that were delivered to the client. This document could also include prices, shipping weights, shipping charges, and any other description.

The date of delivery on the form is the date of service (DOS) that should appear on the claim. Providers must retain individual delivery slips or invoices for each DOS that document the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. This information is not filed with the claim. It must be retained for the life of the piece of equipment or until the equipment is authorized for replacement.

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

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

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

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

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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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.

10.4 Reimbursement

ACDs may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Reimbursement for the purchase or rental of ACDs is as follows:

- Rental will be reimbursed for short term use of the item (less than one year). When the rental period is expected to exceed 10 months, purchase must be considered.
- Purchase of an ACD is justified when the estimated duration of need multiplied by the rental rate exceeds the purchase price of the equipment.

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.*

10.5 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.

Chapter

11

Ambulatory Blood Pressure Monitoring and Devices

11.1 Enrollment

To enroll in the CSHCN Services Program, durable medical equipment (DME) providers must be actively enrolled in Texas Medicaid, have a valid CSHCN Services Program Provider Agreement, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out of state DME (noncustom DME) providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 3.1.4, "Services Provided Outside of Texas," on page 3-3 for more detailed information.

11.2 Benefits, Limitations, and Authorization Requirements

11.2.1 Blood Pressure Devices

Ambulatory blood pressure monitoring (ABPM) is a benefit of CSHCN Services Program when used as a diagnostic tool to assist a physician in diagnosing hypertension in individuals whose blood pressure is either elevated, or inconclusive when evaluated in the office alone.

Blood pressure devices and components are benefits of the CSHCN Services Program only in the home setting for self-monitoring when the equipment is prescribed by a physician.

Providers must maintain documentation, including the diagnosis, that supports medical necessity of the requested equipment in the client's medical record and is subject to retrospective review.

11.2.1.1 Ambulatory Blood Pressure Monitoring

Ambulatory Blood Pressure Monitoring (ABPM) is indicated for the evaluation of one of the following conditions:

- White coat hypertension that is defined as:
  - A clinic or office blood pressure greater than 140/90mm HG on at least three separate clinic or office visits with two separate measurements at each visit.
  - At least two documented separate blood pressure measurements taken outside the clinic or office, which are less than 140/90mm Hg.
  - No evidence of end-organ damage
- Resistant hypertension

- Hypotensive symptoms as a response to hypertension medications
- Nocturnal angina
- Episodic hypertension
- Syncope

Ambulatory blood pressure monitoring is indicated for diagnostic purposes only and should not be used for maintenance monitoring.

11.2.1.2 Manual and Automated Blood Pressure Devices

Manual blood pressure devices (procedure code A4660) require manual cuff inflation with real-time visualization of the results displayed on the manometer. Automated blood pressure devices (procedure code A4670) inflate the cuff manually or automatically and display the blood pressure results on a small screen.

The purchase of manual or automated blood pressure devices may be considered when submitted with one of the following diagnosis codes:

Diagnosis Code	Description
4010	Essential hypertension, malignant
4011	Essential hypertension, benign
4019	Essential hypertension, unspecified
40200	Malignant hypertensive heart disease without heart failure
40201	Malignant hypertensive heart disease with heart failure
40210	Benign hypertensive heart disease without heart failure
40211	Benign hypertensive heart disease with heart failure
40290	Unspecified hypertensive heart disease without heart failure
40291	Unspecified hypertensive heart disease with heart failure
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified
40301	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease
40310	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
40311	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease
40390	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
40391	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease
40400	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40401	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40402	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease
40403	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
40410	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified

Diagnosis Code	Description
40411	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40412	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
40490	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40491	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40492	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease
40493	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease
40501	Secondary renovascular hypertension, malignant
40509	Other secondary hypertension, malignant
40511	Secondary renovascular hypertension, benign
40519	Other secondary hypertension, benign
40591	Secondary renovascular hypertension, unspecified
40599	Other secondary hypertension, unspecified
41411	Aneurysm of coronary vessels
4142	Chronic total occlusion of coronary artery
4150	Acute cor pulmonale
41511	Iatrogenic pulmonary embolism and infarction
41512	Septic pulmonary embolism
41519	Other pulmonary embolism and infarction
4160	Primary pulmonary hypertension
4161	Kyphoscoliotic heart disease
4162	Chronic pulmonary embolism
4168	Other chronic pulmonary heart diseases
4169	Unspecified chronic pulmonary heart disease
4240	Mitral valve disorders
4241	Aortic valve disorders
4242	Tricuspid valve disorders, specified as nonrheumatic
4243	Pulmonary valve disorders
42490	Endocarditis, valve unspecified, unspecified cause
42491	Endocarditis in diseases classified elsewhere
42499	Other endocarditis, valve unspecified
4250	Endomyocardial fibrosis
42511	Hypertrophic obstructive cardiomyopathy
42518	Other hypertrophic cardiomyopathy
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies

Diagnosis Code	Description
4260	Atrioventricular block, complete
42610	Atrioventricular block, unspecified
42611	First degree atrioventricular block
42612	Mobitz (type) II atrioventricular block
42613	Other second degree atrioventricular block
4262	Left bundle branch hemiblock
4263	Other left bundle branch block
4264	Right bundle branch block
42650	Unspecified bundle branch block
42651	Right bundle branch block and left posterior fascicular block
42652	Right bundle branch block and left anterior fasicular block
42653	Other bilateral bundle branch block
4266	Other heart block
42681	Lown-Ganong-Levine syndrome
42689	Other specified conduction disorders
4269	Unspecified conduction disorders
4270	Paroxysmal supraventricular tachycardia
4271	Paroxysmal ventricular tachycardia
4272	Unspecified paroxysmal tachycardia
42731	Atrial fibrillation
42732	Atrial flutter
42781	Snoatrial node dysfunction
4280	Congestive heart failure, unspecified
4281	Left heart failure
42820	Unspecified systolic heart failure
42821	Acute systolic heart failure
42822	Chronic systolic heart failure
42823	Acute on chronic systolic heart failure
42830	Unspecified diastolic heart failure
42831	Acute diastolic heart failure
42832	Chronic diastolic heart failure
42833	Acute on chronic diastolic heart failure
42840	Unspecified combined systolic and diastolic heart failure
42841	Acute combined systolic and diastolic heart failure
42842	Chronic combined systolic and diastolic heart failure
42843	Acute on chronic combined systolic and diastolic heart failure
4289	Unspecified heart failure
4580	Orthostatic hypotension
4581	Chronic hypotension
45829	Other iatrogenic hypotension
4588	Other specified hypotension

Diagnosis Code	Description
4589	Unspecified hypotension
5800	Acute glomerulonephritis with lesion of proliferative glomerulonephritis
5804	Acute glomerulonephritis with lesion of rapidly progressive glomerulonephritis
58081	Acute glomerulonephritis in diseases classified elsewhere
58089	Other acute glomerulonephritis with other specified pathological lesion in kidney
5809	Acute glomerulonephritis with unspecified pathological lesion in kidney
5810	Nephrotic syndrome with lesion of proliferative glomerulonephritis
5811	Nephrotic syndrome with lesion of membranous glomerulonephritis
5812	Nephrotic syndrome with lesion of membranoproliferative glomerulonephritis
5813	Nephrotic syndrome with lesion of minimal change glomerulonephritis
58181	Nephrotic syndrome with other specified pathological lesion in kidney in diseases classified elsewhere
58189	Other nephrotic syndrome with specified pathological lesion in kidney
5819	Nephrotic syndrome with unspecified pathological lesion in kidney
5820	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis
5821	Chronic glomerulonephritis with lesion of membranous glomerulonephritis
5822	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis
5824	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis
58281	Chronic glomerulonephritis with other specified pathological lesion in kidney in diseases classified elsewhere
58289	Other chronic glomerulonephritis with specified pathological lesion in kidney
5829	Chronic glomerulonephritis with unspecified pathological lesion in kidney
5830	Nephritis and nephropathy, not specified as acute or chronic, with lesion of proliferative glomerulonephritis
5831	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranous glomerulonephritis
5832	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranoproliferative glomerulonephritis
5834	Nephritis and nephropathy, not specified as acute or chronic, with lesion of rapidly progressive glomerulonephritis
5836	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal cortical necrosis
5837	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal medullary necrosis
58381	Nephritis and nephropathy, not specified as acute or chronic, with other specified pathological lesion in kidney, in diseases classified elsewhere
58389	Other nephritis and nephropathy, not specified as acute or chronic, with specified pathological lesion in kidney
5839	Nephritis and nephropathy, not specified as acute or chronic, with unspecified pathological lesion in kidney
5845	Acute kidney failure with lesion of tubular necrosis

Diagnosis Code	Description
5846	Acute kidney failure with lesion of renal cortical necrosis
5847	Acute kidney failure with lesion of renal medullary (papillary) necrosis
5848	Acute kidney failure with other specified pathological lesion in kidney
5849	Acute kidney failure, unspecified
5851	Chronic kidney disease, Stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified
586	Unspecified renal failure
587	Unspecified renal sclerosis
5880	Renal osteodystrophy
5881	Nephrogenic diabetes insipidus
58881	Secondary hyperparathyroidism (of renal origin)
58889	Other specified disorders resulting from impaired renal function
5889	Unspecified disorder resulting from impaired renal function
5890	Unilateral small kidney
5891	Bilateral small kidneys
5899	Unspecified small kidney
59000	Chronic pyelonephritis without lesion of renal medullary necrosis
59001	Chronic pyelonephritis with lesion of renal medullary necrosis
59010	Acute pyelonephritis without lesion of renal medullary necrosis
59011	Acute pyelonephritis with lesion of renal medullary necrosis
5902	Renal and perinephric abscess
5903	Pyeloureteritis cystica
59080	Unspecified pyelonephritis
59081	Pyelitis or pyelonephritis in diseases classified elsewhere
5909	Unspecified infection of kidney
591	Hydronephrosis
59371	Vesicoureteral reflux, with reflux nephropathy, unilateral
59372	Vesicoureteral reflux, with reflux nephropathy, bilateral
59373	Vesicoureteral reflux, with reflux nephropathy, NOS
7450	Bulbus cordis anomalies and anomalies of cardiac septal closure, common truncus
74510	Complete transportation of great vessels
74511	Transposition of great vessels, double outlet right ventricle
74512	Transposition of great vessels, corrected transposition of great vessels
74519	Transposition of great vessels, other
7452	Tetralogy of Fallot

Diagnosis Code	Description
7453	Bulbus cordis anomalies and anomalies of cardiac septal closure, common ventricle
7454	Ventricular septal defect
7455	Ostium secundum type atrial septal defect
74560	Unspecified type congenital endocardial cushion defect
74561	Ostium primum defect
74569	Other congenital endocardial cushion defect
7457	Cor biloculare

Manual and automated blood pressure devices that have been purchased are anticipated to last a minimum of 1 year and may be considered for replacement when 1 year has passed or when the equipment is not functional and not repairable.

11.2.1.3 Hospital-Grade Blood Pressure Devices

The rental or purchase of a hospital-grade blood pressure device (procedure code A9279 with modifier U1) may be considered when documentation from the physician supports medical necessity and explains why the client could not use a standard automatic blood pressure device.

A hospital-grade blood pressure device, as defined by the CSHCN Services Program, includes memory for continuous recording, has an alarm system to notify the caregiver of abnormal readings, and is capable of frequent or continuous automatic blood pressure and heart rate monitoring with correction of motion artifact.

The following indications are recognized by the CSHCN Services Program for hospital-grade blood pressure devices:

- Hypotension
- Essential hypertension
- Hypertensive heart disease
- Hypertensive renal disease
- Acute pulmonary heart disease
- Chronic pulmonary heart disease
- Cardiomyopathy
- Conduction disorders
- Cardiac dysrhythmias
- Heart failure
- Acute kidney failure
- Chronic kidney disease
- Hydronephrosis
- Vesicoureteral reflux with neuropathy
- Bulbus cordis anomalies and anomalies of cardiac septal closure

Hospital-grade blood pressure devices that have been purchased are anticipated to last a minimum of 3 years and may be considered for replacement when 3 years have passed or when the equipment is not functional and not repairable.

For clients who are birth through 11 months of age, the rental or purchase of a hospital-grade blood pressure device is a benefit when documentation supports medical necessity and includes an explanation of why the client cannot use a standard automated blood pressure device.

For clients who are 12 months of age or older, the rental or purchase of a hospital-grade blood pressure device is a benefit on a case-by-case basis. Supporting documentation of medical necessity must be provided.

11.2.1.4 Blood Pressure Device Components Repair or Replacement

Replacement of blood pressure cuffs (procedure code A4663) or replacement of other components (procedure code A9900) may be considered when submitted with documentation of medical necessity explaining why a blood pressure cuff or other component(s) needs to be replaced.

Repair of equipment (procedure code A9900) will be considered after the factory warranty has expired.

11.2.2 Authorization Requirements

Providers must submit the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) for services that require prior authorization.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for a hospital-grade blood pressure monitor.

11.2.2.1 Ambulatory Blood Pressure Monitoring

ABPM does not require authorization or prior authorization.

Providers must document that the ABPM was performed for at least 24 hours.

11.2.2.2 Manual and Automated Blood Pressure Devices

Prior authorization is not required for manual (procedure code A4660) and automated (procedure code A4670) blood pressure devices if the client's diagnosis is listed in Section 11.2.1.2, "Manual and Automated Blood Pressure Devices," on page 11-3. Providers must maintain documentation to support medical necessity in the medical record.

Prior authorization is required for all other diagnoses and requires medical review of written documentation of the medical need for a manual and automatic blood pressure device. Documentation should include the diagnosis and the rationale for monitoring blood pressure in the home.

11.2.2.3 Hospital-Grade Blood Pressure Devices

Prior authorization is required for the rental or purchase of the hospital-grade blood pressure device. Documentation must support medical necessity for the hospital-grade blood pressure device, support the client's need for self-monitoring, and explain why the client could not use an automated blood pressure device. The documentation must include:

- All pertinent diagnoses.
- Initial evaluation.
- Symptoms.
- Duration of symptoms.
- Any recent hospitalizations (within the past 12 months).
- Comorbid conditions.
- How frequent or continuous BP monitoring will affect treatment.
- All pertinent laboratory and radiology results.
- Client's weight.
- A family or caregiver(s) who has an understanding of cause and effect , awareness of the client's condition, and who has agreed to accept the responsibility to be trained to use the hospital-grade monitor.

Rental

Prior authorization may be granted for a 6-month rental. The request must be submitted with documentation of medical necessity as outlined above that supports the client's need for self-monitoring and addressing why an automated blood pressure device will not meet the client's needs. The rental of the device may be reimbursed once every calendar month for a maximum of 6 months.

Recertification for one additional 6-month period may be considered when the physician provides current documentation that supports the ongoing medical necessity of self-monitoring and that confirms the client or family is compliant with its use.

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

ABPM is limited to two services per lifetime, any provider.

ABPM over two services may be considered when documentation of medical necessity is submitted with the claim.

Purchase

Purchase of a hospital-grade blood pressure device will not be considered for prior authorization until the client has completed a 6-month trial period.

Purchase of a hospital-grade blood pressure device may be prior authorized when all of the following criteria are met:

- The client is 12 months of age or older.
- Documentation of medical necessity supports the client's need for ongoing self-monitoring and addresses why an automated blood pressure device will not meet the client's needs.

All rental costs of the hospital-grade blood pressure device apply toward the purchase price.

11.2.2.4 Blood Pressure Device Components Repair or Replacement

Replacement of blood pressure cuffs or replacement of other components may be considered for purchase with prior authorization when submitted with documentation of medical necessity explaining why the blood pressure cuff or other component(s) need to be replaced.

Repair of equipment will be considered for prior authorization after the factory warranty has expired.

Refer to: Chapter 4, "Prior Authorizations and Authorizations." on page 4-1 for more information about authorizations and prior authorizations.

Chapter 17, "Durable Medical Equipment (DME)," on page 17-1 for more information about DME service.

Providers must use the following procedure codes for ABPM:

Procedure Code	Description
93784	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report.
93786	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only.
93788	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.
93790	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; review with interpretation and report.

11.3 Documentation of Receipt

When the equipment is delivered, providers must complete the CSHCN Services Program Documentation of Receipt form. The date of delivery on the form is the date of service that should appear on the claim. The provider must request a signature at the time of delivery from the client or client's representative. The provider should retain this form and not submit it with the claim.

Providers must maintain a copy of this form in their files for the life of the piece of equipment or until the equipment is authorized for replacement.

The documentation of receipt form is available in both English and Spanish.

11.4 Claims Information

Modifier RR must be used for DME rental equipment, and modifier NU must be used for the purchase of new DME equipment. Home health DME providers must use the DM3 benefit code when submitting claims and authorization.

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

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as 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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information on electronic claims submissions.

11.5 Reimbursement

DME may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Items or services that do not have a maximum fee determined by the Health and Human Services Commission (HHSC) are manually priced. If an item is manually priced, the manufacturer's suggested retail price (MSRP) must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are considered for reimbursement at the MSRP minus a discount as determined by HHSC.

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

Important: *The provider must agree to accept the CSHCN Services Programs reimbursement as payment in full.*

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.*

Refer to:

11.6 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.

Chapter

12

Certified Registered Nurse Anesthetist (CRNA)

12.1 Enrollment

To enroll in the CSHCN Services Program, a certified registered nurse anesthetist (CRNA) must be a registered nurse (RN) approved by the Texas Board of Nursing (BON) to practice as an advanced practice registered nurse (APRN). They must be currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. They must be actively enrolled in Texas Medicaid. Each CRNA must be enrolled individually. Out-of-state CRNA providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

12.2 Benefits, Limitations, and Authorization Requirements

Services provided by CRNAs must be within the scope of practice for the APRN as defined by Texas State law and prescribed and supervised by a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) who must be licensed in the state in which they practice. CRNA services are a benefit for the same covered services that are provided by a physician. All limitations applied to physicians for the same service will also be applied to the CRNA. Services provided by a CRNA are a benefit of the CSHCN Services Program if provided under one of the following conditions:

- No physician anesthesiologist is on the medical staff of the facility where the services are provided (e.g., rural settings).
- No physician anesthesiologist is available to provide the services.
- The physician performing the procedure requiring the services or the eligible client requiring the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services in accordance with policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

The CSHCN Services Program will not reimburse the CRNA for equipment, drugs, or supplies. These are the responsibility of the facility where the CRNA services are provided and are included in the facility reimbursement. The CRNA may be directly reimbursed for professional services.

Refer to: Section 31.2.5, "Anesthesia Services," on page 31-14 for additional information about services provided by CRNAs.

12.2.1 Authorization Requirements

Anesthesia services are exempt from authorization requirements.

12.3 Claims Information

All CRNA services must be billed with a CRNA individual provider number, even if the CRNA is part of a group. Claims for anesthesia services provided by CRNAs must include the following:

- Appropriate Current Procedural Terminology (CPT) anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary.
- One of the following modifier combinations:
  - QX and U2—Services provided with medical direction of an anesthesiologist. (Must be submitted by a CRNA who provided services under the medical direction of an anesthesiologist.)
  - QZ and U1—Services provided without medical direction of an anesthesiologist; with direction by the surgeon. (Must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the surgeon.)
- Anesthesia time in minutes.
- Provider's usual and customary charges for services being billed.

Modifiers U1 (indicating one anesthesia claim is expected) and U2 (indicating two anesthesia claims are expected) are state-defined modifiers that may be billed by an anesthesiologist or CRNA.

Modifier U1, indicating that only one claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

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

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

The Healthcare Common Procedure Coding System (HCPCS)/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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

12.4 Reimbursement

CRNAs may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician anesthesiologist.

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.*

Refer to: Section 31.2.5, "Anesthesia Services," on page 31-14 for detailed information about the reimbursement methodology for anesthesiology services.

Time units are based on the total time in minutes indicated on the claim divided by 15 minute increments. Providers billing anesthesia time must refer to the *Current Procedural Terminology* (CPT) *Manual*, Time Reporting Section, definition of time: "Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision."

12.5 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.

Chapter

13

Certified Respiratory Care Practitioner (CRCP)

13.1 Enrollment

To enroll in the CSHCN Services Program, a provider must be licensed in the State of Texas as a CRCP and actively enrolled in Texas Medicaid. A provider must be enrolled individually and assigned a provider identifier by the CSHCN Services Program, whether practicing independently or contracting with a home health agency or other outpatient organization.

CRCPs may enroll as a CSHCN Services Program provider by completing the provider enrollment application available through the TMHP-CSHCN Services Program. Out-of-state CRCPs must be located in the United States, within 50 miles of the Texas state border.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program enrollment procedures.

13.2 Benefits, Limitations, and Authorization Requirements

Services performed by CRCPs are a benefit of the CSHCN Services Program if the client meets one of the following criteria:

- Has a respiratory or cardiorespiratory diagnosis requiring CRCP services
- Requires mechanical ventilation or depends on other medical technology to aid respiration

If a client meets the criteria listed above, the client may receive up to 30 visits for respiratory care services provided by a CRCP, per calendar year.

Services that are a benefit include, but are not limited to:

- CRCP services and treatments prescribed by a physician.
- Educating the client or appropriate family members about the in-home respiratory care.

Procedure codes 99503 and 99504 must be used when requesting prior authorization or billing for services. Procedure code 99503 is limited to once per day, per provider.

Expendable supplies are not a benefit for CRCPs.

Refer to: Chapter 35, "Respiratory Equipment and Supplies," on page 35-1 for more information about obtaining supplies.

13.2.1 Prior Authorization Requirements

CRCP services must be prior authorized. Before services are performed, requests for CRCP services must be submitted in writing using the CSHCN Services Program Prior Authorization Request for Respiratory Care—Certified Respiratory Care Practitioner (CRCP). Services may be prior authorized for a maximum of 2 months at a time.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

13.3 Claims Information

All CRCP services must be billed with the CRCP's individual provider identifier whether practicing independently or contracting with a home health agency or other outpatient organization. Claims for CRCP services must include pertinent diagnosis codes.

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

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

The 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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

13.4 Reimbursement

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

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.*

13.5 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.

Chapter

14

Dental

14.1 Enrollment

To enroll in the CSHCN Services Program, dental providers must be actively enrolled in Texas Medicaid, maintain an active license status with the Texas State Board of Dental Examiners (TSBDE), 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 dental providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

To be eligible to receive reimbursement for dental anesthesia providers must have the following information on file with TMHP:

- Current anesthesia permit level issued by the TSBDE (applies to all dental providers)
- Portability permit from the TSBDE (required to be reimbursed for anesthesia provided in a location other than the provider's office or satellite office), if applicable
- Proof of an anesthesiology residency recognized by the American Dental Board of Anesthesiology (required to be reimbursed at the enhanced rate for procedure code D9220), if applicable

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

14.2 Benefits, Limitations, and Authorization Requirements

Diagnostic, therapeutic, and preventive dental services are a benefit of the CSHCN Services Program. Orthodontic services, medically necessary dental rehabilitation and restoration services, care of dental emergencies, and medically necessary services provided by doctors of dental surgery (DDS) or doctors of dental medicine (DMD) including, but not limited to, cleft-craniofacial surgery are also a benefit of the CSHCN Services Program.

14.2.1 Prior Authorization Requirements

Prior authorization is required for all orthodontia services and selected dental services.

All requests for prior authorization must be submitted using the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form. The TMHP-CSHCN Services Program may require the submission of X-rays, models, etc., for specific prior-authorized services. All prior authorization requests must include specific rationale for the requested service, including documentation of medical necessity and appropriateness of the recommended treatment. Additional documentation, including current periapical radiographs, must be maintained in the client's medical or dental record and submitted to the CSHCN Services Program on request.

Authorization and prior authorization request forms submitted to TMHP must be signed and dated by the dental provider treating the client. If indicated on the form, an authorized representative's signature is acceptable. All signatures and dates must be hand-written and current. Computerized or stamped signatures are not permitted. Alterations to dates and signatures, such as cross-outs or white-outs, are not allowed. Submitted forms without an original hand-written signature and date will be rejected. Providers must keep the original, signed forms in the client's medical record as documentation.

Important: *Refer to each individual section under Benefits and Limitations for specific information about prior authorization requirements.*

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

Tip: *Photocopy this form and retain the original for future use.*

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

14.2.2 Diagnostic Services

The CSHCN Services Program may reimburse the following diagnostic dental services for CSHCN Services Program eligible clients:

- Clinical oral evaluations
- Radiographs or diagnostic imaging
- Tests or examinations, including oral pathology procedures

Based on the American Academy of Pediatric Dentistry's (AAPD) definition of a dental home, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, compassionate, culturally competent, and family-centered way. Establishment of a client's dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate.

In providing a dental home for a client, the dentist enhances the ability to assist children and their parents in the quest for optimum oral health care. A First Dental Home (FDH) visit can be initiated as early as 6 months of age and is billed using procedure code D0145. The FDH visit includes, but is not limited to:

- Oral examination.
- Oral hygiene instruction.
- Dental prophylaxis, if appropriate.
- Topical fluoride application using fluoride varnish, if appropriate.
- Caries risk assessment.
- Dental anticipatory guidance.

Diagnostic services should be performed for all clients, preferably starting within the first 6 months of the eruption of the first primary tooth, but no later than 1 year of age. Dental home providers should record the oral and physical health history, perform a caries assessment, develop an appropriate preventive oral health regimen, and communicate with and counsel the client's parent, legal guardian, or primary caregiver.

Caries susceptibility tests (procedure code D0425) are used to analyze the acidic level of the oral cavity using acid or alkali sensitive materials to ascertain the client's likelihood of developing caries. Caries susceptibility tests are considered part of all other dental procedures and are not separately reimbursed.

Requesting providers must retain in the client's medical record all documentation to support the diagnosis and treatment of trauma.

14.2.2.1 Prior Authorization Requirements

Prior authorization is required for cone-beam imaging (procedure code D0367) and for diagnostic services not adequately described by more specific procedure codes where an unspecified procedure code (D0999) is necessary.

To obtain prior authorization, a CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form must be submitted along with documentation supporting medical necessity and appropriateness. Documentation required includes, but is not limited to:

- Presenting condition(s).
- Medical necessity.
- The status of the client's treatment.

Prior authorization is not required for any other diagnostic service.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

Section 14.2.2.3, "Cone-Beam Imaging," on page 14-6.

14.2.2.2 Clinical Oral Evaluations

Documentation supporting medical necessity for procedure codes D0140, D0160, D0170, and D0180 must be maintained by the provider in the client's medical record and must include:

- The client complaint supporting medical necessity for the examination.
- The area of the mouth that was examined or the tooth involved.
- A description of what was done during the treatment.
- Supporting documentation of medical necessity, including, but not limited to, radiographs or photographs.

The following clinical oral evaluation procedure codes may be considered for reimbursement:

Procedure Code	Comments and Limitations
D0120	• Used for periodic and comprehensive oral evaluations • Limited to once every 6 months by the same provider • Procedure code D8660 will deny when billed for the same date of service by the same provider • Age limitation = NA
D0140	• Used only for the initial emergency examination of a specific tooth or area of the mouth • Limited to once per day by the same provider and twice per day for any provider • Provider must document the medical necessity and the specific tooth or area of the mouth on the claim • Denied when billed with procedure code D0160 for the same date of service by the same provider • May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period • Age limitation = NA
D0145	• Age limitation = 6 months through 35 months of age
D0150	• Used for a comprehensive oral evaluation; limited to one service every three years by the same provider; procedure code D8660 will deny when billed for the same date of service by the same provider • Age limitation = NA

Procedure Code	Comments and Limitations
D0160	• Used for a problem-focused, detailed, and extensive oral evaluation; provider must document the medical necessity and the specific tooth or area of the mouth on the claim • May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period • Limited to once per day by the same provider • Age limitation = 1 year of age or older
D0170	• Used as a follow up to a problem-focused evaluation; provider must document the medical necessity and the specific tooth or area of the mouth on the claim • Denied when billed with procedure code D0140 or D0160 on the same date of service by the same provider • Limited to once per day by any provider • Age limitation = NA
D0180	• Used for extensive periodontal evaluation of pain or problems • Denied when billed on the same date of service as procedure code D0120, D0140, D0145, D0150, D0160, or D0170 by the same provider • May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period • Age limitation = 13 years of age or older

14.2.2.3 Cone-Beam Imaging

Cone-beam imaging is used to determine the best course of treatment for cleft palate repair, skeletal anomalies, post-trauma, implanted or fixed prosthodontics, and orthodontic or orthognathic procedures. Cone-beam imaging is limited to initial treatment planning, surgery, and post-surgical follow-up.

Procedure code D0367 must be prior authorized by the TMHP Dental Director.

Procedure code D0367 is limited to a combined maximum of three services per calendar year. Additional services may be considered by the TMHP Dental Director with documentation of medical necessity.

14.2.2.4 First Dental Home

Based on the American Academy of Pediatric Dentistry's definition, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

In providing a dental home for a client, the dental provider enhances the ability to assist clients and their parents in obtaining optimum oral health care. The first dental home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
- Caries risk assessment
- Dental anticipatory guidance

The dental home provider must keep supporting documentation for procedure code D0145 in the client's medical record. The supporting documentation must include, but is not limited to, the following:

- Oral and physical health history review
- Dental history review
- Primary caregiver's oral health
- Oral evaluation
- An appropriate preventive oral health regimen
- Caries risk assessment
- Dental prophylaxis, which may include a toothbrush prophylaxis
- Oral hygiene instruction with parent or caregiver
- Anticipatory guidance communicated to the client's parent, legal guardian, or primary caregiver, to include the following:
  - Oral health and home care
  - Oral health of primary caregiver or other family members
  - Development of mouth and teeth
  - Oral habits
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Medications and oral health
  - Fluoride varnish application
  - Any referrals, including dental specialist's name

Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, and D8660 will be denied when billed on the same date of service, for any provider as D0145.

A First Dental Home examination is limited to ten services per client lifetime with at least 60 days between visits by any provider.

Reimbursement for procedure code D0145 is limited to dentists certified by the Texas Department of State Health Services (DSHS). Providers can complete a free continuing education course online or attend classroom training to be certified to provide First Dental Home services. For information about training, refer to the Department of State Health Services (DSHS) Oral Health Program web page at www.dshs.state.tx.us/dental/firstdentalhometraining.shtm.

14.2.2.5 Radiographs or Diagnostic Imaging

The number of radiograph films required for a complete intraoral series is dependent on the age of the client. An intraoral series requires at least eight films. Adults and children older than 12 years of age require 12 to 20 films to be considered an intraoral series. A panoramic radiographic image (procedure code D0330) plus a minimum of four bitewing radiographic images (procedure code D0274) may be considered equivalent to a complete intraoral series including radiographic images (procedure code D0210).

Supporting documentation must be kept in the client's dental record when medical necessity is not evident on radiographs.

The following radiographs or diagnostic imaging procedure codes may be considered for reimbursement:

Procedure Code	Limitations
D0210	• Age limitation = 2 years or older
D0220	• Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0230	• Age limitation = 1 year of age or older
D0240	• Limited to two per day by the same provider • Age limitation = NA
D0250	• Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0260	• Age limitation = 1 year of age or older
D0270	• Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0272	• Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0273	• Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0274	• Limited to one per day by the same provider • Age limitation = 2 years of age or older
D0277	• Limited to one per day by the same provider • Age limitation = 2 years of age or older
D0290	• Age limitation = 1 year of age or older
D0310	• Age limitation = 1 year of age or older
D0320	• Age limitation = 1 year of age or older
D0321	• Age limitation = 1 year of age or older
D0322	• Age limitation = 1 year of age or older
D0330	• Limited to one per day by any provider • Limited to one service every 3 years by the same provider • Age limitation = 3 years of age or older
D0340	• Denied when billed with procedure code D8050 or D8080 • Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0350	• Must be used when billing for photographs • Accepted only when diagnostic quality radiographs cannot be taken • Documentation of medical necessity must be submitted with the claim • Limited to one per day by the same provider • Age limitation = NA
D0367	• Age limitation = NA

14.2.2.6 Tests and Oral Pathology Procedures

The following procedure codes may be considered for reimbursement and are limited to clients who are 1 year of age or older:

Procedure Codes			
D0415	D0460	D0470	D0502

Procedure code D0460:

- Includes multiple teeth and contralateral comparisons based on medical necessity.
- Is considered part of any endodontic procedure and is not separately reimbursed when billed on the same date of service as any endodontic procedure.
- Is not payable when billed for primary teeth.
- Is limited to one service per day by the same provider.

Refer to: Section 14.2.5, "Therapeutic Services," on page 14-17 for additional information about endodontic procedures.

When billing for diagnostic procedures not adequately described by other procedure codes, providers should use procedure code D0999.

Only one emergency or trauma claim per client, per day may be submitted. Separate services may be submitted for the same client on the same date of service, one for emergency or trauma and one for nonemergency or routine care.

When billing electronically for emergency or trauma-related dental services, use the ET modifier to indicate emergency.

14.2.3 Orthodontia Services

Orthodontia services are benefits of the CSHCN Services Program for clients with the following diagnosis codes of cleft-craniofacial anomalies:

Diagnosis Code	Description
52400	Unspecified major anomaly of jaw size
52401	Maxillary hyperplasia
52402	Mandibular hyperplasia
52403	Maxillary hypoplasia
52404	Mandibular hypoplasia
52405	Macrogenia
52406	Microgenia
52407	Excessive tuberosity of jaw
52409	Other specified major anomaly of jaw size
52410	Unspecified anomaly of relationship of jaw to cranial base
52411	Maxillary asymmetry
52412	Other jaw asymmetry
52419	Other unspecified anomaly of relationship of jaw to cranial base
52451	Abnormal jaw closure
52452	Limited mandibular range of motion
52453	Deviation in opening and closing of the mandible
52454	Insufficient anterior guidance
52455	Centric occlusion maximum intercuspation discrepancy

Diagnosis Code	Description
52456	Dentofacial functional abnormality, nonworking side interference
52457	Lack of posterior occlusal support
52459	Other dentofacial functional abnormalities
74900	Unspecified cleft palate
74901	Unilateral cleft palate, complete
74902	Unilateral cleft palate, incomplete
74903	Bilateral cleft palate, complete
74904	Bilateral cleft palate, incomplete
74910	Unspecified cleft lip
74911	Unilateral cleft lip, complete
74912	Unilateral cleft lip, incomplete
74913	Bilateral cleft lip, complete
74914	Bilateral cleft lip, incomplete
74920	Unspecified cleft palate with cleft lip
74921	Unilateral cleft palate with cleft lip, complete
74922	Unilateral cleft palate with cleft lip, incomplete
74923	Bilateral cleft palate with cleft lip, complete
74924	Bilateral cleft palate with cleft lip, incomplete
74925	Other combinations of cleft palate with cleft lip
7540	Congenital musculoskeletal deformities of skull, face, and jaw
75555	Acrocephalosyndactyly
7560	Congenital anomalies of skull and face bones

Orthodontia for cosmetic purposes only is not a benefit of the CSHCN Services Program. All removable or fixed orthodontic appliances must be billed with procedure codes D8210 or D8220.

14.2.3.1 Prior Authorization Requirements

Prior authorization is required for all orthodontic services except for the initial orthodontic visit. Prior authorization is only approved for a complete orthodontic treatment plan. Prior authorization is not transferable to another dentist. The new provider must request prior authorization to complete the orthodontic treatment initiated by the previous provider.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

14.2.3.2 Required Documentation

To obtain prior authorization, the provider must submit the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form.

The following documentation must accompany the form, and must include the date of service the documentation was obtained:

- A complete orthodontia treatment plan including all the procedure s required to complete full treatment such as:
  - Extractions
  - Orthognathic surgery
  - Upper and lower appliances

  - Monthly adjustments
  - Appliance removal (if needed)
  - Special appliances
- All diagnostic models
- A cephalometric radiograph with tracing
- Facial photographs
- A full series or radiographs or a panoramic radiograph

Note: *Diagnostic models, radiographs, and any other paper diagnostic tools submitted to TMHP will be returned to the submitting provider. Requests submitted with damaged diagnostic models will be returned to the provider as an incomplete request.*

A prior authorization request for comprehensive orthodontic treatment or crossbite therapy submitted without the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form, diagnostic model, radiographs (X-rays), and any other necessary supporting documentation will not be considered and will be returned to the provider as incomplete.

The following information must be provided in the case of a transfer of care from one provider to another:

- A request for prior authorization as outlined above
- Explanation of why the client left the previous provider
- Explanation of the client's treatment status

14.2.3.3 Submitting Local Codes for Orthodontic Procedures

To ensure appropriate claims processing, the local code reflecting the specific service is required on the claim.

For electronic submissions other than TexMedConnect submissions, providers must follow the steps below to ensure the correct local code is accurately applied to the appropriate claim detail:

1) Submit the DPC prefix in the first three bytes of *NTE02* at the *2400* loop. Submit the DPC prefix only once.
2) Submit the remark code (local code) in bytes 4–8, based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate that the detail is not billed with D8210 or D8220.

Example: *For a claim with three details, where details 1 and 3 are submitted with procedure code W-D8210 and detail 2 is not, enter the following information in the NTE02 at the 2400 loop:*

DPC1014D 1046D
(The space shows that detail 2 needs no local code.)

Example: *If all three details require a local code, enter DPC and the appropriate local codes in sequence without any spaces between the codes:*

DPC1024D1055D1056D
(The absence of spaces indicates that local codes are needed for all three details.)

To submit using TexMedConnect, enter the local code into the Remarks Code field, located under the Details header. The Remarks Code field is the field following the Procedure Code field. TexMedConnect submitters are not required to enter the DPC prefix, because it is automatically placed in the appropriate field on the TexMedConnect electronic claim.

For paper claim submissions, providers must enter the local code in the Remarks section of the claim form.

Failure to follow the above steps does not cause the claim to deny; however, manual intervention is required to process the claim and a delay of payment may be the result.

Orthodontic procedure codes that were local codes used for prior authorization and reimbursement have been converted to CDT (national) procedure codes.

The following procedures are not included in comprehensive treatment:

CDT Procedure Code	Remarks Code	Description
D8660	Z2008	Initial orthodontic visit
D8670	Z2013	Orthodontic adjustments, per month
D7997*	Z2016	Premature appliance removal, per arch
*May only be paid to a provider not billing for comprehensive treatment.		

Procedure code D8080 is a comprehensive code and includes a diagnostic workup as well as all upper and lower orthodontic appliances (braces) necessary to treat the client.

CDT Procedure Code	Remarks Code	Description
D8080	Z2008 *or* Z2011 *or* Z2012	Diagnostic workup, approved *or* Orthodontic appliance, upper (braces) *or* Orthodontic appliance, lower (braces)

When a diagnostic workup is not approved, individual components may be considered for separate reimbursement. Use the following procedure codes:

CDT Procedure Code	Remarks Code	Description
D0330	Z2010	Diagnostic workup, not approved
D0340		
D0350		
D0470		

Procedure code D8680 includes all retainers necessary to treat the client. Use the following remarks codes according to the services provided:

Remarks Code	Description
1033D	Mandibular, fixed, 2x4 retainer
1034D	Mandibular, fixed, 3x3 retainer
1035D	Mandibular, fixed, 4x4 retainer
Z2014	Orthodontic retainer, upper
Z2015	Orthodontic retainer, lower

Procedure code D8050 includes a crossbite workup and removable appliance. Use the following remarks codes according to the services provided:

Remarks Code	Description
8110D	Crossbite therapy, removable appliance
Z2018	Crossbite, workup

Procedure code D8060 includes a crossbite workup and the fixed appliance. Use the following remarks codes according to the services provided:

Remarks Code	Description
8120D	Crossbite therapy, fixed appliance
Z2018	Crossbite, workup

The orthodontic diagnostic work up procedures are considered inclusive procedures. Procedure codes D0330, D0340, D0350, and D0470 are denied when billed with a diagnostic work up procedure.

The following tables display the special fixed and removable orthodontic appliances. Under the current provisions of the *Health Insurance Portability and Accountability Act* (HIPAA), all fixed appliances are designated as procedure code D8220, and all removable appliances are designated as procedure code D8210. These are entered as a line item on the paper American Dental Association (ADA) Dental Claim Form with the appropriate fee. However, the remarks codes (former local procedure codes), as appropriate and listed below, also need to be entered on the authorization request form and in the Remarks field of the dental claim form (paper and electronic) to ensure correct authorization, accurate records, and reimbursement. *Failure to bill the correct procedure codes may result in claim processing delays.*

Note: *Prior authorization must be requested using both the CDT procedure code and the remarks codes for orthodontia services.*

Use the following remarks codes in the Remarks field for fixed appliances (procedure code D8220):

Remarks Code	Fixed Appliances Description
1000D	Appliance for horizontal projections
1001D	Appliance for recurved springs
1002D	Arch wires for crossbite correction, for total treatment
1003D	Banded maxillary expansion appliance
1008D	Bonded expansion device
1012D	Crib
1015D	Distalizing appliance with springs
1016D	Expansion device
1018D	Fixed expansion device
1019D	Fixed lingual arch
1020D	Fixed mandibular holding arch
1021D	Fixed rapid palatal expander
1025D	Herbst appliance, fixed or removable
1026D	Interocclusal cast cap surgical splints
1028D	Jasper jumpers
1029D	Lingual appliance with hooks
1030D	Mandibular anterior bridge
1031D	Mandibular bihelix, similar to a quad helix for mandibular expansion to attempt nonextraction treatment
1036D	Mandibular lingual, 6x6, arch wire
1042D	Maxillary lingual arch with spurs
1043D	Maxillary and mandibular distalizing appliance
1044D	Maxillary quad helix with finger springs
1045D	Maxillary and mandibular retainer with pontics
1049D	Modified quad helix appliance
1050D	Modified quad helix appliance, with appliance
1051D	Nance stent
1052D	Nasal stent
1057D	Palatal bar
1058D	Post surgical retainer
1059D	Quad helix appliance held with transpalatal arch horizontal projections
1060D	Quad helix maintainer

Remarks Code	Fixed Appliances Description
1061D	Rapid palatal expander (RPE), i.e., quad helix, haas, or menne
1068D	Stapled palatal expansion appliance
1072D	Thumb sucking appliance, requires submission of models
1076D	Transpalatal arch
1077D	Two bands with transpalatal arch and horizontal projections forward
1078D	W-appliance

Use the following remarks codes in the Remarks field for removable appliances (procedure code D8210):

Remarks Code	Removable Appliances Description
1004D	Bite plate/bite plane
1005D	Bionator
1006D	Bite block
1007D	Bite plate with push springs
1010D	Chateau appliance (face mask, palatal expander, and hawley)
1011D	Coffin spring appliance
1013D	Dental obturator, definitive (obturator)
1014D	Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)
1017D	Face mask (protraction mask)
1022D	Frankel appliance
1023D	Functional appliance for reduction of anterior open bite and crossbite
1024D	Head gear (face bow)
1027D	Intrusion arch
1032D	Mandibular lip bumper
1037D	Mandibular removable expander with bite plane (crozat)
1038D	Mandibular ricketts rest position splint
1039D	Mandibular splint
1040D	Maxillary anterior bridge
1041D	Maxillary bite-opening appliance with anterior springs
1046D	Maxillary Schwarz
1047D	Maxillary splint
1048D	Mobile intraoral arch (MIA), similar to a bihelix for nonextraction treatment
1053D	Occlusal orthotic device
1054D	Orthopedic appliance
1055D	Other mandibular utilities
1056D	Other maxillary utilities
1062D	Removable bite plane
1063D	Removable mandibular retainer
1064D	Removable maxillary retainer
1065D	Removable prosthesis
1066D	Sagittal appliance, 2-way

Remarks Code	Removable Appliances Description
1067D	Sagittal appliance, 3-way
1069D	Surgical arch wires
1070D	Surgical splints (surgical stent/wafer)
1071D	Surgical stabilizing appliance
1073D	Tongue thrust appliance, requires submission of models
1074D	Tooth positioner, full maxillary and mandibular
1075D	Tooth positioner with arch

The following procedure codes are used to bill orthodontic services:

ADA Procedure Codes				
D5951	D5952	D5953	D5954	D5955
D5958	D5959	D5960	D7280	D7997
D8050	D8060	D8080	D8210	D8220
D8660	D8670	D8680	D8690	D8693
D8999				

The procedure codes in the table above are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

The rebonding or recementing (procedure code D8693) is limited to one per arch, per lifetime. Procedure code D8693 is limited to clients who are 6 years of age or older.

14.2.4 Preventive Services

The following dental preventive services are benefits of the CSHCN Services Program:

- Oral hygiene instruction
- Dental prophylaxis and topical fluoride treatment
- Dental sealants
- Space maintainers, including recementation and removal

14.2.4.1 Authorization Requirements

Authorization or prior authorization is not required for preventive dental services.

14.2.4.2 Oral Hygiene Instruction

Procedure code D1330 may be considered for reimbursement for clients who are 1 year of age or older when the services are above and beyond the routine brushing and flossing instructions included in the prophylaxis procedure codes and when additional time and expertise is directed toward the client's care. Procedure code D1330 is limited to once per year by any provider and is denied when billed on the same day as procedure codes D1110, D1120, D1206, or D1208 by the same provider.

Procedure code D1330 is not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

14.2.4.3 Dental Prophylaxis and Topical Fluoride Treatment

When performing fluoride treatments, procedure code D1120 and D1208 or procedure code D1110 and D1208 must be billed on the same date of service.

The following procedure codes may be considered for reimbursement but are not payable on the same date of service as any D4000 series (periodontal) procedure codes:

Procedure Code	Age Limitation
D1110	13 years of age or older
D1120	6 months through 12 years of age
D1206	NA
D1208	NA

The procedure codes in the table above are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

14.2.4.4 Dental Sealants

Dental sealants may be considered for reimbursement when applied to the deciduous (baby or primary) teeth or permanent teeth for clients who are 1 year of age or older. Dental sealants may be applied by a dentist or dental hygienist.

Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth. The tooth must be at risk for dental decay and be free of proximal caries and restorations on the surface to be sealed. Each tooth must be billed separately using procedure code D1351. Reimbursement is on a per tooth basis, regardless of the number of surfaces sealed. Tooth numbers and surfaces must be indicated on the claim form.

Dental sealants and replacement sealants are limited to one every 3 years, per tooth, for the same provider. Procedure code D1351 is not payable on the same date of service as any of D4000 series (periodontal) procedure codes. During claims processing or retrospective review, if the claim, narrative, documentation, or charting by a provider includes language, terms, or acronyms indicating a preventative resin was applied, the procedure will be reimbursed as a dental sealant, not as a restorative procedure.

Procedure code D1351 is not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

14.2.4.5 Space Maintainers

One space maintainer per tooth ID may be reimbursed per lifetime, per client. Replacement space maintainers may be considered on appeal with documentation supporting medical or dental necessity.

Space maintainers may be reimbursed with procedure codes D1510, D1515, D1520, and D1525.

When procedure codes D1510 or D1515 have been previously reimbursed, the recementation of space maintainers may be considered for reimbursement to either the same or a different CSHCN Services Program dental provider when billed with procedure code D1550.

Procedure codes D1510, D1515, D1520, D1525, D1550, and D1555 may be reimbursed for clients who are 1 year of age or older. These procedure codes are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

Procedure code D1555 may be considered for reimbursement for the removal of a space maintainer. This procedure code is denied to the provider or group practice that originally placed the appliance.

14.2.4.6 Noncovered Counseling Services

Dental Nutrition Counseling

Procedure code D1310 is not a benefit of the CSHCN Services Program as a separate procedure. Dental nutrition counseling is included as part of all preventive, therapeutic, and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to their primary care physician. The provider can refer the client to a CSHCN Services Program-enrolled licensed dietitian for further nutrition counseling.

Tobacco Counseling

Procedure code D1320 is not a benefit of the CSHCN Services Program as a separate procedure. Tobacco counseling may be reimbursed as a part of all preventive, therapeutic, and diagnostic dental procedures.

14.2.5 Therapeutic Services

The following therapeutic dental services are benefits of the CSHCN Services Program:

- Restorations
- Endodontics
- Periodontics
- Prosthodontics, both fixed and removable
- Maxillofacial prosthetics
- Implants
- Oral and maxillofacial surgery
- Adjunctive general services, including, but not limited to:
  - Dental anesthesia
  - Dental hospital call
  - Desensitizing medicaments
  - Dental behavior management
  - Internal bleaching of discolored tooth
  - Occlusal adjustments

14.2.5.1 Prior Authorization Requirements

Prior authorization requirements for specific procedures are contained within each section below. Prior authorization for therapeutic services is valid up to 90 days (this does not apply to orthodontic services). To obtain prior authorization, the following must be submitted:

- The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form
- Provider documentation supporting the medical necessity and appropriateness of the recommended treatment

Additional documentation, including current periapical radiographs, must be maintained in the client's medical record and submitted to the CSHCN Services Program on request.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

14.2.5.2 Interrupted Treatment Plan

Prior authorization for an incomplete treatment plan is not transferable to the new provider. The new provider must obtain prior authorization to complete the treatment plan initiated by the original provider.

14.2.5.3 Restorations

Restorations do not require prior authorization except for inlay or onlay restorations and crowns (single restorations only) in excess of four in a lifetime by any provider. Procedure code D2999 requires prior authorization.

Gold foil restoration (procedure codes D2410, D2420, and D2430) and inlay or onlay (procedure codes D2610, D2620, D2630, D2642, D2643, and D2644) require prior authorization with documentation of medical necessity.

Consideration of restoration reimbursement is contingent on compliance with the following limitations:

- Restorations on primary teeth and permanent posterior teeth may be reimbursed on the basis of the surface or surfaces restored and are paid as a total maximum fee per tooth.
- More than one restoration on a single surface is considered a single restoration. A multiple surface restoration cannot be billed as two or more separate one-surface restorations.
- The restorations must show definite crossing of the plane of each surface listed for primary and permanent tooth restoration completed to be considered for reimbursement as a multiple surface restoration.
- All reimbursement for tooth restorations include local anesthesia and pulp protection media, where indicated, without additional charges. These services will deny as part of another service if billed separately.
- The CSHCN Services Program may reimburse restorations and therapeutic care based on medical necessity. Therapeutic procedures are not reimbursed for preventive purposes.

Inlay or onlay restorations and crowns–single restorations only may be reimbursed a maximum fee when performed on permanent teeth. This fee includes the actual inlay or onlay or crown, any provisional crown, and any preparatory work before the seating of the permanent crown.

Single restoration only crown procedure codes are limited to CSHCN Services Program clients who are 13 years of age or older.

Procedure code D2799 is denied as part of the global fee for a crown.

Use the following procedure codes for restoration services:

Procedure Codes	Limitations
Amalgam Restorations	
D2140	A = NA
D2150	A = NA
D2160	A = 1 year of age or older
D2161	A = 1 year of age or older
Resin-Based Composite Restorations	
D2330	A = NA
D2331	A = NA
D2332	A = 1 year of age or older
D2335	A = 1 year of age or older
D2390	A = NA
D2391	A = NA
D2392	A = NA
D2393	A = 1 year of age or older
D2394	A = 1 year of age or older
Gold Foil Restorations	
D2410	A = 13 years of age or older
A = Age limitation	

Procedure Codes	Limitations
D2420	A = 13 years of age or older
D2430	A = 13 years of age or older
Inlay or Onlay Restorations	
D2510	A = 13 years of age or older
D2520	A = 13 years of age or older
D2530	A = 13 years of age or older
D2542	A = 13 years of age or older
D2543	A = 13 years of age or older
D2544	A = 13 years of age or older
D2610	A = 13 years of age or older
D2620	A = 13 years of age or older
D2630	A = 13 years of age or older
D2642	A = 13 years of age or older
D2643	A = 13 years of age or older
D2644	A = 13 years of age or older
D2650	A = 13 years of age or older
D2651	A = 13 years of age or older
D2652	A = 13 years of age or older
D2662	A = 13 years of age or older
D2663	A = 13 years of age or older
D2664	A = 13 years of age or older
D2710	A = 13 years of age or older
D2720	A = 13 years of age or older
D2721	A = 13 years of age or older
D2722	A = 13 years of age or older
D2740	A = 16 years of age or older, limited to TID #4-13 and 20-29 only.
D2750	A = 16 years of age or older, limited to TID #4-13 and 20-29 only.
D2751	A = 16 years of age or older, limited to TID #4-13 and 20-29 only.
D2752	A = 16 years of age or older, limited to TID #4-13 and 20-29 only.
D2780	A = 13 years of age or older
D2781	A = 13 years of age or older
D2782	A = 13 years of age or older
D2783	A = 13 years of age or older
D2790	A = 13 years of age or older
D2791	A = 13 years of age or older
D2792	A = 13 years of age or older
D2794	A = 13 years of age or older
D2910	A = 13 years of age or older
D2915	A = 6 years of age or older
A = Age limitation	

Procedure Codes	Limitations
D2920	A = 1 year of age or older, payable to any CSHCN Services Program dental provider, including the same provider that performed the original crown cementation
D2930	A = NA
D2931	A = 6 years of age or older
D2932	A = 1 year of age or older
D2933	A = NA
D2934	A = NA
D2940	A = NA
D2950	A = 6 years of age or older
D2951	A = 6 years of age or older
D2952	A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2952 for the same tooth, for the same date of service, by the same provider
D2953	A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2953 for the same tooth, for the same date of service, by the same provider
D2954	A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2954 for the same tooth, for the same date of service, by the same provider
D2955	A = 4 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2955 for the same tooth, for the same date of service, by the same provider
D2957	A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2957 for the same tooth, for the same date of service, by the same provider
D2960	A = 13 years of age or older
D2961	A = 13 years of age or older
D2962	A = 13 years of age or older
D2970	A = 6 years of age or older, procedure code D2970 may be reimbursed once per lifetime for each tooth, any provider
D2971	A = 13 years of age or older, limited to four services per lifetime for each tooth by any provider
D2980	A = 1 year of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2980 for the same tooth, for the same date of service, by the same provider
D2999	A = 1 year of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2999 for the same tooth, for the same date of service, by the same provider, prior authorization
A = Age limitation	

14.2.5.4 Endodontics

The following procedures are limited to four permanent teeth without prior authorization:

- Initial endodontic therapy (procedure codes D3310, D3320, and D3330)
- Retreatment of previous root canal therapy (procedure codes D3346, D3347, and D3348)

Procedure code D3221 is considered part of all endodontic procedures and will not be reimbursed separately.

Prior Authorization

Prior authorization is required for root canal therapy and retreatment of previous root canal therapy (procedure codes D3346, D3347, and D3348) in excess of four root canals. To obtain prior authorization, the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form must be submitted with documentation of medical necessity.

Documentation supporting medical necessity must be maintained in the client's medical record and include the following:

- The medical necessity before treatment, during treatment, and post treatment
- Periapical radiographs
- The final size of the file to which the canal was enlarged and the type of filling material used
- Any reason that the root canal may appear radiographically unacceptable must be documented in the client's chart

Prior authorization is required for procedure code D3460. Documentation of medical necessity must include the following:

- The client is 16 years of age or older.
- Regular treatment failed.
- The client's anatomy is such that no other fixed or removable prosthodontic alternatives are available, including, but not limited to anodontia, a result of trauma, or birth defect.

Prior authorization is required for an unspecified endodontic procedure, procedure code D3999.

Refer to: Section 14.2.5.1, "Prior Authorization Requirements," on page 14-17 for more information about prior authorization requirements.

Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

Pulp Caps and Pulpotomy

Procedure Code	Limitations
D3110	A = 1 year and older
D3120	A = 1 year and older
D3220	• A = NA. • Will be denied when performed within 6 months of pulpal therapy (procedure codes D3230 and D3240) on the same primary TID, by the same provider • Will be denied when performed within 6 months of root canal therapy (procedure codes D3310, D3320, and D3330) on the same permanent TID by the same provider
D3230	A = 1 year and older
D3240	A = 1 year and older
A = Age limitation	

Direct pulp caps (procedure code D3110) may be reimbursed separately from any final tooth restoration performed on the same tooth, on the same date of service, by the same provider.

Procedure code D3110 may be reimbursed when billed with the following procedure codes for the same tooth, on the same date of service, by the same provider:

Procedure Code				
D2140	D2150	D2160	D2161	D2330
D2331	D2332	D2335	D2390	D2391
D2392	D2393	D2394	D2410	D2420
D2430	D2510	D2520	D2530	D2542
D2543	D2544	D2610	D2620	D2630

Procedure Code				
D2642	D2643	D2644	D2650	D2651
D2652	D2662	D2663	D2664	D2710
D2712	D2720	D2721	D2722	D2740
D2750	D2751	D2752	D2780	D2781
D2782	D2783	D2790	D2791	D2792
D2794	D2799	D2910	D2915	D2920
D2930	D2931	D2932	D2933	D2934
D2940	D2950	D2951		

Procedure codes D3110 and D3120 will be denied when billed with the following procedure codes for the same tooth, for the same date of service, by the same provider.

Procedure Code				
D2952	D2953	D2954	D2955	D2957
D2980	D2999	D3220	D3230	D3240
D3310	D3320	D3330		

Procedure code D3221 is considered part of all endodontic procedures and will not be reimbursed separately.

Root Canals

Root canals may only be reimbursed when performed on permanent teeth.

Reimbursement for endodontic therapy (procedure codes D3310, D3320, and D3330), or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348) includes all appointments, radiographs, and procedures necessary to complete the treatment, including, but not limited to:

- Pulpotomy
- Radiographs performed pre-, intra-, and postoperatively

The following services are not considered part of the endodontic therapy procedures or the retreatment procedures of a previous root canal and may be reimbursed separately:

- Diagnostic evaluation
- Radiographs performed at the initial, periodic, or emergency service visits

Root canal therapy not carried to completion with a final filling should not be billed using a root canal therapy procedure code. It must be billed using procedure code D3999. Providers must file the claim with a narrative description of the procedures that were completed.

The date of service for a root canal is the date when the service was initiated.

Procedure codes D3220, D3351, D3352, and D3353 performed on a tooth within the 6 months preceding a root canal is considered part of the root canal. The total amount reimbursed will not exceed the total dollar amount allowed for procedure codes D3310, D3320, and D3330, or D3346, D3347, and D3348.

Apicoectomy (procedure codes D3410, D3421, D3425, and D3426) billed after root canal therapy or retreatment of a previous root canal may be reimbursed separately.

Refer to the following table for additional limitations for endodontic services:

Procedure Codes	Limitations
D3110	A = 1 year of age or older, refer to Section 14.2.5.3, "Restorations," on page 14-18 for additional limitations
D3120	A = 1 year of age or older
A = Age limitation	

Procedure Codes	Limitations
D3220	A = NA; see additional restrictions in Section , "Pulp Caps and Pulpotomy," on page 14-21
D3230	A = 1 year of age or older
D3240	A = 1 year of age or older
D3310	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3320	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3330	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3346	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3347	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3348	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3351	A = 6 years of age or older
D3352	A = 6 years of age or older
D3353	A = 6 years of age or older
D3410	A = 6 years of age or older
D3421	A = 6 years of age or older
D3425	A = 6 years of age or older
D3426	A = 6 years of age or older
D3430	A = 6 years of age or older
D3450	A = 6 years of age or older
D3460	A = 16 years of age or older, prior authorization
D3470	A = 6 years of age or older
D3910	A = 1 years of age or older
D3920	A = 6 years of age or older
D3950	A = 6 years of age or older
D3999	A = 1 year of age or older, prior authorization
A = Age limitation	

14.2.5.5 Periodontics

Medical necessity for *third-molar* sites includes, but is not limited to:

- Medical or dental history documenting need due to inadequate healing of bone following third-molar extraction, including date of third-molar extraction.
- Secondary procedure several months postextraction.
- Position of the third molar preoperatively.
- Postextraction probing depths to document continuing bony defect.
- Postextraction radiographs documenting continuing bony defect.
- Bone graft and barrier material used.

Medical necessity for *other than third-molar* sites, includes, but is not limited to:

- Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injury).
- Intra- or extra-oral radiographs of treatment sites.
- If medical necessity is not radiographically evident, intraoral photographs would be appropriate to request; otherwise, intraoral photographs would be optional unless requested preoperatively by the Health and Human Services Commission (HHSC) or its agent.
- Periodontal probing depths.
- Number of intact walls associated with an angular bony defect.
- Bone graft and barrier material used.

The preventive dental procedure codes D1110, D1120, D1206, D1208, and D1351 will be denied when billed on the same date of service as any D4000 series periodontal procedure code.

Procedure code D4341 will not be reimbursed within 21 days of procedure code D4355.

Periodontal medicaments (procedure code D4381) must be applied to all affected teeth at the same visit to be effective, and are limited to one service per client per year for clients who are 13 years of age or older.

Periodontal maintenance (procedure code D4910) may be reimbursed only if one of the following occurs:

- A periodontal surgery or nonsurgical periodontal service (procedure code (D4240, D4241, D4260, or D4261) is billed for the same client by any provider.
- There is documented evidence of periodontal therapy while the client was not CSHCN Services Program eligible in the client's dental record within 90 days before the periodontal maintenance.

Periodontal maintenance may be reimbursed no more than 3 times within this 90-day period for the same client, by any provider.

The periodontic procedure codes in the following table that are limited to clients who are 13 years of age or older may also be considered for younger clients based on the medical condition with supporting documentation of medical necessity.

Procedure Codes	Limitations
D4210	A = 13 years of age or older, DOC, PP1
D4211	A = 13 years of age or older, DOC, PP1
D4230	A = 13 years of age or older
D4231	A = 13 years of age or older
D4240	A = 13 years of age or older, DOC, PP2
D4241	A = 13 years of age or older, DOC, PP2
D4245	A = 13 years of age or older, prior authorization, DOC, PP2
D4249	A = 13 years of age or older, prior authorization
D4260	A = 13 years of age or older
D4261	A = 13 years of age or older
D4266	A = 13 years of age or older, prior authorization, DOC, PP2
D4267	A = 13 years of age or older, prior authorization, DOC, PP2

A = Age limitation.
Photo = photographs are required when medical necessity is not evident on the radiographs.
DOC = Documentation is required when medical necessity is not evident on radiographs.
PP1 = Pre- and postoperative photographs are required, pre- and postoperative.
PP2 = Pre- and postoperative photographs are required when medical necessity is not evident on the radiographs.

Procedure Codes	Limitations
D4270	A = 13 years of age or older, prior authorization, DOC, PP1
D4273	A = 13 years of age or older, prior authorization, DOC, PP1
D4274	A = 13 years of age or older, prior authorization
D4275	A = 13 years of age or older, DOC, PP1
D4276	A = 13 years of age or older, prior authorization, DOC, PP1
D4277	A = 13 years of age or older, prior authorization, DOC, PP1
D4278	A = 13 years of age or older, prior authorization, DOC, PP1; procedure code D4278 must be billed on the same date of service as procedure code D4277 or it will be denied
D4320	A = 1 year of age or older
D4321	A = 1 year of age or older
D4341	A = 13 years of age or older, denied if billed within 21 days of procedure code D4355
D4342	A = 13 years of age or older
D4355	A = 13 years of age or older, DOC, PP1
D4381	A = 13 years of age or older, limited to one service per client, per year
D4910	A = 13 years of age or older, denied if billed within 90 days after a full mouth debridement, additional limitations, DOC, PP1
D4920	A = 13 years of age or older
D4999	A = 13 years of age or older, prior authorization

A = Age limitation.
Photo = photographs are required when medical necessity is not evident on the radiographs.
DOC = Documentation is required when medical necessity is not evident on radiographs.
PP1 = Pre- and postoperative photographs are required, pre- and postoperative.
PP2 = Pre- and postoperative photographs are required when medical necessity is not evident on the radiographs.

Refer to: Section 14.2.5.1, "Prior Authorization Requirements," on page 14-17.

14.2.5.6 Prosthodontics (Removable) and Maxillofacial Prosthetics

Local anesthesia is denied as part of removable prosthodontics procedures.

Denture reline procedures are allowed if the reline makes the denture serviceable. Denture reline procedures are denied if billed within 1 year of a complete or partial denture.

- Maxillary reline and rebase procedure codes D5710, D5720, D5730, D5740, D5750, and D5760 are denied as part of complete or partial maxillary denture procedures D5110, D5130, D5211, and D5213.
- Mandibular reline and rebase procedure codes D5711, D5721, D5731, D5741, D5751, and D5761 are denied as part of complete or partial mandibular denture procedures D5120, D5140, D5212, and D5214.

Repairs to partial maxillary dentures (procedure code D5670) are denied as part of maxillary procedure codes D5211, D5213, D5281, and D5640. Procedure code D5671 is denied as part of mandibular procedure codes D5212, D5214, D5281, and D5640.

Repairs to partial mandibular dentures (procedure code D5671) are denied as part of mandibular procedure codes D5212, D5214, D5281, and D5640.

The cost of repairs cannot exceed replacement costs.

Procedure codes D5867 and D5875 are denied as part of any repair or modification of any removable prosthetic.

Use the following procedure codes for prosthodontic (removable) services:

Procedure Codes	Limitations
D5110	A = 1 year of age or older, prior authorization
D5120	A = 1 year of age or older, prior authorization
D5130	A = 3 years of age or older, prior authorization
D5140	A = 3 years of age or older, prior authorization
D5211	A = 6 years of age or older, prior authorization
D5212	A = 6 years of age or older, prior authorization
D5213	A = 6 years of age or older, prior authorization
D5214	A = 6 years of age or older, prior authorization
D5281	A = 6 years of age or older, prior authorization
D5410	A = 1 year of age or older
D5411	A = 1 year of age or older
D5421	A = 6 years of age or older
D5422	A = 6 years of age or older
D5510	A = 1 year of age or older, prior authorization
D5520	A = 3 years of age or older, prior authorization
D5610	A = 3 years of age or older
D5620	A = 6 years of age or older
D5630	A = 6 years of age or older
D5640	A = 6 years of age or older
D5650	A = 6 years of age or older
D5660	A = 6 years of age or older
D5670	A = 6 years of age or older
D5671	A = 6 years of age or older
D5710	A = 1 year of age or older, refer to previously listed limitations, prior authorization
D5711	A = 1 year of age or older, refer to previously listed limitations, prior authorization
D5720	A = 6 years of age or older, refer to previously listed limitations, prior authorization
D5721	A = 6 years of age or older, refer to previously listed limitations, prior authorization
D5730	A = 1 year of age or older, refer to previously listed limitations
D5731	A = 1 year of age or older, refer to previously listed limitations
D5740	A = 6 years of age or older, refer to previously listed limitations
D5741	A = 6 years of age or older, refer to previously listed limitations
D5750	A = 1 year of age or older, refer to previously listed limitations
D5751	A = 1 year of age or older, refer to previously listed limitations
D5760	A = 6 years of age or older, refer to previously listed limitations
D5761	A = 6 years of age or older, refer to previously listed limitations
D5810	A = 1 year of age or older, prior authorization
A = Age limitation and NA = Not applicable	

Procedure Codes	Limitations
D5811	A = 1 year of age or older, prior authorization
D5820	A = 6 years of age or older, prior authorization
D5821	A = 6 years of age or older, prior authorization
D5850	A = 1 year of age or older, prior authorization
D5851	A = 1 year of age or older, prior authorization
D5862	A = 13 years of age or older, prior authorization
D5863	A = 6 years of age or older, prior authorization
D5864	A = 6 years of age or older, prior authorization
D5865	A = 6 years of age or older, prior authorization
D5866	A = 6 years of age or older, prior authorization
D5899	A = 1 year of age or older, prior authorization
A = Age limitation and NA = Not applicable	

Refer to: Section 14.2.5.1, "Prior Authorization Requirements," on page 14-17.

Maxillofacial Prosthetics

Use the following procedure codes for maxillofacial prosthetic services:

Procedure Codes	Limitations
D5911	A = NA, prior authorization
D5912	A = NA, prior authorization
D5913	A = NA, prior authorization
D5914	A = NA, prior authorization
D5915	A = NA, prior authorization
D5916	A = NA, prior authorization
D5919	A = NA, prior authorization
D5922	A = NA, prior authorization
D5923	A = NA, prior authorization
D5924	A = NA, prior authorization
D5925	A = NA, prior authorization
D5926	A = NA, prior authorization
D5927	A = NA, prior authorization
D5928	A = 1 year of age or older, prior authorization
D5929	A = 1 year of age or older, prior authorization
D5931	A = 1 year of age or older, prior authorization
D5932	A = NA, prior authorization
D5933	A = NA, prior authorization
D5934	A = 1 year of age or older, prior authorization
D5935	A = 1 year of age or older, prior authorization
D5936	A = 1 year of age or older, prior authorization
D5937	A = NA, prior authorization
D5951	A = NA, prior authorization
D5952	A = birth through 12 years of age, prior authorization
A = Age limitation and NA = Not applicable	

Procedure Codes	Limitations
D5953	A = 13 years of age or older, prior authorization
D5954	A = NA, prior authorization
D5955	A = 13 years of age or older, prior authorization
D5958	A = NA, prior authorization
D5959	A = NA, prior authorization
D5960	A = NA, prior authorization
D5982	A = NA, prior authorization
D5983	A = NA, prior authorization
D5984	A = NA, prior authorization
D5985	A = NA, prior authorization
D5986	A = NA, prior authorization
D5987	A = NA, prior authorization
D5988	A = NA, prior authorization
D5999	A = NA, prior authorization
A = Age limitation and NA = Not applicable	

Refer to: Section 14.2.5.1, "Prior Authorization Requirements," on page 14-17

Implants

Implants require prior authorization.

Use the following procedure codes for implant services:

Procedure Codes	Limitations
D6010	A = 16 years of age or older, prior authorization
D6040	A = 16 years of age or older, prior authorization
D6050	A = 16 years of age or older, prior authorization
D6055	A = 16 years of age or older, prior authorization
D6056	A = 16 years of age or older, prior authorization
D6057	A = 16 years of age or older, prior authorization
D6080	A = 16 years of age or older, prior authorization
D6090	A = 16 years of age or older, prior authorization
D6092	A = 16 years of age or older, prior authorization, limited to one service per tooth, once per calendar year, by any provider
D6093	A = 16 years of age or older, prior authorization, limited to one service per tooth, once per calendar year, by any provider
D6095	A = 16 years of age or older, prior authorization
D6100	A = 16 years of age or older, prior authorization
D6199	A = 16 years of age or older, prior authorization
A = Age limitation	

Refer to: Section 14.2.5.1, "Prior Authorization Requirements," on page 14-17 for more information about prior authorization requirements.

Fixed Prosthodontics

Prior authorization is required for fixed prosthodontics. Fixed prosthodontics are limited to CSHCN Services Program clients who are 16 years of age or older, as the client must be old enough to have mature teeth and minimal jaw growth remaining.

Required documentation for prior authorization includes, but is not limited to:

- The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form.
- Documentation of medical necessity for the requested procedure includes, but is not limited to:
  - Documentation supporting that the mouth is free of disease; no untreated periodontal, endodontic disease, or rampant caries.
  - Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown, except when a Maryland bridge is placed.
  - Tooth Identification (TID) System noting only permanent teeth.
  - Documentation supporting that a removable partial is not a viable option to fill the space between the teeth.
  - Appropriate pretreatment radiographs of each involved tooth, such as periapical views must be maintained in the client's medical record and submitted to the CSHCN Services Program on request. Panoramic films are inadequate to detect caries or tooth structure necessary to evaluate the request.

Prior authorization will not be given when:

- Films show two good abutment teeth, except when a Maryland bridge will be replaced.
- There is untreated periodontal or the presence of endodontic disease, or rampant caries which would contraindicate the treatment.

Refer to: Section 14.2.5.1, "Prior Authorization Requirements," on page 14-17.

The following fixed prosthetics (pontics, retainers, and abutments), may be reimbursed with a maximum fee and include any preparatory work before placement of the fixed prosthetic.

Procedure Codes				
D6210	D6211	D6212	D6240	D6241
D6242	D6245	D6250	D6251	D6252
D6545	D6548	D6549	D6720	D6721
D6722	D6740	D6750	D6751	D6752
D6780	D6781	D6782	D6783	D6790
D6791	D6792			

Each abutment and each pontic constitutes a unit in a fixed partial-denture bridge (bridgework).

The following procedure codes are considered part of any other service and are not reimbursed separately:

Procedure Codes				
D6600	D6601	D6602	D6603	D6604
D6605	D6606	D6607	D6608	D6609
D6610	D6611	D6612	D6613	D6614
D6615				

Use the following procedure codes for fixed prosthodontics services. These codes require prior authorization:

Procedure Codes	Limitations			
Fixed Partial Denture Pontics				
D6210	D6211	D6212	D6240	D6241
D6242	D6245	D6250	D6251	D6252
Fixed Partial Denture Retainers—Inlays or Onlays				
D6545	D6548	D6549		

Procedure Codes	Limitations			
Fixed Partial Denture Retainers—Crowns				
D6720	D6721	D6722	D6740	D6750
D6751	D6752	D6780	D6781	D6782
D6783	D6790	D6791	D6792	
Other Fixed Partial Denture Services				
D6920	D6930	D6940	D6950	D6980
D6999				

14.2.5.7 Oral and Maxillofacial Surgery

Prior authorization is required for most oral and maxillofacial surgery, including, but not limited to, invasive procedures for clients with cleft lip, cleft palate, or craniofacial anomalies, which must be performed by a cleft and craniofacial team or a coordinated multidisciplinary team.

All oral surgery procedures include local anesthesia and visits for routine postoperative care.

Use the following table for oral and maxillofacial surgery procedure codes and prior authorization requirements.

Procedure Codes	Limitations
D7111	A = NA
D7140	A = NA
D7210	A = NA
D7220	A = NA
D7230	A = NA
D7240	A = NA
D7241	A = 1 year of age or older
D7250	A = 1 year of age or older
D7260	A = NA, prior authorization
D7261	A = NA, prior authorization
D7270	A = NA
D7272	A = 1 year of age or older, prior authorization
D7280	A = 1 year of age or older
D7282	A = 1 year of age or older
D7283	A = 1 year of age or older
D7285	A = NA, prior authorization
D7286	A = NA, prior authorization
D7290	A = NA, prior authorization
D7291	A = 1 year of age or older, prior authorization
D7310	A = 1 year of age or older, prior authorization
D7320	A = 1 year of age or older, prior authorization
D7340	A = 1 year of age or older, prior authorization
D7350	A = 1 year of age or older, prior authorization
D7410	A = NA, prior authorization
D7411	A = NA, prior authorization
A = Age limitation and NA = Not applicable	

Procedure Codes	Limitations
D7413	A = NA, prior authorization
D7414	A = NA, prior authorization
D7440	A = NA, prior authorization
D7441	A = NA, prior authorization
D7450	A = NA, prior authorization
D7451	A = NA, prior authorization
D7460	A = NA, prior authorization
D7461	A = NA, prior authorization
D7465	A = NA, prior authorization
D7471	A = NA, prior authorization
D7472	A = NA, prior authorization
D7510	A = NA
D7520	A = NA
D7530	A = NA, prior authorization
D7540	A = NA, prior authorization
D7550	A = NA, prior authorization
D7560	A = NA, prior authorization
D7670	A = NA
D7820	A = NA, prior authorization
D7880	A = NA, prior authorization
D7899	A = 1 year of age or older, prior authorization
D7910	A = NA
D7911	A = NA
D7912	A = NA
D7955	A = NA, prior authorization
D7960	A = NA, prior authorization
D7970	A = NA, prior authorization
D7971	A = NA, prior authorization
D7972	A = 1 year of age or older, prior authorization
D7980	A = NA, prior authorization
D7983	A = NA, prior authorization
D7997	A = NA, prior authorization
D7999	A = NA, prior authorization
A = Age limitation and NA = Not applicable	

Refer to: Section 14.2.5.1, "Prior Authorization Requirements," on page 14-17.

14.2.5.8 Adjunctive General Services

Refer to individual procedure codes in the following table for prior authorization requirements:

Procedure Code	Limitations
D9110	A = NA
D9120	A = 13 years of age or older, prior authorization
D9210	A = NA, denied when billed for the same date of service as procedure code D9248
D9211	A = NA, denied when billed for the same date of service as procedure code D9248
D9212	A = NA, denied when billed for the same date of service as procedure code D9248
D9220	A = NA, prior authorization, DOC, denied when billed for the same date of service as procedure code D9248
D9221	A = NA, prior authorization, must be billed with D9220, denied when billed for the same date of service as procedure code D9248
D9230	A = NA
D9241	A = NA, denied when billed for the same date of service as procedure code D9248
D9242	A = NA, must be billed with D9241, denied when billed for the same date of service as procedure code D9248
D9248	A = NA, DOC, limited to one service per day and two services per 12 months without prior authorization, refer to Section 14.2.5.9, "Dental Anesthesia," on page 14-33
D9310	A = NA, prior authorization
D9420	A = NA, prior authorization, DOC, refer to Section 14.2.6.1, "Dental Hospital Calls," on page 14-35
D9430	A = NA
D9440	A = NA
D9610	A = NA, prior authorization, limited to once per client per day, DOC
D9612	A = NA, prior authorization, limited to once per client per day, DOC
D9630	A = NA, prior authorization, DOC
D9910	A = NA, limited to once per year, not to be used for bases, liners, or adhesives
D9920	A = 1 year of age or older, prior authorization, denied when billed on the same day as procedure code D9220, D9221, D9230, D9241, or D9248 or with an evaluation, prophylactic treatment, or radiographic procedure, DOC; claim must include diagnosis of MR, refer to Section 14.2.5.10, "Dental Behavior Management," on page 14-34
D9930	A = NA
D9940	A = NA, prior authorization
D9950	A = 13 years of age or older, prior authorization
D9951	A = 13 years of age or older, prior authorization, may be reimbursed once per year per client, considered full-mouth procedure
D9952	A = 13 years of age or older, prior authorization, may be reimbursed once per lifetime per provider, considered full-mouth procedure
D9970	A = NA, one service per day, any provider
A = Age limitation, NA = Not applicable, and DOC = Documentation required	

Procedure Code	Limitations
D9974	A = 13 years of age or older, DOC, refer to Section 14.2.5.11, "Internal Bleaching of Discolored Tooth," on page 14-35
D9999	A = NA, prior authorization, DOC
A = Age limitation, NA = Not applicable, and DOC = Documentation required	

Note: *For those procedures requiring prior authorization, the prior authorization is valid up to 90 days from the date it is issued.*

Refer to: Section 14.2.5.1, "Prior Authorization Requirements," on page 14-17 for more information about prior authorization requirements.

Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

14.2.5.9 Dental Anesthesia

All dental providers must comply with the American Academy of Pediatric Dentistry (AAPD) guidelines and TSBDE rules and regulations, including the standards for documentation and record maintenance for dental anesthesia.

Providers must have a portability permit from TSBDE to perform anesthesia in a location other than their office or satellite office. If the provider does not have a permit, the services will be denied.

Providers must have a level 4 permit, a TSBDE portability permit, and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to receive an enhanced rate for procedure code D9220.

Anesthesia Permit Levels

The following table shows the levels of anesthesia permits that are issued by the TSBDE:

Permit Level	Description of Level	Permit Privileges
Nitrous oxide/oxygen inhalation conscious sedation		Stand-alone permit
Level 1	Minimal sedation	Stand-alone permit
Level 2	Moderate enteral	Automatically qualifies for Level 1 and Level 2 permit privileges
Level 3	Moderate parenteral	Automatically qualifies for Level 1, Level 2, and Level 3 permit privileges
Level 4	Deep sedation/general anesthesia	Automatically qualifies for Level 1, Level 2, Level 3, and Level 4 permit privileges

Providers will be reimbursed only for those procedure codes that are covered by their anesthesia permit level. The following procedure codes may be used to bill dental anesthesia and indicates the minimum anesthesia permit level to be reimbursed for these procedure codes:

Procedure Codes	Level of Sedation
D9211	Level 3
D9212	Level 3
D9220	Level 4
D9221	Level 4
D9230	Level 1
D9241	Level 3

Procedure Codes	Level of Sedation
D9242	Level 3
D9248	Level 2

Dental anesthesia is not age-restricted.

Local anesthesia in conjunction with operative or surgical services (procedure code D9215) is all inclusive with any other dental service and is not reimbursed separately.

Procedure code D9221 is not payable unless procedure code D9220 is also paid. Procedure code D9242 is not payable unless procedure code D9241 is also paid.

Procedure codes D9221 and D9242 are not limited to once per day. Procedure codes D9241 and D9242 are also payable in an inpatient or outpatient setting.

Procedure code D9248 is a benefit when provided in the office setting. Reimbursement of procedure code D9248 is limited to one service per client per day. Procedure code D9248 is limited to two times per year, per client, without prior authorization.

Any dentist providing nonintravenous (IV) conscious sedation must comply with all TSBDE Rules and American Academy of Pediatric Dentistry (AAPD) Guidelines, including maintaining a current permit to provide non-IV conscious sedation. Claims must include a provider statement indicating that the procedure was provided in full compliance with these guidelines. Documentation supporting medical necessity and appropriateness for the use of non-IV conscious sedation must be maintained in the client's records and is subject to retrospective review.

Supporting documentation includes, but is not limited to the following:

- Narrative addressing the reason non-IV conscious sedation was necessary
- Medications used to provide the non-IV conscious sedation
- The duration of the non-IV conscious sedation, including the start and end times
- Monitored statistics, such as vital signs and oxygen saturation levels
- Any resuscitative measures that may have been necessary

The following procedure codes are denied when billed for the same date of service as procedure code D9248:

Procedure Codes				
D9210	D9211	D9212	D9215	D9220
D9221	D9241	D9242	D9920	

Refer to: Section 14.2.6.3, "Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services)," on page 14-36.

14.2.5.10 Dental Behavior Management

Procedure code D9920 is considered for prior authorization in addition to therapeutic procedures when provided in the office and when the client has one of the following diagnoses:

Diagnosis Codes	Description
317	Mild intellectual disabilities
3180	Moderate intellectual disabilities
3181	Severe intellectual disabilities
3182	Profound intellectual disabilities
319	Unspecified intellectual disabilities

Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client's chart and is subject to retrospective review.

Supporting documentation includes, but is not limited to, the following:

- A current physician statement addressing the intellectual disabilities, signed and dated within 1 year before the dental behavior management
- A description of the service performed, including the specific problem and the behavior management technique applied
- Personnel and supplies required to provide the behavioral management
- The duration of the behavior management, including the start and end times

Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure.

Except for those procedures requiring prior authorization, admission to an outpatient or freestanding ambulatory surgical center (ASC) for the purpose of performing dentistry services must be authorized.

Refer to: Section 24.5.1, "Benefits, Limitations, and Authorization Requirements," on page 24-22 for more information about prior authorization in an ASC.

14.2.5.11 Internal Bleaching of Discolored Tooth

Internal bleaching of a discolored tooth is an accepted endodontic treatment for clients who are 13 years of age or older. It is intended to remove and change the organic material in the enamel of an infected or traumatized tooth. It is considered medically necessary when chemical change of the contents in the interior of the tooth is judged necessary to complete an endodontic treatment to the tooth for therapeutic, not cosmetic purposes. Prior authorization is not required. Procedure code D9974 may be considered for reimbursement when the claim is filed with documentation supporting medical necessity. Claims that are filed without documentation supporting medical necessity are denied as incomplete.

14.2.5.12 Noncovered Services

The following therapeutic services are not benefits of the CSHCN Services Program.

Procedure Codes				
D3331	D3332	D3333	D6058	D6059
D6060	D6061	D6062	D6063	D6064
D6065	D6066	D6067	D6068	D6069
D6070	D6071	D6072	D6073	D6074
D6075	D6076	D6077	D6094	D6194
D7412	D7671	D7771	D7830	D9972
D9973				

14.2.6 Dental Treatment in Hospitals and ASCs

Dental rehabilitation and restoration services requiring general anesthesia may be performed in the inpatient or outpatient setting.

14.2.6.1 Dental Hospital Calls

Dental hospital calls may be reimbursed for clients of any age that require medically necessary anesthesia or dental treatment in the inpatient or outpatient hospital setting. Providers may bill procedure code D9420 in addition to the dental services performed in the inpatient or outpatient setting. Documentation supporting the medical necessity of the dental hospital call must be retained in the client's record and is subject to retrospective review. Procedure code D9420 is limited to twice per year.

Refer to: Chapter 24, "Hospital," on page 24-1 for more information about requirements for inpatient and outpatient services.

14.2.6.2 Authorization and Prior Authorization Requirements

All inpatient hospital admissions for dental services require prior authorization. Except for those specific procedures that require prior authorization, admission to freestanding ASCs or outpatient hospital ambulatory surgical centers (HASCs) for the purpose of performing dentistry services require authorization.

The CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form must be submitted to the TMHP-CSHCN Services Program with supporting documentation of medical necessity.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for additional information.

Chapter 24, "Hospital," on page 24-1.

CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only form

CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only form.

14.2.6.3 Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services)

Dental rehabilitation or restoration services requiring general anesthesia may be performed in the inpatient or outpatient setting.

CSHCN Services Program dental services should be billed using the following Current Procedural Terminology (CPT) procedure codes and modifier where appropriate:

- Anesthesia services for dental rehabilitation or restoration and general dental anesthesia, procedure code 00170 with modifier U3
- ASC or HASC dental rehabilitation or restoration, procedure code 41899 with modifier U3
- Physical examinations before dental restorations under anesthesia, procedure codes 99202, 99222, and 99282
- Restorations under anesthesia, procedure codes 99222 and 99282

Prior authorization is not required for the use of general anesthesia while rendering treatment (to include the dental service fee, the anesthesia fee and facility fee), regardless of place of service. Supporting documentation must be retained in the client's chart and must reflect compliance with the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form. Dental general anesthesia may be reimbursed once every 6 months per client per provider.

All supporting documentation must be maintained in the client's medical record. The client's record must be available for review by representatives of the CSHCN Services Program, the Department of State Health Services (DSHS), the CSHCN Services Program claims contractor, and HHSC. The dental provider is required to maintain the following documentation in the client's dental record:

- The medical evaluation justifying the need for anesthesia
- Description of relevant behavior and reference scale
- Other relevant narrative justifying the need for general anesthesia
- Client's demographics, including date of birth
- Relevant dental and medical history
- Dental radiographs, intraora or perioral photography, or diagram of dental pathology
- Proposed dental plan of care
- Consent signed by parent or guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained
- Completed CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form

- The parent or guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that the parent or guardian understands and agrees with the dentist's assessment of their child's behavior
- Dentist's attestation statement and signature, which is put on the bottom of the CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form or included in the record as a separate form

Hospital and outpatient facility admissions are subject to medical necessity review.

14.2.7 Doctor of Dentistry Services as a Limited Physician

The CSHCN Services Program covers services provided by a DDS or DMD if the services are a benefit and furnished within the dentist's scope of practice as defined by Texas state law. To participate in the CSHCN Services Program as a dentist practicing as a limited physician, a dentist (DDS or DMD) must be enrolled separately as a dentist practicing as a limited physician.

The CSHCN Services Program recognizes the standards of care needed to appropriately address the repair of cleft and craniofacial anomalies as outlined in the guidelines prepared by the American Cleft Palate - Craniofacial Association (www.acpa-cpf.org).

A comprehensive, multidisciplinary approach is medically necessary to meet all of the needs of clients with complex medical conditions who require treatment by a broad range of medical specialists. Standard of care for the comprehensive repair or reconstruction of craniofacial anomalies for CSHCN Services Program clients requires a team approach either by a C/C team or by an equivalent coordinated multidisciplinary team. The following exceptions may be considered to this requirement:

- A C/C or equivalent multidisciplinary team is not available in the area and the client is unable to travel. (Medical record documentation must explain the reasons the client is unable to travel.)
- A C/C or equivalent multidisciplinary team is not available in the area, or the team approach cannot be coordinated over multiple locations. (Medical record documentation must describe attempts to coordinate a team approach.)
- A C/C or equivalent multidisciplinary team is available but the client or the client's parent/guardian refuses to receive care from the team. (Medical record documentation must explain the reason for the refusal of the care offered by the team.)

Refer to: Section 31.2.37.11, "Cleft/Craniofacial Procedures," on page 31-115 for more detailed information.

If a client has third-party insurance coverage available that requires reconstructive facial surgery involving the bony skeleton of the face (including midface osteotomies and cleft lip and palate repairs performed by a physician), the CSHCN Services Program cannot consider a claim for payment unless all third-party payer requirements are met.

14.2.7.1 Authorization Requirements

The following procedure codes require authorization and may be considered with medical review of documentation of medical necessity. These procedures may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.

Procedure Codes				
11950	11951	11952	11954	15780
15781	15788	15789	15876	

Documentation of medical necessity indication that the procedure was performed due to trauma or injury must be submitted with the authorization request.

Unless otherwise noted in the following tables, all other procedure codes in this section do not require authorization or prior authorization.

14.2.7.2 Surgery

The following surgery CPT procedure codes are payable to a dentist enrolled in the CSHCN Services Program as a dentist physician:

Procedure Codes					
10060	10061	10140	10160	10180	11010
11011	11012	11042	11043	11044	11100
11101	11200	11201	11305	11306	11307
11308	11310	11311	11312	11313	11420
11421	11422	11423	11424	11426	11440
11441	11442	11443	11444	11446	11620
11621	11622	11623	11624	11626	11640
11641	11642	11643	11644	11646	11900
11901	11950**	11951**	11952**	11954**	11960
11970	11971	12001	12002	12004	12005
12006	12007	12011	12013	12014	12015
12016	12017	12018	12020	12021	12031
12032	12034	12035	12036	12037	12051
12052	12053	12054	12055	12056	12057
13120	13121	13122	13131	13132	13133
13151	13152	13153	13160	14020	14021
14040*	14041*	14060*	14061*	14301	14302
15004	15005	15115	15116	15120*	15121*
15135*	15136*	15155*	15156*	15157*	15240*
15241*	15260*	15261*	15275	15276	15277
15278	15574	15576*	15620	15630	15732
15740	15750	15756	15757	15758	15760
15770	15780**	15781**	15786	15787	15788**
15789**	15819	15820	15821	15822	15823
15838	15850	15851	15852	15876**	17250
20005	20100	20525	20551	20552	20600
20604	20605	20606	20615	20660	20670
20680	20690	20692	20693	20694	20696
20697	20900	20902*	20910	20912	20920
20922	20926	20955	20956	20957	20962
20969	20970	20972	20973	20999	21010
21011	21012	21013	21014	21025	21026
21029	21030	21031	21032	21040	21046
21047	21048	21049	21050	21060	21070

*If performed as part of a repair or reconstruction of cleft lip, cleft palate, or craniofacial anomaly, must be prior authorized and performed by a CSHCN Services Program provider that is a member of, or affiliated with, an approved cleft/craniofacial team or an equivalent coordinated multidisciplinary team.
** Authorization is required and may be considered with medical review of documentation of medical necessity. These procedure may be considered cosmetic and are not a benefit when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.

Procedure Codes					
21073	21076*	21077	21079*	21080*	21081*
21082*	21083*	21084*	21085*	21086*	21087*
21088*	21089*	21100*	21110*	21116	21120*
21121*	21122*	21123*	21125*	21127*	21137*
21138*	21139*	21141*	21142*	21143*	21145*
21146*	21147*	21150*	21151*	21154*	21155*
21159*	21160*	21172*	21175*	21179*	21180*
21181*	21182*	21183*	21184*	21188*	21193*
21194*	21195*	21196*	21198*	21199*	21206*
21208*	21209*	21210*	21215*	21230*	21235*
21240	21242	21243	21244*	21245*	21246*
21247*	21248*	21249*	21255*	21256*	21260*
21261*	21263*	21267*	21268*	21270*	21275*
21280*	21282*	21295*	21296*	21299*	21310
21315	21320	21325	21330	21335	21336
21337	21338	21339	21340	21343	21344
21345	21346	21347	21348	21355	21356
21360	21365	21366	21385	21386	21387
21390	21395	21400	21401	21406	21407
21408	21421	21422	21423	21431	21432
21433	21435	21436	21440	21445	21450
21451	21452	21453	21454	21461	21462
21465	21470	21480	21485	21490	21495
21497*	21499	21685	29800	29804	29999
30000	30020	30120	30124	30125	30130
30140	30150	30160	30200	30300	30310
30460*	30462*	30580*	30600*	30620*	30630*
30801	30802	30901	30903	30905	30906
30930	30999	31020	31080	31081	31084
31085	31086	31087	31603	31605	31830
40490	40500	40510	40520	40525	40527*
40530	40650*	40652*	40654*	40700*	40701*
40702*	40720*	40761*	40799*	40800	40801
40804	40805	40806	40808	40810	40812
40814	40816	40818	40819	40820	40830
40831	40840	40842	40843	40844	40845

*If performed as part of a repair or reconstruction of cleft lip, cleft palate, or craniofacial anomaly, must be prior authorized and performed by a CSHCN Services Program provider that is a member of, or affiliated with, an approved cleft/craniofacial team or an equivalent coordinated multidisciplinary team.
** Authorization is required and may be considered with medical review of documentation of medical necessity. These procedure may be considered cosmetic and are not a benefit when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.

Procedure Codes					
40899	41000	41005	41006	41007	41008
41009	41010	41015	41016	41017	41018
41100	41105	41108	41110	41112	41113
41114	41115	41116	41120	41250	41251
41252	41500	41510	41520	41599	41800
41805	41806	41820	41821	41822	41823
41825	41826	41827	41828	41830	41850
41870	41872	41874	41899	42000	42100
42104	42106	42107	42120	42140	42145*
42160	42180	42182	42200*	42205*	42210*
42215*	42220*	42225*	42226*	42227*	42235*
42260*	42280*	42281*	42299	42300	42305
42310	42320	42330	42335	42340	42400
42405	42408	42409	42410	42415	42420
42440	42450	42500	42505	42507	42509
42510	42550	42600	42650	42660	42665
42699	42700	42720	42725	42800	42804
42806	42808	42809	42810	42890	42892
42894	42900	42950	42960	42961	42962
42970	42999	61501	61559*	62147	64400
64402	64722	64736	64738	64740	67900
67914	67915	67916	67917	67921	67922
67923	67924	67930	67935	67950*	67961*
67966*	67971	67973	67974	67975	J0558
J0561					

*If performed as part of a repair or reconstruction of cleft lip, cleft palate, or craniofacial anomaly, must be prior authorized and performed by a CSHCN Services Program provider that is a member of, or affiliated with, an approved cleft/craniofacial team or an equivalent coordinated multidisciplinary team.
** Authorization is required and may be considered with medical review of documentation of medical necessity. These procedure may be considered cosmetic and are not a benefit when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.

14.2.7.3 Cleft/Craniofacial Surgery by a Dentist Physician

The following additional codes may be reimbursed to a provider enrolled as a cleft/craniofacial surgeon. Prior authorization is required.

Procedure Codes				
30540	30545	30560	61550	61552
61556	61557	61558	62115	62117

Septoplasty (procedure code 30520) for nonrelated repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies may be prior authorized with documentation to support medical necessity.

14.2.7.4 Evaluation and Management or Consultation

The following evaluation and management or consultation service procedure codes are payable to a dentist physician:

Procedure Codes				
99201	99202	99203	99204	99205
99211	99212	99213	99214	99215
99218	99219	99220	99221	99222
99223	99231	99232	99233	99238
99241	99242	99243	99244	99245
99251	99252	99253	99254	99255
99281	99282	99283	99284	99285

Evaluation and management codes for home services are not reimbursed to dentists or dentistry groups.

14.2.7.5 Radiology and Laboratory Procedures

The following diagnostic radiology and laboratory procedure codes are payable to a dentist physician:

Procedure Codes				
70100	70110	70120	70130	70140
70150	70160	70170	70190	70200
70250	70260	70300	70310	70320
70328	70330	70332	70336	70350
70355	70370	70371	70380	70390
73100	76942	88305	88331	88332

Refer to: The CMS website at www.cms.gov/CLIA/10 Categorization of Tests.asp for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

The following additional CPT procedure codes are payable to a dentist enrolled in the CSHCN Services Program as a dentist physician:

Procedure Codes				
90284	92511	96369	96370	96372
96374	J0290	J0295	J0330	J0558
J0561	J0690	J0692	J0694	J0696
J0697	J0698	J0702	J0710	J0715
J0720	J0744	J1020	J1030	J1040
J1094	J1100	J1165	J1170	J1200
J1364	J1580	J1631	J1700	J1710
J1720	J1790	J1810	J1840	J1850
J1885	J1890	J1940	J1990	J2010
J2060	J2400	J2460	J2510	J2540
J2560	J2650	J2700	J2770	J2920
J2930	J3000	J3260	J3300	J3301

Procedure Codes				
J3302	J3303	J3370	J3430	J3480
J3490	J3520	S0021		

Procedure codes 90284, J1459, J1561, J1568, J1569, and J1572 will be denied if billed with the same date of service by any provider as the following procedure codes (unless otherwise indicated):

Procedure Codes				
90284	J1459*	J1460	J1560	J1561*
J1566	J1568*	J1569*	J1572*	J7504
J7511				
*These procedure codes may be billed more than once per day but will not be reimbursed if billed in combination with any other procedure code in this table.				

14.2.7.6 Anesthesia by Dentist Physician

In addition to the procedure codes discussed under "Benefits and Limitations" in this chapter, the following anesthesia CPT procedure codes are payable to a dentist physician:

Procedure Codes				
00100	00102	00160	00162	00164
00170	00190	00192	00300	99100
99116	99135	99140		

14.3 Claims Information

Dental services must be submitted to TMHP in an approved electronic format or on a paper ADA Dental Claim Form (Copyright 2012, American Dental Association). Providers can obtain copies of this form by contacting the ADA at 1-800-947-4746 or ordering online from the ADA website at www.ada.org. TMHP does not supply the forms. Any paper dental claim submitted using any other version of the dental claim form is not processed and is returned to the submitter.

When completing a paper ADA Dental 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.

Providers billing electronically must submit dental claims in American National Standards Institute (ANSI) ASC X12 837D format. Specifications are available to providers developing in-house systems, software developers, and vendors. Because each software package is different, field locations may vary. Providers should contact the software developer or vendor for information about their software. Providers or software vendors may direct questions about development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Claims must contain the billing provider's full name, address, and provider identifier. The billing provider's full name and address must be entered in Block 48 of the paper ADA Dental Claim Form, and the ten-digit NPI must be entered in Block 49. *A claim without a provider name, address, and NPI cannot be processed.*

The Healthcare Common Procedure Coding System (HCPCS)/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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.13, "Instructions for Completing the Paper ADA Dental Claim Form," on page 5-41 for instructions on completing paper claims. Blocks that are not referenced are not required for processing and may be left blank.

14.3.1 Dental Emergency Claims

The Emergency Indicator field has been removed from the HIPAA-approved 837D electronic transaction. Dental providers submitting electronic claims in the 837D format must use modifier *ET* to report emergency services. Modifier ET must be placed in the SVC01 section of the 837D format.

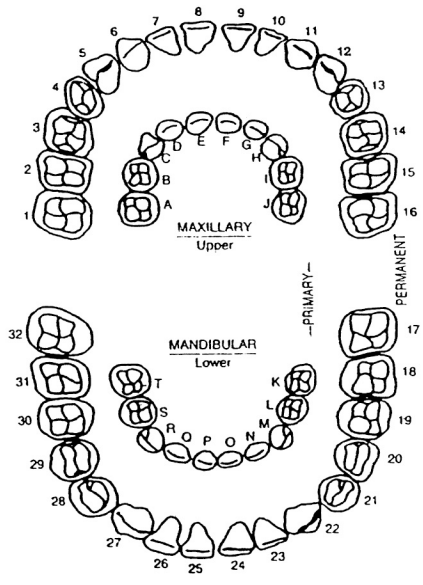
Additionally, the Comments field should be used to document the specific nature of the emergency. The Comments field in the HIPAA-approved 837D electronic transaction is 80 bytes long.

To indicate a dental emergency on a paper claim submission (ADA Dental Claim Form), check Block 45, Treatment Resulting From (check the applicable box), and check the Other Accident box for emergency claim reimbursement. If the Other Accident box is checked, information about the emergency must be provided in Block 35, Remarks.

Only one emergency or trauma claim per client, per day may be submitted. Separate services (one for emergency or trauma and one for nonemergency or routine) may be submitted for the same client on the same day, any provider, for separate services and procedure codes.

14.3.2 Tooth Identification (TID) and Surface Identification (SID) Systems

Claims are denied if the procedure code is not compatible with TID or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. Anterior teeth have facial and incisal surfaces only. Posterior teeth have buccal and occlusal surfaces only.



SID	SID	SID	SID
Buccal	DB	DFI	DLIF
Distal	DF	DFL	DOLB
Facial	DI	DFM	MIDF
Incisal	DL	DIL	MIDL
Lingual	DO	DLB	MIDLF
Mesial	IL	DLM	MIFL
Occlusal	MB	DOB	MLBD
	MI	DOL	MLDF
	ML	ILF	MODB
	MO	MBD	MODL
	OB	MID	MODLB
	OL	MIF	MOLB
		MLB	
		MLF	
		MLI	
		MOB	
		MOD	
		MOL	
		OBL	

14.3.3 Supernumerary Tooth Identification

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the 2007–2008 CDT published by the ADA.

The TID for each identified supernumerary tooth is used for paper and electronic claims and can only be billed with the following codes:

- For primary teeth only: D7111
- For both primary and permanent teeth the following codes are billable: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510

Permanent Teeth Upper Arch																
Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Super #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Permanent Teeth Lower Arch																
Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Super #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Primary Teeth Upper Arch										
Tooth #	A	B	C	D	E	F	G	H	I	J
Super #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Primary Teeth Lower Arch										
Tooth #	T	S	R	Q	P	O	N	M	L	K
Super #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

14.4 Reimbursement

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

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.*

14.5 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.

Chapter

15

Diabetic Equipment and Supplies

15.1 Enrollment

To enroll in the CSHCN Services Program, providers of diabetic equipment and 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 diabetic equipment and supplies providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

15.2 Benefits, Limitations, and Authorization Requirements

Diabetic equipment and supplies including glucose monitors, testing supplies, insulin and insulin syringes, and external insulin pumps and supplies may be reimbursed by the CSHCN Services Program.

15.2.1 Glucose Monitor and Supplies

Glucose monitors and diabetic supplies do not require prior authorization when provided to a client with one of the following diagnoses:

Diagnosis Code	Description
Diabetic Diagnosis Codes	
24900	Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified
24901	Secondary diabetes mellitus without mention of complication, uncontrolled
24910	Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified
24911	Secondary diabetes mellitus with ketoacidosis, uncontrolled
24920	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified
24921	Secondary diabetes mellitus with hyperosmolarity, uncontrolled
24930	Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified
24931	Secondary diabetes mellitus with other coma, uncontrolled

Diagnosis Code	Description
24940	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified
24941	Secondary diabetes mellitus with renal manifestations, uncontrolled
24950	Secondary diabetes mellitus with ophthalmic manifestations, not stated as uncontrolled, or unspecified
24951	Secondary diabetes mellitus with ophthalmic manifestations, uncontrolled
24960	Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified
24961	Secondary diabetes mellitus with neurological manifestations, uncontrolled
24970	Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified
24971	Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled
24980	Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified
24981	Secondary diabetes mellitus with other specified manifestations, uncontrolled
24990	Secondary diabetes mellitus with unspecified complication, not stated as uncontrolled, or unspecified
24991	Secondary diabetes mellitus with unspecified complication, uncontrolled
25000	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
25001	Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled
25002	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled
25003	Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled
25010	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled
25011	Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled
25012	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled
25013	Diabetes with ketoacidosis, type I [juvenile type], uncontrolled
25020	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled
25021	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled
25022	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled
25023	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled
25030	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled
25031	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled
25032	Diabetes with other coma, type II or unspecified type, uncontrolled
25033	Diabetes with other coma, type I [juvenile type], uncontrolled
25040	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled

Diagnosis Code	Description
25041	Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled
25042	Diabetes with renal manifestations, type II or unspecified type, uncontrolled
25043	Diabetes with renal manifestations, type I [juvenile type], uncontrolled
25050	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled
25051	Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled
25052	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled
25053	Diabetes with ophthalmic manifestations, type I [juvenile type], uncontrolled
25060	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
25061	Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled
25062	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled
25063	Diabetes with neurological manifestations, type I [juvenile type], uncontrolled
25070	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled
25071	Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled
25072	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled
25073	Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled
25080	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
25081	Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled
25082	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled
25083	Diabetes with other specified manifestations, type I [juvenile type], uncontrolled
25090	Diabetes with unspecified complication, type II or unspecified type, not stated as uncontrolled
25091	Diabetes with unspecified complication, type I [juvenile type], not stated as uncontrolled
25092	Diabetes with unspecified complication, type II or unspecified type, uncontrolled
25093	Diabetes with unspecified complication, type I [juvenile type], uncontrolled
7751	Neonatal diabetes mellitus
Non-Diabetic Diagnosis Codes	
2511	Hypoglycemia, other
2512	Hypoglycemia, unspecified
2711	Galactosemia

Diagnosis Code	Description
2777	Dysmetabolic Syndrome X
27785	Disorders of fatty acid oxidation
5642	Postgastric Surgery
79029	Other abnormal glucose
7915	Glycosuria

Diagnoses not listed may be considered for prior authorization with supporting documentation of medical necessity.

15.2.1.1 Glucose Monitor

The purchase of a blood glucose monitor may be reimbursed once every three years using the following procedure codes:

Procedure Code	Limitation
E2100	1 per 3 years with prior authorization
E2101	1 per 3 years with prior authorization

Blood glucose monitors with integrated voice synthesizers (procedure code E2100) and blood glucose monitors with integrated lancing blood sample (procedure code E2101) may be considered for prior authorization with documentation of medical necessity.

Prior authorization is required for blood glucose monitors with special features (procedure codes E2100 and E2101). The following documentation supporting medical necessity of the special feature requested must be submitted with the prior authorization request:

- *Integrated voice synthesizer.* Supporting documentation for procedure code E2100 must include an additional diagnosis such as significant visual impairment and must include a statement from the physician that indicates that the client is unable to use a regular monitor and that the additional diagnosis or condition is not correctable.
- *Integrated lancing/blood sample.* Supporting documentation for procedure code E2101 must include a diagnosis of diabetes and significant manual dexterity impairment related, but not limited to, neuropathy, seizure activity, cerebral palsy, or Parkinson's. The documentation must include a statement from the physician indicating that the client is unable to use a regular monitor and has a significant manual dexterity impairment that is not correctable.

Standard home glucose monitors (procedure code E0607) are not a benefit of the CSHCN Services Program.

15.2.1.2 Glucose Testing Supplies

The following procedure codes may be reimbursed for glucose testing supplies when billed with one of the diagnosis codes listed in the "Glucose Monitor and Supplies" section of this chapter:

Procedure Code	Limitation
A4233	1 per 6 months
A4234	1 per 6 months
A4235	1 per 6 months
A4236	1 per 6 months
A4250	1 box per 6 months
A4252	10 strips per month
A4256	2 per year
A4258	2 per year

Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require authorization up to the quantities listed when they are provided to an insulin-dependent client with a valid diagnosis. If the client is insulin-dependent, providers must submit claims for these procedure codes with modifier U9:

Procedure Code	Limitation
A4253*	2 boxes per month
A4259	1 box per month
A9275*	2 per month
* A client may receive a combined total of two per calendar month of procedure codes A4253 and A9275, either two of one procedure code or one of each procedure code.	

Non-Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require authorization up to the quantities listed when provided to a non-insulin-dependent client with an approved diagnosis:

Procedure Code	Limitation
A4253*	1 box per month
A4259	1 box every 2 months
A9275*	1 per month
* A client may receive only one per calendar month of either procedure code A4253 or A9275.	

Blood testing supplies for diagnoses other than those listed in the "Glucose Monitor and Supplies" section of this chapter may be considered for prior authorization with documentation of medical necessity.

For items that do not require prior authorization, the provider must indicate on a completed, signed prescription how many times a day the client is required to test blood glucose or ketone levels when applicable (not all supplies are related to testing glucose or urine, e.g., batteries).

15.2.1.3 Glucose Tabs and Gel

Procedure code A9150 may be reimbursed for glucose tablets or gel with prior authorization. Documentation of medical necessity and one of the diagnosis codes listed in the "Glucose Monitor and Supplies" section of this chapter must be included with the prior authorization request. Procedure code A9150 may be prior authorized with a quantity of 1 every 6 months as determined with prior authorization.

15.2.1.4 Prior Authorization Requirements

Diabetic supplies and related testing equipment do not require prior authorization unless otherwise specified in the specific sections of this chapter. Prior authorization is required when documentation of medical necessity supports additional quantities that exceed specified limits.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested equipment or supplies. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the diabetic equipment or supplies.

15.2.2 Insulin Pump

An external insulin pump may be considered for rental or purchase with prior authorization and documentation of medical necessity. The following procedure codes may be reimbursed with prior authorization for the external insulin pump:

Procedure Code	Limitation
E0784	1 per month (rental) 1 per 3 years (purchase)
A9900	As needed for the replacement bag

External insulin pump supplies do not require prior authorization up to the maximum quantities allowed. The following procedure codes may be reimbursed for the external insulin pump supplies:

Procedure Code	Limitation
A4230	10 per month
A4231	15 per month
A4232	10 per month
A4601	1 per 6 months
A4602	1 per 6 months
A6257	15 per month
A6258	15 per month
A6259	15 per month
K0604	1 per 6 months
K0605	1 per 6 months

Additional quantities may be considered with documentation of medical necessity and prior authorization.

Note: *Tubeless insulin delivery systems and their supplies are not benefits of the CSHCN Services Program.*

An external insulin pump must be ordered by, and the client's follow-up care must be managed by, a prescribing provider with experience managing clients with insulin pumps and who is knowledgeable in the use of insulin pumps.

15.2.2.1 Prior Authorization Requirements

Prior authorization requests for the rental and purchase of the external insulin pumps (procedure code E0784) must be submitted on the CSHCN Services Program Prior Authorization Request for External Insulin Pump form. Supporting medical necessity documentation must include past and current blood glucose levels and the most recent glycosylated hemoglobin level (Hb/A1C).

The rental of an external insulin pump may be considered for prior authorization with submission of clinical documentation that indicates one of the following:

- A client with a diagnosis of type 1 or 2 diabetes must meet at least 2 of the following criteria while on multiple daily injections of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) greater than 7.0 percent
  - History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
  - History of severe glycemic excursions with wide fluctuations in blood glucose
  - History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness

In addition to the clinical documentation, the provider must submit the CSHCN Services Program Prior Authorization Request for External Insulin Pump form and include documentation that the client or caregiver possess the following competencies:

- The cognitive and physical abilities to use the recommended insulin pump treatment regimen
- An understanding of cause and effect
- The willingness to support the use of the external insulin pump

The prior authorization request form must also include documentation that the prescribing provider has attested to the following:

- A training/education plan will be completed prior to initiation of pump therapy.
- The client or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

Note: *Providers may bill with procedure code A9900 for the replacement of alkaline batteries for the external ambulatory infusion pump during the rental period.*

The purchase of an external insulin pump may be considered for prior authorization after it has been rented for a three-month trial period and all of the following documentation is provided:

- The training/education plan has been completed.
- The pump is the appropriate equipment for the specific client.
- The client is compliant with the use of the pump.

Rental of an external insulin pump may be reimbursed for a 3-month trial, which must occur before purchase can be authorized.

In order for the external insulin pump to be considered for purchase, the physician must provide documentation that it is the appropriate equipment for the client and the client is compliant with use.

Replacement leg bag (procedure code A9900) must be prior authorized with documentation supporting medical necessity.

An internal insulin pump will not be prior authorized because the pump is included in the reimbursement for the surgery to place the pump.

15.2.3 Insulin and Insulin Syringes

Insulin and insulin syringes are available through the Texas Medicaid Vendor Drug Program.

Refer to: Section 3.1.1, "Prescription Drug Benefits," on page 3-3 for more information.

15.3 Documentation of Receipt

When the equipment is delivered, providers must complete the CSHCN Services Program Documentation of Receipt form. The date of delivery on the form is the date of service that should appear on the claim. The provider must request a signature from the client or client's representative at the time of delivery. The provider should retain this form and not submit it with the claim.

Providers must maintain a copy of this form in their files for the life of the piece of equipment or until the equipment is authorized for replacement.

The documentation of receipt form is available in both English and Spanish.

15.4 Claims Information

Diabetic equipment and 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.

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.

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

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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

15.5 Reimbursement

Diabetic equipment and supplies are reimbursed the lower of the billed amount, the amount allowed by CMS when available, or the amount allowed by Texas Medicaid.

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.*

15.6 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.

Chapter

16

Diagnostic Radiology Services

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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 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
72125	72126
72125, 72126	72127
72128	72129
72128, 72129	72130
72131	72132

Column A (Denied)	Column B
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 arterio-pulmonary 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.
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.

Region	Procedure Code(s)	Benefits and Limitations
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	77058
77059	77084			

16.2.7.1 MRI Authorization Requirements

Authorization is not required for up to four MRI procedures per 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 4.3, "Prior Authorizations," on page 4-5 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, and 78813) 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 is limited to the professional interpretation component and must be submitted with one of the following diagnosis codes:

Diagnosis Code	Description
34540	Partial epilepsy with impairment of consciousness, without mention of intractable epilepsy
34541	Partial epilepsy with intractable epilepsy
78039	Other convulsions

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

Diagnosis Code	Description
1720	Malignant melanoma of skin of lip
1721	Malignant melanoma of skin of eyelid, including canthus
1722	Malignant melanoma of skin of ear and external auditory canal
1723	Malignant melanoma of skin of other and unspecified parts of face
1724	Malignant melanoma of skin of scalp and neck
1725	Malignant melanoma of skin of trunk, except scrotum
1726	Malignant melanoma of skin of upper limb, including shoulder
1727	Malignant melanoma of skin of lower limb, including hip
1728	Malignant melanoma of other specified sites of skin
1729	Melanoma of skin, site unspecified
17300	Unspecified malignant neoplasm of skin of lip
17309	Other specified malignant neoplasm of skin of lip
17310	Unspecified malignant neoplasm of eyelid, including canthus
17319	Other specified malignant neoplasm of eyelid, including canthus
17320	Unspecified malignant neoplasm of skin of ear and external auditory canal
17329	Other specified malignant neoplasm of skin of ear and external auditory canal
17330	Unspecified malignant neoplasm of skin of other and unspecified parts of face
17339	Other specified malignant neoplasm of skin of other and unspecified parts of face
17340	Unspecified malignant neoplasm of scalp and skin of neck
17349	Other specified malignant neoplasm of scalp and skin of neck
17350	Unspecified malignant neoplasm of skin of trunk, except scrotum
17359	Other specified malignant neoplasm of skin of trunk, except scrotum
17360	Unspecified malignant neoplasm of skin of upper limb, including shoulder
17369	Other specified malignant neoplasm of skin of upper limb, including shoulder
17370	Unspecified malignant neoplasm of skin of lower limb, including hip
17379	Other specified malignant neoplasm of skin of lower limb, including hip
17380	Unspecified malignant neoplasm of other specified sites of skin
17389	Other specified malignant neoplasm of other specified sites of skin
17390	Unspecified malignant neoplasm of skin, site unspecified

Diagnosis Code	Description
17399	Other specified malignant neoplasm of skin, site unspecified
1860	Malignant neoplasm of undescended testis
1869	Malignant neoplasm of other and unspecified testis
1910	Malignant neoplasm of cerebrum, except lobes and ventricles
1911	Malignant neoplasm of frontal lobe of brain
1912	Malignant neoplasm of temporal lobe of brain
1913	Malignant neoplasm of parietal lobe of brain
1914	Malignant neoplasm of occipital lobe of brain
1915	Malignant neoplasm of ventricles of brain
1916	Malignant neoplasm of cerebellum NOS
1917	Malignant neoplasm of brain stem
1918	Malignant neoplasm of other parts of brain
1919	Malignant neoplasm of brain, unspecified site

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:

Procedure Codes				
70030	76831	76881	76882	93980

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

Procedure Codes	
Q9956	Q9957

Procedure code 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
76930	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 2-33881.

Procedure code 75958 may be reimbursed when it is billed in conjunction with procedure code 2-33883.

Note: Procedure code 33884 may be reimbursed when it is billed in conjunction with procedure code 33883. 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 may be reimbursed when it is billed in conjunction with on of the following procedure codes:

Procedure Codes				
36555	36556	36557	36558	36560
36561	36563	36565	36566	36568
36569	36570	36571	36575	36576
36578	36580	36581	36582	36583
36584	36585	36589	36590	36591
36593	36595	36596	36597	36598

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 CSHCN Services Program provider identifier 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Chapter 5, "CMS-1500 Paper Claim Form Instructions," on page 5-26 and "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form," on page 5-31 for instructions on completing paper 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," on page 24-25 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," on page 24-13 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.

Chapter

17

Durable Medical Equipment (DME)

17.1 Enrollment

To enroll in the CSHCN Services Program, DME providers must be actively enrolled in Texas Medicaid, have a valid CSHCN Services Program Provider Agreement, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state DME (noncustom DME) providers must meet all these conditions, be located in the United States within 50 miles of the Texas state border and be approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 3.1.4, "Services Provided Outside of Texas," on page 3-3 for more detailed information.

17.1.1 Custom DME Requirements

Providers who wish to enroll with the CSHCN Services Program as customized DME providers must complete the CSHCN Services Program Provider Enrollment Application as specified in Section 3.1, "Provider Enrollment," on page 3-2. Additionally, applicants must either provide evidence of having current certification from the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) as an assistive technology supplier and/or assistive technology practitioner, or provide three separate letters of recommendation from practicing occupational therapists (OTs) or physical therapists (PTs) serving a pediatric population. These letters must include the name, address, and telephone number of the recommending therapist, place of therapist's employment, and number of years the therapist has worked with the specific custom DME applicant in providing custom DME. The CSHCN Services Program requires that PTs and OTs writing letters of recommendation are not employed by the applicant nor receive any form of compensation for the letters of recommendation.

Providers must send the completed documentation to:

Texas Medicaid & Health Partnership
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78720–0795
1-800-568-2413

Additional information and provider enrollment forms are available on the TMHP website at www.tmhp.com.

17.2 Program Overview and Guidelines

The CSHCN Services Program considers requests for coverage of the following types of DME and services when they are medically necessary and appropriate:

- *Rehabilitative equipment:* purchase, rental, modification, and repair items such as ambulation aids, wheelchairs (manual and power), standers, hospital beds, hygiene equipment, etc.
- *Miscellaneous equipment:* items such as paraffin units, enuresis alarms, and special needs car seats

All DME must be prescribed by a licensed physician. This equipment is primarily and customarily used to serve a medical purpose and is generally not useful to a person in the absence of illness, injury, or disability. DME is appropriate for use in the home or community setting. Unique or novel DME that is a benefit of the CSHCN Services Program must have a well-established history or efficacy. The DME must have valid and peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

There is no single authority, such as a federal agency, that confers the official status of "DME" on any device or product. Therefore, the CSHCN Services Program within the Department of State Health Services (DSHS), retains the right to determine which DME devices or products are benefits of the CSHCN Services Program. To be considered for reimbursement, DME must be a benefit of the CSHCN Services Program and must be authorized or prior authorized, if required, as indicated in the sections below. Requests for authorization or prior authorization must be submitted in writing. Requests for equipment that requires *prior* authorization must be completed and received before the requested date of service.

The CSHCN Services Program may reimburse providers for both custom and standard (noncustom) DME.

17.2.1 Custom DME

Custom DME is medical equipment that is made or modified specifically to address the *individual* client's needs. After it is issued, customized equipment is the client's property. Examples of covered custom DME include:

- Adaptive strollers.
- Custom-fitted wheelchairs (manual and power) and positioning components.
- Gait trainers.
- Hospital crib or enclosed bed.
- Portable wheelchair ramps.
- Scooters.
- Special needs car seats.
- Standers (prone and supine).
- Travel chair.

17.2.2 Standard DME

Noncustom DME is medical equipment that can be obtained from a store or a mail-order company and does not require adaptation or modification for the client's use. Examples of covered noncustom DME include:

- Adaptive feeder seats.
- Ambulation aids.
- Feeding equipment (parenteral and enteral).
- Hospital beds.
- Hygiene equipment.
- Portable paraffin units.
- Standard wheelchairs.

- Transcutaneous electrical nerve stimulator (TENS) units.
- Transfer boards.

17.2.3 Program Guidelines

All DME providers must adhere to the following program guidelines concerning the products and services they provide:

- Provide new equipment—not used, reconditioned, or damaged equipment or parts.
- Ensure that clients are measured and that the equipment is assembled and fitted by knowledgeable staff.
- Request authorization or prior authorization for equipment based on the recommendations of a team that includes the client, physician, therapist, and vendor, whenever possible.
- Ensure that staff experienced in the fitting of DME delivers the equipment with all accessories directly to the person specified in the delivery instructions. The parent, client, or guardian must sign the CSHCN Services Program Documentation of Receipt form only at the time of delivery, and only when the item with all accessories meets the satisfaction of the parent, client, or guardian.
- Provide instruction to the family, client, or guardian about the proper use and maintenance of the equipment.
- Provide free inspection, adjustments, and maintenance between the fourth and the fifth months after delivery of a power chair.
- Lend a medically appropriate item to the client, at no charge, if the prescribing physician determines immediate need from the time the vendor receives authorization and until the prescribed item is delivered.
- Do not purchase accessories, inserts, or other positioning devices shop-built by a vendor unless specifically approved after review of medical justification submitted from the prescribing physician, OT, or PT. Detailed cost justification is also required.
- Never reclaim an item delivered to a client when the CSHCN Services Program Documentation of Receipt form has been signed by the parent, client, or guardian, even if the CSHCN Services Program denies vendor payment for failure to comply with claims processing deadlines.
- Use objective OTs or PTs to perform the wheelchair and equipment evaluations and to make equipment recommendations for CSHCN Services Program clients. An objective therapist is one who is not hired or paid by the DME provider or company to perform these evaluations.

Any evidence of noncompliance with items above may be grounds for removing the provider from the CSHCN Services Program provider list or other sanctions as agreed upon by the medical reviewers.

17.3 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program must authorize all requests for both standard and custom DME. Requests must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) form.

Note: *The physician's signature is only required on page 1 of the form in the Statement of Medical Necessity section. Providers must submit page 1 of the form to TMHP. Pages 2 through 5 are only required for certain DME requests. Refer to the text under the form title to determine which of these pages must be submitted in addition to page 1.*

Custom DME and more complex equipment requires prior authorization; all other and standard DME must be authorized. The sections below identify the equipment that requires authorization and the equipment that requires prior authorization. Authorization requests and prior authorization requests should be submitted on a CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) form.

The custom DME prior authorization period is no more than 75 days from the date of approval. If the client's eligibility is due to end before the 75 days, providers will still receive a 75-day authorization from the date of the approval.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for more information about authorizations and prior authorizations.

17.3.1 Adaptive Strollers

Adaptive strollers may be noncustom DME, or they may be custom DME if they are in any way customized to the individual client's needs.

Adaptive strollers are mobility devices that resemble regular strollers purchased for healthy infants and toddlers. Adaptive strollers have a limited range of accessories that allow some positioning for clients with minor postural problems.

17.3.1.1 Authorization Requirements

Adaptive strollers may be authorized only when medically necessary and when all of the following conditions are met:

- The stroller has a firm back and seat, or insert.
- A stroller (rather than a wheelchair) is specifically recommended by the licensed therapist completing the wheelchair evaluation.
- The requested stroller meets *all* recommendations made in the wheelchair evaluation.
- The client is not expected to develop motor skills necessary for self-propulsion and is not expected to need a travel chair or wheelchair within 2 years of the request date, *or* the client is expected to be ambulatory within 1 year of the request date.

Authorization requests for clients older than 2 years of age must meet the above criteria, and there must be medical documentation of the need for a stroller versus a wheelchair. Medical documentation should indicate that a stroller allows adequate support for a client's particular condition, stature, and need for positioning (completion of the CSHCN Services Program Wheelchair Seating Evaluation Form serves as medical documentation).

The following criteria must be met for the level of stroller requested:

- *Level 1: Basic stroller.* The client meets the criteria for a stroller.
- *Level 2: Stroller with tray for oxygen and/or ventilator.* The client meets the criteria for a Level 1 stroller and is oxygen- or ventilator-dependent.
- *Level 3: Stroller with positioning inserts.* The client meets the criteria for a Level 1 or Level 2 stroller and requires additional positioning support.

Providers should use the following procedure codes and modifiers to submit claims for strollers. Levels 2 and 3 require the addition of a modifier:

Description	Procedure Code and Modifier (As Applicable)
Level 1: Basic Stroller	E1035
Level 2: Stroller with tray for oxygen and/or ventilator	E1035 with TF modifier
Level 3: Stroller with positioning inserts	E1035 with TG modifier

17.3.2 Ambulation Aids

17.3.2.1 Crutches, Walkers, Gait and Ambulation Belts, and Canes

Ambulation aids may be noncustom DME, or they may be custom DME if they are in any way customized to the individual client's needs.

Crutches, walkers, gait and ambulation belts, and canes may be authorized for any condition resulting in limited functional ambulation. Any enrolled DME provider may be reimbursed for nonspecialized equipment at Medicare-allowable rates. The provider is required to submit authorization requests and claims with the appropriate procedure codes. Ambulation aids may be rented if the need is short term. The anticipated total rental cost must be less than the purchased price.

17.3.3 Breast Prosthesis

The following procedure codes for external breast prostheses are benefits of the CSHCN Services Program when provided by a licensed prosthetist or licensed orthotist to clients with a history of a medically necessary mastectomy procedure:

Procedure Code	Limitations
L8000	4 per rolling year, same procedure, any provider
L8001	4 per rolling year, same procedure, any provider Modifier LT or RT required.
L8002	4 per rolling year, same procedure, any provider
L8010	8 per rolling year, same procedure, any provider
L8015	2 per lifetime, any provider regardless of modifier
L8020	1 per 6 rolling months, same procedure, any provider
L8030	1 per 2 rolling years, same procedure, any provider
L8031	1 per 2 rolling years, same procedure, any provider Modifier LT or RT required.
L8032	8 per rolling year, same procedure, any provider
L8035	Requires prior authorization
L8039	Requires prior authorization

Refer to: Section 31.2.37.12, "Mastectomy and Related Services," on page 31-117, for information about mastectomy procedures and related services.

17.3.3.1 Breast Prosthesis Prior Authorization Requirements

Prior authorization is required for the following:

- Medically necessary prostheses beyond set limitations outlined in the table above.
- Procedure codes L8035 and L8039.

Prior authorization must be requested using the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

Prior Authorization for Medically Necessary Prostheses Beyond Set Limitations
Medically necessary prostheses beyond set limitations may be prior authorized if any of the following is met for procedure codes L8000, L8001, L8002, L8010, L8015, L8020, L8030, L8031, and L8032:

- Loss or irreparable damage. If the external breast prosthesis is lost or irreparably damaged, prior authorization for a replacement of the same type may be considered for coverage at any time.
- Change in the client's condition. If a different external breast prosthesis is needed due to a change in the client's medical condition, prior authorization for prosthesis of a different type will be considered for coverage at any time.

Prior Authorization for Procedure Codes L8035 and L8039

Prior authorization requests for external breast prosthesis procedure codes L8035 or L8039 must include documentation of medical necessity for the requested device.

The prior authorization request for procedure code L8039 must also include the following information:

- The client's diagnosis
- Medical records indicating prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A procedure code that is comparable to the procedure being requested
- Documentation that indicates this procedure is not investigational or experimental
- The setting in which the service is to be rendered
- The physician's intended fee for this procedure

The physician must maintain documentation of medical necessity in the client's medical record. Services are subject to retrospective review.

17.3.4 Burn Care Garments

The CSHCN Services Program may reimburse providers for burn care products. The burn must be second or third degree with hypertrophic scarring, and the garment must be specific to the location of the burn. Burn care management garments may also be considered for reimbursement for other conditions (e.g., large hemangiomas or lymphangiomas), with documentation from the physician regarding medical necessity. Providers must use the following procedure codes when submitting claims for burn care services:

Procedure Codes				
A6501	A6502	A6503	A6504	A6505
A6506	A6507	A6508	A6509	A6510
A6511	A6512			

17.3.5 Cochlear Implant Device

Refer to: Chapter 20, "Hearing Services," on page 20-1 for more information about cochlear implant benefits and limitations.

17.3.6 Continuous Passive Motion (CPM) Device

A CPM may be authorized for rental only for no more than a 2-week period after knee surgery. Recertification for additional services may be considered with documentation of medical necessity.

17.3.7 Enuresis Alarms

Enuresis alarms used for the treatment of primary nocturnal enuresis may be considered for purchase using procedure code S8270 with documentation of medical necessity.

17.3.7.1 Prior Authorization Requirements

The CSHCN Services Program may consider prior authorization for a once in a lifetime purchase of an enuresis alarm if the client meets all of the following criteria:

- Is 5 to 20 years of age
- Has experienced bedwetting a minimum of three nights a week in the previous month or at least one bedwetting episode weekly for 1 year
- Has no daytime bedwetting
- Has been examined by a physician, and physical or organic causes for nocturnal enuresis (e.g., renal disease, neurological disease, infection, etc.) have been ruled out

17.3.8 Gait Trainers (Supported or Sling Walkers)

Gait trainers may be noncustom DME, or they may be custom DME if they are in any way customized to the individual client's needs.

The gait trainer should be needed at home as well as school or the therapy clinic. The CSHCN Services Program does not cover equipment for use solely in schools or clinics.

17.3.8.1 Authorization Requirements

The following documentation must be included with an authorization request for gait trainers:

- Client's condition, functional level, height, and weight
- Whether the client is expected to be ambulatory, and if so, when
- The time, frequency, and location where the gait trainer is used
- The length of time the gait trainer is expected to be needed (should be a minimum of 6 months)
- The plan for training the school and home caregivers in the correct and safe use of the equipment

17.3.9 Hospital Beds (Manual and Electric)

The rental or purchase of the following beds and cribs may be reimbursed:

- Manual or an electric hospital bed with or without a mattress
- Hospital crib
- Enclosed bed
- Accessories (e.g., safety enclosure frame or canopy)

A rental may be approved if the need is short-term (e.g., postsurgery or life expectancy of 6 months or less as certified by the prescribing physician). The anticipated total rental cost must be less than the purchase price.

A purchase may be approved for the long-term care of clients whose conditions have progressed to the point that they are severely neurologically or orthopedically limited, etc.

17.3.9.1 Authorization and Prior Authorization Requirements

To request authorization for manual or electric hospital beds, the provider must submit documentation of medical necessity and a completed CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

The following documentation must be included with the request for authorization or with the first claim:

- Client's diagnosis
- Client's age
- Client's height and weight
- Limitations of the caregiver
- Explanation addressing why a standard bed or crib will not meet the client's needs

Electric hospital beds may be considered for prior authorization as a purchase (long-term use) or as a rental (short-term use) if any of the following conditions exist:

- Client is able to assist with his or her personal care and can physically operate the controls
- Caregiver is physically limited and cannot crank a manual bed
- Caregiver needs to be able to adjust the bed quickly to assist with the client's personal care

All requests for the purchase of an electric hospital bed with or without a mattress require medical review.

The following procedure codes may be used to request authorization and to submit claims for reimbursement of rental or purchase of equipment:

Procedure Codes				
E0250	E0251*	E0255	E0256*	E0260
E0261*	E0265	E0266*	E0271*	E0272*
E0277	E0290*	E0303	E0304	E0305
E0310	E0315*			
*For purchase only.				

The purchase of a hospital bed without a mattress may be considered for reimbursement only if a custom mattress or bed positioning system is also authorized due to medical necessity.

17.3.9.2 Pressure Reducing Pads

Pressure-reducing pads for beds may be a benefit of the CSHCN Services Program.

Most pressure-reducing pads do not require prior authorization up to the approved limitations.

The following pressure-reducing pads procedure codes require prior authorization and the provider must submit with documentation of medical necessity and appropriateness:

Procedure Codes				
E0184	E0185	E0186	E0371	E0372
E0373				

To request authorization for pressure-reducing pads, the provider must submit documentation of medical necessity and a completed CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

Pressure relief beds are not benefits of the CSHCN Services Program.

17.3.9.3 Positional Pillows and Cushions

Procedure code E0190 must be billed with modifier UD for the purchase of reflex wedges and positional devices (positional pillows and cushions).

17.3.9.4 Hospital Cribs and Enclosed Beds

Hospital cribs and enclosed beds must be prior authorized. Hospital cribs or enclosed beds are considered custom equipment.

Prior Authorization Requirements
Documentation supporting medical necessity must be submitted with the prior authorization request form. Prior authorization is not granted when the documentation indicates strictly a behavioral control need. A diagnosis alone without documentation of medical necessity and functional skills is insufficient information to approve a hospital crib or enclosed bed. Documentation must include all of the following:

- Client's diagnosis, medical needs, developmental level, and functional skills
- Age, length or height, and weight of client
- Description of any other less-restrictive devices that have been used, the length of time used, and why they were ineffective
- Description of why a regular child's crib, regular bed, or standard hospital bed cannot be used
- Name of manufacturer and the manufacturer's suggested retail price (MSRP)

Accessories may include safety enclosure frame or canopy. The protective crib top may also be prior authorized based on the criteria previously listed.

Providers must use procedure codes E0300, E0328, and E0329 to bill for hospital cribs. Providers must use procedure code E0316 when requesting a safety enclosure or canopy for a hospital bed or crib. Requests must be made to the CSHCN Services Program using the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

17.3.10 Hygiene Equipment

Hygiene equipment may be noncustom DME, or may be custom DME if it is in any way customized to the individual client's needs.

Hygiene equipment should be rented if the need is for short-term use and if renting is more cost-effective. The anticipated total rental cost must be less than the purchased price. Documentation of the client's anticipated independence with the equipment is required for rental and purchase. Additionally, equipment may be authorized for clients who are nonambulatory in order to assist the parents and enhance safety in the care of clients with spina bifida, cerebral palsy, and other paralytic conditions.

The following hygiene equipment may be authorized:

- Tub rails (not wall mounted or permanently attached)
- Manual or hydraulic bathtub lifts
- Commodes or potty chairs
- Commode chair with integrated seat lift
- Commode seat lift mechanism
- Hygiene adaptations (e.g., raised toilet seats)
- Patient lifts
- Bath seats or chairs

Note: *Bath seats may be covered for clients when the medical condition indicates the need for support when bathing. Bath chairs will not be purchased for clients who are younger than 1 year of age or who weigh less than 30 pounds.*

17.3.10.1 Bath or Shower Chair

A bath or shower chair (procedure code E0240), bathtub stool or bench, or bathtub transfer bench may be considered for those clients who cannot safely utilize a regular bath tub or shower.

A bath or shower chair may be prior authorized for clients who meet the Level 1, 2, or 3 criteria.

A Level 3 custom bath or shower chair may be prior authorized only if the client does not also have any type of commode chair. The client must have a shower that is adapted for rolling equipment. Ramps will not be prior authorized for access to showers.

A custom bath or shower chair may be considered for prior authorization only if the client does not also have any type of commode chair.

Levels of Design

- A **level 1 device** may be considered if the client:
  - Is either unable to stand independently or is unstable while standing, or
  - Is unable to independently enter or exit the shower or bathtub due to limited functional use of the upper or lower extremities, and
  - Maintains the ability to ambulate short distances (with or without) assistive device), or
  - Has a condition that is defined as a short-term disability without a concomitant long-term disability (including, but not limited to postoperative status).
- A **level 2 device** may be considered if the client:
  - Has good upper body stability, and
  - Has impaired functional ambulation, including, but not limited to lower body paralysis, osteoarthritis, or
  - Is nonambulatory
  - The client must have a shower that is adapted for rolling equipment; access ramps for showers will not be considered for prior authorization.
- A **level 3 device** may be considered if the client requires:
  - Trunk and/or head or neck support, or
  - Positioning to accommodate conditions, including, but not limited to spasticity, or frequent/uncontrolled seizures.

A tub stool or bench may be considered for prior authorization for clients who meet the Level 1 criteria.

A tub transfer bench may be considered for prior authorization for clients who meet the Level 1 or 2 criteria.

A heavy-duty tub transfer bench may be considered for prior authorization for clients who meet the Level 1 or 2 criteria and who weigh more than 200 pounds.

The purchase of a bath or shower chair is limited to one every five years.

Providers may be reimbursed for procedure code E0240 using the following modifiers:

Level	Modifier
Level 1	No modifier
Level 2	TF
Level 3	TG

17.3.10.2 Authorization Requirements

Noncustom hygiene equipment must be authorized. The following documentation should be included with the authorization request for any custom and noncustom hygiene equipment:

- Client's condition, height, weight, age, and functional level
- Anticipated length of time the client will need the equipment
- Description of postural condition of the child including tone, head control, trunk control, upper extremity, and lower extremity
- Transfer status

Note: *Custom hygiene equipment must be prior authorized.*

17.3.10.3 Adaptive Feeder Seats

Adaptive feeder seats may be authorized for any condition resulting in postural insecurity, including cerebral palsy and spina bifida. Documentation of medical necessity must be submitted with the claim.

17.3.10.4 Commode Chair

The following limitations apply to commode chair and accessory procedure codes:

Procedure Code	Limitation
E0163	1 per 3 years
E0163-TG	1 per 3 years
E0165	1 per 3 years
E0165-TG	1 per 3 years
E0167	1 per 3 years
E0168	1 per 3 years
E0168-TF	1 per 3 years
E0168-TG	1 per 3 years
E0170	1 per 3 years
E0171	1 per 3 years
E0172	1 per 3 years
E0175	1 per 3 years

Prior Authorization Requirements for Level 1: Stationary Commode Chair

A stationary commode chair with fixed or removable arms may be considered for prior authorization when the client has a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

For stationary commode chairs to be considered for reimbursement, providers should use commode chair procedure codes without a modifier.

Prior Authorization Requirements for Level 2: Mobile Commode Chair

A mobile commode chair with fixed or removable arms may be considered for prior authorization when the following criteria are met:

- Client meets the criteria for a Level 1 commode chair
- Client is on a bowel program and requires a combination commode and bath chair for performing the bowel program and then bathing
- Client does not have any type of bath chair

For mobile commode chairs to be considered for reimbursement, providers should use commode chair procedure codes with modifier TF.

Prior Authorization Requirements for Level 3: Custom Commode Chair

A custom stationary or mobile commode chair with fixed or removable arms and head, neck, and/or trunk support attachments may be considered for prior authorization when the following criteria are met:

- Client meets the criteria for a Level 1 or 2 commode chair
- Client has a medical condition that results in an inability to support their head, neck, and/or trunk without assistance
- Client does not have any type of bath chair

For custom stationary commode chairs to be considered for reimbursement, providers should use commode chair procedure codes with modifier TG.

Authorization Requirements for Extra-wide and Heavy-Duty Commode Chair

An extra-wide/heavy-duty commode chair is defined as one with a width greater than or equal to 23 inches and capable of supporting a patient who weighs 300 pounds or more. The client must meet the criteria for a Level 1, 2, or 3 commode chair and weigh 300 pounds or more.

Providers should use a heavy-duty commode chair procedure code with modifier TF or TG for an extra-wide or heavy-duty commode chair. Modifier TF should be used for a mobile extra-wide heavy-duty commode chair. Modifier TG should be used for a custom extra-wide heavy-duty commode chair.

Authorization Requirements for Foot Rest

A foot rest is used to support the feet during use of the commode chair and may be considered for prior authorization when the client meets the criteria for a Level 1, 2, or 3 commode chair, and the foot rest is necessary to support contractures of the lower extremities for a client who is paraplegic or quadriplegic.

Authorization Requirements for Replacement Commode Pail or Pan

Replacement commode pails or pans may be prior authorized once per year. With documentation of medical necessity, additional quantities may be considered for prior authorization.

17.3.10.5 Commode Chair with Integrated Seat Lifts

A commode chair with an integrated seat lift mechanism for the top of the commode (procedure codes E0170 and E0171) must be prior authorized for clients who meet all of the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The commode chair with integrated seat lift must be a part of the physician's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in their home.

The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

The submitted documentation must include an assessment completed by a physician, physical or occupational therapist that includes:

- A description of the client's current level of function without the device.
- An explanation for why a nonmechanical commode elevation device, such as commode rails or elevated commode seat, will not meet the client's needs.
- Documentation identifying how the commode seat lift will improve the client's function.
- What mobility-related activities of daily living (MRADLs) the client will be able to perform with the commode chair with integrated seat lift that he or she is unable to perform without the commode seat lift and how this will increase independence.
- The client's goals for use of the commode chair with integrated seat lifts.

A commode chair with an integrated seat lift mechanism option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs.

Documentation confirming that all appropriate therapeutic modalities, such as medication and physical therapy, have been tried but have failed to enable the client to transfer from a chair to a standing position must be kept in the client's medical record.

Prior authorization will be given for only mechanical or powered commode assist devices, not both. If a client already owns one or more mechanical commode assist devices, a powered commode seat lift will not be prior authorized unless there has been a documented change in the client's condition such that the client can no longer use the mechanical equipment.

A seat lift mechanism is limited to those types which operate smoothly, can be controlled by the client, and effectively assist a patient in standing up and sitting down without other assistance. A commode seat lift operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of the CSHCN Services Program.

17.3.10.6 Commode Seat Lift Mechanism

A commode seat lift mechanism for the top of the commode (procedure code E0172) must be prior authorized for clients who meet all of the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in their home.

The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

The submitted documentation must include an assessment completed by a physician, physical or occupational therapist that includes:

- A description of the client's current level of function without the device.
- An explanation for why a nonmechanical commode elevation device, such as commode rails or elevated commode seat, will not meet the client's needs.
- Documentation identifying how the commode seat lift mechanism will improve the clients function.
- What MRADLs the client will be able to perform with the commode seat lift mechanism that he or she is unable to perform without the seat lift mechanism and how this will increase independence.
- The client's goals for use of the commode seat lift mechanism.

A commode seat lift mechanism option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs.

Documentation confirming that all appropriate therapeutic modalities, such as medication and physical therapy, have been tried but have failed to enable the client to transfer from a chair to a standing position must be kept in the client's medical record.

Prior authorization will be given for only mechanical or powered commode assist devices, not both. If a client already owns one or more mechanical toilet assist devices, a seat lift mechanism will not be prior authorized unless there has been a documented change in the client's condition such that the client can no longer use the mechanical equipment.

Seat lift mechanisms are limited to those types which operate smoothly, can be controlled by the client, and effectively assist a patient in standing up and sitting down without other assistance. A seat lift mechanism operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of the CSHCN Services Program.

17.3.11 Infusion Pumps

The CSHCN Services Program may reimburse providers for an external ambulatory infusion pump, when it is prescribed by a physician and authorized by the program. Requests must be submitted to the CSHCN Services Program using the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

17.3.12 Portable Paraffin Units

Portable paraffin units (procedure code E0235) may be authorized for clients with juvenile rheumatoid arthritis or similar conditions resulting in decreased range of motion and joint pain. Documentation of a home program developed and monitored by an OT or PT or the client's physician must be submitted with the authorization request. Only one portable paraffin unit may be authorized in a 3-year period without documentation of medical necessity for the second unit.

17.3.13 Seat Lift Mechanism

A medically necessary seat lift mechanism is one that operates smoothly, can be controlled by the client, and effectively assist the client in standing up and sitting down without other assistance.

A seat lift mechanism (procedure codes E0628 and E0629) may be prior authorized for clients who meet all of the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in their home.

The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

The submitted documentation must include an assessment completed by a physician, physical or occupational therapist that includes:

- A description of the client's current level of function without the device.
- The duration of time the client is alone during the day without assistance.
- Documentation identifying how the seat lift mechanism will improve the client's function.
- What MRADLs the client will be able to perform with the seat lift mechanism that he or she is unable to perform without the seat lift mechanism and how this will increase independence.
- The client's goals for use of the seat lift mechanism.

A seat lift mechanism option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs.

Documentation confirming that all appropriate therapeutic modalities, such as medication and physical therapy, have been tried but have failed to enable the client to transfer from a chair to a standing position must be kept in the client's medical record.

Seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and effectively assist a client in standing up and sitting down without other assistance. A seat lift mechanism operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of the CSHCN Services Program.

17.3.14 Special Needs Car Seats and Travel Restraints

The CSHCN Services Program may reimburse providers for special needs car seats and travel restraints when they are medically necessary and appropriate. Services and equipment must be authorized and must be provided by a trained provider who is certified in car seat installation.

The CSHCN Services Program reimburses providers for special-needs car seats and travel restraints using the same methodology as custom manual rehabilitative equipment.

17.3.14.1 Car Seats

All children must be transported as safely as possible. Children with breathing disorders, casts, neuromuscular deficits, or other health-care needs may need to use special needs car seats or travel restraints.

Providers supplying special-needs car seats must be CSHCN Services Program custom DME providers and must have received approved training from the manufacturer of the product requested. The comprehensive training *must* include correct use of car seats for children with special needs, and the proper installation of top tethers. Providers must demonstrate proficiency in the installation of the top tethers during this training. Installation of the top tether is essential for proper use of the car seat and is included in the reimbursement of the car seat.

Providers must keep a statement on record that is signed and dated by the child's parent or guardian and the provider stating:

- A manufacturer-trained provider has installed the top tether in the automobile in which the child will be transported.
- A manufacturer-trained provider has trained the client's parent(s) or guardian(s) in the correct use of the car seat.
- The client's parent(s) or guardian(s) has demonstrated the correct use of the car seat to a manufacturer-trained provider.

Prior Authorization Requirement for Car Seats

Requests for authorization of special-needs car seats must be submitted for medical review using procedure code E1399 (rental or purchase) and must include the following written documentation:

- Providers must include the child's weight and height (if the child weighs 40 pounds or is more than 40 inches in height, the actual height and weight must be provided).
- Providers must include a description of the child's postural condition, specifically including head and trunk control.
- Providers must include the child's expected long-term need for the car seat.
- A photocopy of the training certification of the individual installing the car seat must accompany each request for authorization to be considered for reimbursement by the CSHCN Services Program. Authorizations are not given to a provider until training is completed and the CSHCN Services Program claims contractor receives a copy of the training certificate.
- Providers must include the name of the individual installing the car seat on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) form or providers must include documentation with the form indicating that the top tether was factory installed by the vehicle's manufacturer before vehicle purchase.
- Installation of the top tether is essential for proper use of the car seat and is included in reimbursement for the car seat. Providers may not bill the CSHCN Services Program for the installation of the top tether.
- Providers must keep a statement on record that is signed and dated by the child's parent or guardian and the provider stating that a top tether was installed by a manufacturer-trained provider in the automobile used to transport the child; parent training in the correct use of the car seat was provided by a manufacturer-trained provider; and the parent demonstrated the correct use of the car seat to a manufacturer-trained provider.

The manufacturer's weight limitation should be carefully considered when fitting the child for a car seat and should allow for at least 12 months of anticipated growth.

The CSHCN Services Program considers replacement after 7 years (normal useful life) or if a car is involved in an accident. (Some manufacturers may replace car seats at no cost following an accident, if a police report from the accident is provided.)

Car seat accessories for correct positioning, available from the manufacturers, may be authorized when medically necessary. Only car seat modifications and accessories that have been crash-tested with the car seat and provided by the manufacturer of the car seat may be authorized.

17.3.14.2 Travel Restraints

The CSHCN Services Program may reimburse providers for travel restraints used in a family vehicle to restrain a child whose medical condition requires him or her to be transported in a supine position.

Requests for authorization of a travel restraint must document the medical necessity of transporting the child in a supine position.

Procedure code E0700 may be used to submit claims for travel restraints.

17.3.15 Standers, Prone or Supine

Prone or supine standers (procedure codes E0638, E0641, and E0642) may be considered for reimbursement when prescribed by a practitioner licensed to do so for clients with diagnoses such as cerebral palsy, spina bifida, paraplegia, or other conditions resulting in paralysis of both lower extremities. The medical condition must indicate the need for a standing program that must specifically be provided in the home environment. As many clients receive standing programs at school, the home standing program should coordinate with the school plan.

Standers provided by the CSHCN Services Program are for use *only* in the client's home environment. Schools and therapy providers must provide their own equipment for standing programs in settings outside the client's home. The equipment provided for home use does *not* need to be identical to the equipment used in the school setting because they have to accommodate a variety of changing postural issues, and they require more heavy-duty equipment due to increased use and wear and tear on the equipment. DME providers supplying standers *must* be enrolled in the CSHCN Services Program as custom DME providers.

17.3.15.1 Authorization Requirements

The following documentation must be included with an authorization request:

- Client's condition, functional level, height, and weight
- Frequency and amount of time of client's standing program (e.g., 45 minutes, three times daily)
- The anticipated medical benefits expected from the stander
- Name of the therapist coordinating school and home standing programs or monitoring the home standing program
- Plan for training the school and home caregivers in the correct and safe use of the equipment

17.3.16 TENS Units

When prescribed by a physician or other provider authorized to do so, a TENS unit may be authorized for rental or purchase for the management of pain. Medical review is required. Reimbursement is at Medicare-allowable rates. Replacement electrodes may be authorized as a supply item if a TENS unit was previously purchased by the CSHCN Services Program.

Documentation of a home program developed and monitored by an OT or PT or the client's physician must be submitted with the authorization request. No more than one TENS unit may be authorized in a 2-year period without documentation of medical necessity for the second unit.

Refer to: Chapter 27, "Neurostimulators and Neuromuscular Stimulators," on page 27-1.

17.3.17 Transfer Boards

Transfer boards (procedure code E0705) may be approved for any covered condition that results in paralysis or significant weakness of both lower extremities. This item *cannot* be considered for rental. Documentation of medical necessity must be submitted with the claim.

17.3.18 Travel Chairs

Travel chairs may be noncustom DME, or they may be custom DME if they are in any way customized to the individual client's needs. Travel chairs are generally lighter in weight than noncustom manual wheelchairs and are designed to be pushed with ease by attendants or caretakers rather than being self-propelled. Travel chairs have little flexibility for customization.

17.3.18.1 Prior Authorization Requirements

Travel chairs may be prior authorized using the same guidelines as manual wheelchair prior authorizations for clients who are unable to self-propel a manual wheelchair and who are not appropriate for a power wheelchair due to cognitive issues, inaccessibility of the home, types of diagnoses, or levels of physical function.

17.3.19 Wheelchairs

The CSHCN Services Program may authorize a standard manual wheelchair. All other wheelchair requests for custom manual or power wheelchair, seating system, or modification of a wheelchair must be prior authorized. The CSHCN Services Program does not reimburse providers for wheelchairs for children who are residents of nursing facilities or intermediate care facilities for persons with mental retardation (ICF-MR). Providing wheelchairs for these children is the responsibility of the facility licensed to care for them.

17.3.19.1 Wheelchair Authorization Requirements

Written requests for prior authorization and authorization of all wheelchairs must include the following two forms:

- CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

Note: *The physician's signature is only required on page 1 of the form in the Statement of Medical Necessity section. Providers must submit page 1 of the form to TMHP. Pages 2 through 5 are only required for certain DME requests. Refer to the text under the form title to determine which of these pages must be submitted in addition to page 1.*

- CSHCN Services Program Wheelchair Seating Evaluation Form.

A PT or an OT who is not employed by the DME provider must complete the evaluation and the CSHCN Services Program Wheelchair Seating Evaluation Form.

Authorization for wheelchair modifications or repairs for an existing seating system also require the wheelchair seating evaluation.

CSHCN Services Program-approved custom DME providers are required to submit these assessments with their requests for the wheelchairs. Therapists must use the CSHCN Services Program Wheelchair Seating Evaluation Form.

The initial purchase of all manual wheelchairs and wheeled mobility systems must include the wheelchair base or frame, and the following standard components, which will not be prior authorized separately:

- Complete set of standard propulsion and caster wheels, including all of the following:
  - Propulsion or caster tires of any size, made of solid rubber or plastic
  - Standard hand rims
  - Complete wheel lock assembly
  - Bearings
- Standard footrest assembly (fixed, detachable, or swing away), including standard footplates, calf rests/pads, and ratchet assembly
- Standard armrests (fixed non-adjustable or detachable non-adjustable), including standard foam or plastic arm pads
- Standard seat and back upholstery

Medically necessary non-standard components may be considered for prior authorization with documentation of medical necessity for the requested component. Such components include, but are not limited to, the following:

- Flat-free inserts
- Foam filled propulsion or caster tires
- Pneumatic propulsion or caster tires
- Non-standard hand rims (including ergonomic and contoured)
- Non-standard length footrests
- Custom footrests
- Elevating footrests
- Angle adjustable footplates

- Adjustable height fixed armrests
- Adjustable height detachable armrests
- Custom size arm pads
- Gel arm pads
- Arm troughs
- Elevating leg rests

Each power motorized device must include all of the following basic components that may not be prior authorized separately:

- Lap belt or safety belt (This does not include multiple-attachment-point positioning belts or padded belts.)
- Battery charger, single mode
- Batteries (initial)
- Complete set of tires and casters, any type
- Leg rests
- Foot rests or foot platform
- Arm rests
- Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by client weight capacity
- Controller and input device

Wheelchairs, components, and accessories must be billed using the most appropriate procedure code that describes the item.

17.3.19.2 Manual Wheelchairs

Manual wheelchairs may be noncustom DME, or they may be custom DME if they are modified or in any way customized to the individual client's needs.

The CSHCN Services Program may reimburse providers for a manual wheelchair when the equipment is medically necessary. The physician or therapist is responsible for maintaining documentation indicating nonfunctional ambulation, situations where ambulation is contraindicated, or when ambulation is not adequate for independently accessing the community. Conditions that may debilitate a client to the point that ambulation would be detrimental to the client's health (e.g., cancer, cystic fibrosis, cardiac conditions, etc.) may also be considered.

Eligible clients may receive a manual wheelchair in addition to a power wheelchair or travel chair. The manual chair is purchased as a backup; therefore, cost and accessories should be minimal. Aside from having a manual wheelchair backup for a power wheelchair, the CSHCN Services Program does not authorize purchase of more than one form of mobility equipment per eligible client.

No more than one manual wheelchair may be authorized in a 3-year period without documentation of medical necessity for a second or replacement wheelchair. If the wheelchair is stolen or damaged in an accident before it is scheduled to be replaced, a police report must be submitted with the authorization request form to justify replacing it.

Rental must be considered for short-term needs when the total rental cost is expected to be less than the purchase price. If public funds were used to pay for a wheelchair within the last 3 years, specific justification is required to prior authorize a new chair.

If an immediate need for a wheelchair is indicated in the CSHCN Services Program Wheelchair Seating Evaluation Form and the CSHCN Services Program has approved a wheelchair, DME providers are required to provide a loaner wheelchair free of charge until the approved equipment is delivered to the client.

17.3.19.3 Custom Manual Wheelchairs

When any custom wheelchair or seating system is requested, the CSHCN Services Program requires an assessment utilizing the CSHCN Services Program Wheelchair Seating Evaluation Form to be submitted by a PT or OT not employed by a DME provider. Assessments are also required when an existing seating system is being modified. CSHCN Services Program-approved custom DME providers are required to submit these forms with their requests for prior authorization.

Requests for customized manual wheelchairs must include a complete description of the specific base, any attached seating system components, and any attached accessories not included in the base price. Requests must also include the MSRPs for the individual components, including justification for components that would be considered part of the wheelchair. The CSHCN Services Program requires that the manufacturers' price sheets be submitted along with price quotes at the time of submission for authorization. If a price change occurs after the authorization has been granted, the provider must submit new price sheets with the claim to document the price changes so that the price discrepancy between the authorization and the claim can be manually reviewed.

17.3.19.4 Power Wheelchairs

Model-specific power wheelchairs, including three-wheelers and scooters, must be prior authorized. Eligible children may receive, or already have, a manual wheelchair or travel chair in addition to the power wheelchair. No more than one electric wheelchair may be authorized in a 5-year period without documentation of medical necessity for a second or replacement wheelchair. If public funds were used for payment of a power wheelchair within the last 5 years, medical justification is required to give authorization for a new power wheelchair. If the wheelchair is stolen or damaged in an accident before it is scheduled to be replaced, a police report must be submitted with the authorization request form to justify replacing the equipment.

Requests for customized power wheelchairs must include a complete description of the specific base, any attached seating system components, and any attached accessories not included in the base price. Requests must also include the MSRPs for the individual components, including justification for components that would be considered part of the wheelchair. The CSHCN Services Program requires that the manufacturers' price sheets be submitted along with price quotes at the time of submission for authorization. If a price change occurs after the authorization has been granted, the provider must submit new price sheets with the claim to document the price changes so that the price discrepancy between the authorization and the claim can be manually reviewed.

17.3.19.5 Approval Criteria for Power Wheelchairs

Written requests for prior authorization of power wheelchairs should be submitted on a CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form. A CSHCN Services Program Wheelchair Seating Evaluation Form completed by an OT or PT not employed by the DME provider requesting the equipment modification must be submitted with the authorization request.

Note: *The physician's signature is only required on page 1 of the form in the Statement of Medical Necessity section. Providers must submit page 1 of the form to TMHP. Pages 2 through 5 are only required for certain DME requests. Refer to the text under the form title to determine which of these pages must be submitted in addition to page 1.*

Age

Power wheelchairs can be approved for clients who are 18 months to 21 years of age (the normally developing child begins to walk and explore between 18 months to 2 years of age). The CSHCN Services Program supports providing power wheelchairs to match normal developmental milestones.

Level of Physical Function

The child must have control of some body part to operate a power wheelchair. The child's level of function must be defined by one of the following:

- The child is unable to self-propel a manual wheelchair, even if adapted
- Self-propulsion is possible, but activity is extremely labored leaving the child exhausted at the necessary destination, such as classroom or school bathroom

- Self-propulsion is possible, but contrary to treatment regimen. Examples include joint protection, energy conservation, and preservation of cardiovascular or respiratory function

Cognitive Level

The child must be able to receive and follow directions related to driving or controlling the wheelchair in a safe manner.

The client's level of judgment and impulse control must be such that the wheelchair will be used appropriately with minimal risk of either accidental or intentional injury to self or others.

Environmental Assessment

The therapist assessing the client is required to ask pertinent questions found on the CSHCN Services Program Wheelchair Seating Evaluation Form to ensure safe use and selection of the appropriate power wheelchair that will best serve the client.

17.3.19.6 Wheelchair Battery

A battery charger and initial batteries are included as part of the purchase price of a power wheelchair.

Replacement batteries and/or a replacement battery charger for a power wheelchair require prior authorization. The provider must submit the date of purchase and serial number of the client's currently owned wheelchair as well as the reason for the replacement batteries and/or the replacement battery charger. Documentation must include why the batteries and or battery charger no longer meets the client's needs.

17.3.19.7 Wheelchair Positioning Equipment

Wheelchair positioning equipment includes, but is not limited to, tilt-in-space options, solid backs and seats, abductors, cushions, and footrests. The equipment may be authorized based on the individual client's seating or positioning needs as detailed in the CSHCN Services Program Wheelchair Seating Evaluation Form.

17.3.19.8 Wheelchair Power Elevating Leg Lifts

Power elevating leg lifts (procedure code E1010) may be prior authorized for clients who have compromised upper extremity function that limits the client's ability to use manual elevating leg rests. The client must meet criteria for a power wheelchair with a reclining back and one of the following:

- A musculoskeletal condition such as flexion contractures of the knees and legs or the placement of a cast or brace that prevents 90 degree flexion at the knee
- Significant edema of the lower extremities that requires having an elevating leg rest
- Hypotensive episodes that require frequent positioning changes
- Required to maintain anatomically correct positioning and reduce exposure to skin shear in clients needing power tilt and recline

The submitted documentation must include an assessment completed by a physician, physical, or occupational therapist that includes:

- A description of the client's current level of function without the device.
- Documentation identifying how the power elevating leg lifts will improve the client's function.
- What MRADLs the client will be able to perform with the power elevating leg lifts that he or she is unable to perform without the seat lift mechanism and how this will increase independence.
- The client's goals for use of the power elevating leg lifts.
- A power elevating leg lifts option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs.

17.3.19.9 Wheelchair Power Seat Elevation System

Use of a power seat elevation system will:

- Facilitate independent transfers, particularly uphill transfers, to and from the wheelchair with less upper arm strain.
- Augment the client's reach to facilitate independent performance of MRADLs in the home, school, or community.

A power seat elevation system may be prior authorized to promote independence in a client who meets both of these criteria:

- Does not have the ability to stand and pivot transfer independently.
- Has limited reach or range of motion in the shoulder or hand that prohibits independent performance of MRADLs, (such as bathing, dressing, feeding, grooming, hygiene, meal preparation, and toileting).

The submitted documentation must include an assessment completed by a physician, physical, or occupational therapist that includes:

- A description of the client's current level of function without the device.
- The duration of time the client is alone during the day without assistance.
- Documentation identifying how the seat lift will improve the client's function.
- What MRADLs the client will be able to perform with the seat lift that he or she is unable to perform without the commode seat lift and how this will increase independence.
- The client's goals for use of the power seat elevation system.

A power seat elevation system option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs and transfers.

17.3.20 Portable Wheelchair Ramps

Providers must submit documentation of medical necessity with the request for authorization form. The CSHCN Services Program may authorize and reimburse portable or threshold ramps only. A portable ramp is defined as a ramp that is not physically attached to the dwelling, that may be moved (disassembly may be required, such as in the case of a modular ramp), and that meets the standards as set by the *Americans with Disabilities Act*.

Portable wheelchair ramps that allow access to the client's home may be authorized if the need is documented. The CSHCN Services Program may approve requests for ramps to allow access to two entrances to the client's home. Once two accessible entrances are provided, the client or family is not expected to require another ramp or a replacement ramp. Requests for a replacement ramp require medical review and documentation of need, including an explanation of what happened to the previous ramp.

The ramp is expected to go with the client if he or she changes residential locations. The CSHCN Services Program does *not* replace portable ramps due to a client's relocation. Ramps may need to be modified to fit a different dwelling if the client moves. The CSHCN Services Program considers the required modifications for reimbursement rather than the purchase of a replacement ramp.

17.3.21 Noncovered Rehabilitative and Therapeutic DME

Noncovered rehabilitative and therapeutic DME includes, but is not limited to:

- Adaptive furniture, bolsters, and wedges.
- Corner chairs and floor sitters.
- Creepers.
- Home modifications, including ramps (except portable ramps for wheelchairs).
- Hydrocollators.
- Parallel bars.

- Powered equipment, including ceiling or track lifts (except powered wheelchairs and electric beds).
- Pressure relief beds.
- Vehicle modifications.
- Vocational, educational, and recreational equipment, even when adapted.

Other miscellaneous DME may be authorized based on review of documentation of medical necessity. This documentation must be submitted with the authorization request form.

17.3.22 Repairs and Modifications

The term *repair* is used to describe replacing existing parts or accessories. The term *modification* is used to describe adding or changing parts or accessories. If the item was purchased by the program or through another source, and is a CSHCN Services Program-approved item (e.g., hospital bed, stander, or wheelchair), the item may be authorized. All manufacturers' warranties must be upheld. Providers must submit the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form for repairs or modifications.

Powered equipment (electronics) may be repaired only by DME vendors who are authorized by the specific manufacturer to repair electronics.

Authorization requests for wheelchair repairs or modifications for an existing seat system must be submitted with an assessment and completed CSHCN Services Program Wheelchair Seating Evaluation Form.

For repairs to be considered for reimbursement, repairing the equipment must be more cost-effective than purchasing a new piece of equipment. For the repairs to be authorized, the age of the current equipment must be considered, including the amount of time that remains before the equipment may be replaced (e.g., every 3 years for a manual wheelchair and every 5 years for a power wheelchair). Providers must use procedure code K0739 when requesting authorization and submitting a claim for reimbursement of repairs.

17.4 Documentation of Receipt

When the equipment is delivered, providers must complete the CSHCN Services Program Documentation of Receipt form. The documentation of receipt form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver.

The documentation of receipt form is available in both English and Spanish.

Providers must retain individual delivery slips or invoices for each DOS that document the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. Documentation of delivery must include one of the following:

- Delivery slip or invoice signed and dated by client or caregiver. The delivery slip or invoice must contain the client's full name and address to which the supplies were delivered, the item description, and the numerical quantities that were delivered to the client.
- A dated carrier tracking document with shipping date and delivery date. The dated carrier tracking document must be attached to the delivery slip or invoice. The dated delivery slip or invoice must include an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client. This document could also include prices, shipping weights, shipping charges, and any other description.

Providers must maintain a copy of this form in their files for the life of the piece of equipment or until the equipment is authorized for replacement.

The CSHCN Services Program does not reimburse providers separately for shipping and handling or freight charges, except when power equipment must be sent to a location other than to the vendor for repair.

17.5 Rental of Equipment

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

17.6 Claims Information

Modifier RR must be used for DME rental equipment, and modifier NU must be used for the purchase of new DME equipment. Home health DME providers must use the DM3 benefit code when submitting claims and authorization requests.

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

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

Note: *The CSHCN Services Program reimburses prior authorized custom DME even if the client is no longer eligible to receive services when the equipment is delivered. Claims must be submitted with a valid authorization number for the custom DME procedure code.*

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

The provider must submit the delivery date as the date of service along with the appropriate procedure codes when requesting authorization and when submitting claims.

The CSHCN Services Program requires that manufacturers' price sheets be submitted along with price quotes at the time of submission for authorization. If a price change occurs after authorization, the provider must submit new price sheets with the claim to document the price changes so the price discrepancy between the authorization and claim can be manually reviewed.

All claims and authorization requests submitted by CSHCN Services Program home health DME providers must be submitted with benefit code DM3.

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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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.

17.7 Reimbursement

Items or services addressed in this chapter are reimbursed by the lessor or one of the following:

- The provider's billed charges.
- A maximum fee determined by CSHCN.
- Manual pricing based on the retail price minus a discount as determined by CSHCN.

Note: *Manual pricing is based on the manufacturer's suggested retail price (MSRP) less 18 percent or average wholesale price (AWP) less 10.5 percent whichever is applicable or the provider's documented invoice cost. The MSRP, AWP, or the documented invoice cost must be submitted with the appropriate procedure code to be considered for reimbursement.*

- *Noncustomized.* The lessor of the billed amount or the maximum fee allowed by the CSHCN Services Program.
- *Customized, nonpowered equipment (e.g., manual wheelchairs)*. The lower of the billed amount or the MSRP less 18 percent.
- *Power wheelchairs.* The lower of the billed amount or the MSRP less 18 percent.
- *Other.* When no MSRP is published, the lower of the billed amount or the dealer's cost plus 25 percent.
- *Delayed delivery penalty.* A claim submitted for customized DME delivered to the client more than 75 days after the authorization date shall be reduced by 10 percent.
- *Repairs and modifications.* Providers may be reimbursed for repairs and modifications at the MSRP of the part minus 18 percent, plus labor time for all equipment or wheelchairs including standard or custom and powered or nonpowered. Actual shipping costs may be reimbursed if the component is serviced at a regional center. Replacement versus repair costs must be considered.
- *Replacement batteries and/or replacement battery chargers*. Replacement batteries and/or replacement battery chargers may be considered for reimbursement if no longer under warranty. Batteries and battery chargers will not be considered for replacement within the first six months of delivery to the client. Batteries and battery chargers within the six months after delivery are considered part of the purchase price. A maximum of one hour of labor may be prior authorized to install new batteries. Labor will not be prior authorized for a new power wheelchair or for replacement battery chargers.
- *Battery disposal fees, taxes, and other associated DME charges*. The CSHCN Services Program does not reimburse providers separately for associated DME charges including, but not limited to, battery disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment.

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

Important: *The provider must agree to accept the CSHCN Services Programs reimbursement as payment in full.*

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.*

17.8 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-925-9126 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.

Chapter

18

Expendable Medical Supplies

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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2for 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. 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.

Expendable is defined as being intended for single or short-term use before being discarded. Most supplies are not reusable and will be discarded after use. 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 with documentation of medical necessity that supports additional quantities greater than maximum limitations listed in the tables below for a client with exceptional needs. The following tables provide listings of these supplies and limitation amounts.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about authorization requirements.

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	2 per month	A4322	4 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	A4365	1 per month	A4367	As needed
A4368	As needed	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	A4397	As needed
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
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

*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.

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
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 (must include Modifier U1)	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	T4541	120 per month
T4542	120 per month	T4543	Limited per policy*	T4544	Limited per policy*

*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.

Note: *For purposes of this policy, bariatric size (procedure code 9-T4528 with modifier U1) is defined as adult size 2XL or larger.*

Wound Care Supplies

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
A4213	As needed	A4216	As needed	A4217	As needed
A4244	1 per month	A4246	1 per month	A4247	1 per month
A4248	As needed	A4305	As needed	A4306	As needed
A4331	50 per month	A4332	2 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	A4452	20 per month
A4455	4 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	A6200	As needed	A6201	As needed
A6202	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

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
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	As needed	A6259	As needed
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
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	1 per 3 years

18.2.1 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," on page 15-1 for more detailed information.

Chapter 17, "Durable Medical Equipment (DME)," on page 17-1 for more detailed information.

Chapter 35, "Respiratory Equipment and Supplies," on page 35-1 for more detailed information.

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

18.2.2 Diapers, Briefs, Pull-ups, and Liners

Authorization is not required for diapers, pull-ups, briefs, and liners in any combination up to 240 items per month and may be covered if the client's diagnosis is included in the table below. Clients must be 4 years of age or older and be incontinent as a direct complication of a medical condition.

Prior authorization must be obtained for clients with diagnoses not listed in the following table or for supplies over the 240 limitation.

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

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Diapers, Pull-ups, Briefs, or Liners Form and Instructions.

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV)
138	Late effects of acute poliomyelitis
1880	Malignant neoplasm of trigone of urinary bladder
1881	Malignant neoplasm of dome of urinary bladder
1882	Malignant neoplasm of lateral wall of urinary bladder
1883	Malignant neoplasm of anterior wall of urinary bladder
1884	Malignant neoplasm of posterior wall of urinary bladder
1885	Malignant neoplasm of bladder neck
1886	Malignant neoplasm of ureteric orifice
1887	Malignant neoplasm of urachus
1888	Malignant neoplasm of other specified sites of bladder
1889	Malignant neoplasm of bladder, part unspecified
1890	Malignant neoplasm of kidney, except pelvis
1891	Malignant neoplasm of renal pelvis
1892	Malignant neoplasm of ureter
1893	Malignant neoplasm of urethra
1894	Malignant neoplasm of paraurethral glands
1898	Malignant neoplasm of other specified sites of urinary organs
1899	Malignant neoplasm of urinary organ, site unspecified
1910	Malignant neoplasm of cerebrum, except lobes and ventricles
1911	Malignant neoplasm of frontal lobe of brain
1912	Malignant neoplasm of temporal lobe of brain
1913	Malignant neoplasm of parietal lobe of brain
1914	Malignant neoplasm of occipital lobe of brain
1915	Malignant neoplasm of ventricles of brain
1916	Malignant neoplasm of cerebellum NOS
1917	Malignant neoplasm of brain stem
1918	Malignant neoplasm of other parts of brain
1919	Malignant neoplasm of brain, unspecified site
1920	Malignant neoplasm of cranial nerves
1921	Malignant neoplasm of cerebral meninges
1922	Malignant neoplasm of spinal cord
1923	Malignant neoplasm of spinal meninges
1928	Malignant neoplasm of other specified sites of nervous system
1929	Malignant neoplasm of nervous system, part unspecified
20917	Malignant carcinoid tumor of the rectum
2250	Benign neoplasm of brain

Diagnosis Code	Description
2251	Benign neoplasm of cranial nerves
2252	Benign neoplasm of cerebral meninges
2253	Benign neoplasm of spinal cord
2254	Benign neoplasm of spinal meninges
2258	Benign neoplasm of other specified sites of nervous system
2259	Benign neoplasm of nervous system, part unspecified
23770	Neurofibromatosis, unspecified
2552	Adrenogenital disorders
3313	Communicating hydrocephalus
3314	Obstructive hydrocephalus
3332	Myoclonus
33371	Athetoid cerebral palsy
33379	Other acquired torsion dystonia
3360	Syringomyelia and syringobulbia
3430	Diplegic infantile cerebral palsy
3431	Hemiplegic infantile cerebral palsy
3432	Quadriplegic infantile cerebral palsy
3433	Monoplegic infantile cerebral palsy
3434	Infantile hemiplegia
3438	Other specified infantile cerebral palsy
3439	Unspecified infantile cerebral palsy
3441	Paraplegia
34461	Cauda equina syndrome with neurogenic bladder
34481	Locked-in state
34489	Other specified paralytic syndrome
34500	Generalized nonconvulsive epilepsy without mention of intractable epilepsy
34501	Generalized nonconvulsive epilepsy, with intractable epilepsy
34510	Generalized convulsive epilepsy without mention of intractable epilepsy
34511	Generalized convulsive epilepsy with intractable epilepsy
3452	Epileptic petit mal status
3453	Epileptic grand mal status
34540	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial epilepsy, without mention of intractable epilepsy
34541	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial epilepsy, with intractable epilepsy
34550	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy
34551	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy
34560	Infantile spasms without mention of intractable epilepsy
34561	Infantile spasms with intractable epilepsy
34570	Epilepsia partialis continua without mention of intractable epilepsy

Diagnosis Code	Description
34571	Epilepsia partialis continua with intractable epilepsy
34580	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy
34581	Other forms of epilepsy and recurrent seizures, with intractable epilepsy
34590	Unspecified epilepsy without mention of intractable epilepsy
34591	Unspecified epilepsy with intractable epilepsy
3590	Congenital hereditary muscular dystrophy
3591	Hereditary progressive muscular dystrophy
436	Acute, but ill-defined, cerebrovascular disease
43820	Hemiplegia affecting unspecified side due to cerebrovascular disease
43821	Hemiplegia affecting dominant side due to cerebrovascular disease
43822	Hemiplegia affecting nondominant side due to cerebrovascular disease
43830	Monoplegia of upper limb affecting unspecified side due to cerebrovascular disease
43831	Monoplegia of upper limb affecting dominant side due to cerebrovascular disease
43832	Monoplegia of upper limb affecting nondominant side due to cerebrovascular disease
43840	Monoplegia of lower limb affecting unspecified side due to cerebrovascular disease
43841	Monoplegia of lower limb affecting dominant side due to cerebrovascular disease
43842	Monoplegia of lower limb affecting nondominant side due to cerebrovascular disease
43850	Other paralytic syndrome affecting unspecified side due to cerebrovascular disease
43851	Other paralytic syndrome affecting dominant side due to cerebrovascular disease
43852	Other paralytic syndrome affecting nondominant side due to cerebrovascular disease
43853	Other paralytic syndrome, bilateral
43881	Apraxia due to cerebrovascular disease
43882	Dysphagia due to cerebrovascular disease
43889	Other late effects of cerebrovascular disease
4389	Unspecified late effects of cerebrovascular disease due to cerebrovascular disease
591	Hydronephrosis
59800	Urethral structure due to unspecified infection
59801	Urethral structure due to infective diseases classified elsewhere
5981	Traumatic urethral stricture
5982	Postoperative urethral stricture
5988	Other specified causes of urethral stricture
5989	Unspecified urethral stricture
5991	Urethral fistula

Diagnosis Code	Description
74100	Spina bifida with hydrocephalus, unspecified region
74101	Spina bifidax with hydrocephalus, cervical region
74102	Spina bifida with hydrocephalus, dorsal (thoracic) region
74103	Spina bifida with hydrocephalus, lumbar region
74190	Spina bifida without mention of hydrocephalus, unspecified region
7420	Encephalocele
7422	Congenital reduction deformities of brain
7423	Congenital hydrocephalus
7424	Other specified congenital anomalies of brain
74251	Diastematomyelia
74253	Hydromyelia
74259	Other specified congenital anomaly of spinal cord
7511	Congenital atresia and stenosis of small intestine
7512	Congenital atresia and stenosis of large intestine, rectum, and anal canal
7513	Hirschsprung's disease and other congenital functional disorders of colon
7514	Congenital anomalies of intestinal fixation
7515	Other congenital anomalies of intestine
75320	Unspecified obstructive defect of renal pelvis and ureter
75321	Congenital obstruction of ureteropelvic junction
75322	Congenital obstruction of ureterovesical junction
75323	Congenital ureterocele
75329	Other obstructive defect of renal pelvis and ureter
7533	Other specified anomalies of kidney
7534	Other specified anomalies of ureter
7535	Exstrophy of urinary bladder
7536	Congenital atresia and stenosis of urethra and bladder neck
7537	Congenital anomalies of urachus
7538	Other specified congenital anomaly of bladder and urethra
75670	Unspecified congenital anomaly of abdominal wall
75671	Prune belly syndrome
75679	Other congenital anomalies of abdominal wall
7674	Injury to spine and spinal cord, birth trauma
78072	Functional quadriplegia
78899	Other symptoms involving urinary systems
80500	Closed fracture of cervical vertebra, unspecified level without mention of spinal cord injury
80501	Closed fracture of first cervical vertebra without mention of spinal cord injury
80502	Closed fracture of second cervical vertebra without mention of spinal cord injury
80503	Closed fracture of third cervical vertebra without mention of spinal cord injury
80504	Closed fracture of fourth cervical vertebra without mention of spinal cord injury

Diagnosis Code	Description
80505	Closed fracture of fifth cervical vertebra without mention of spinal cord injury
80506	Closed fracture of sixth cervical vertebra without mention of spinal cord injury
80507	Closed fracture of seventh cervical vertebra without mention of spinal cord injury
80508	Closed fracture of multiple cervical vertebrae without mention of spinal cord injury
80510	Open fracture of cervical vertebra, unspecified level without mention of spinal cord injury
80511	Open fracture of first cervical vertebra without mention of spinal cord injury
80512	Open fracture of second cervical vertebra without mention of spinal cord injury
80513	Open fracture of third cervical vertebra without mention of spinal cord injury
80514	Open fracture of fourth cervical vertebra without mention of spinal cord injury
80515	Open fracture of fifth cervical vertebra without mention of spinal cord injury
80516	Open fracture of sixth cervical vertebra without mention of spinal cord injury
80517	Open fracture of seventh cervical vertebra without mention of spinal cord injury
80518	Open fracture of multiple cervical vertebrae without mention of spinal cord injury
8052	Closed fracture of dorsal (thoracic) vertebra without mention of spinal cord injury
8053	Open fracture of dorsal (thoracic) vertebra without mention of spinal cord injury
8054	Closed fracture of lumbar vertebra without mention of spinal cord injury
8055	Open fracture of lumbar vertebra without mention of spinal cord injury
8056	Closed fracture of sacrum and coccyx without mention of spinal cord injury
8057	Open fracture of sacrum and coccyx without mention of spinal cord injury
8058	Closed fracture of unspecified part of vertebral column without mention of spinal cord injury
8059	Open fracture of unspecified part of vertebral column without mention of spinal cord injury
80600	Closed fracture of C1-C4 level with unspecified spinal cord injury
80601	Closed fracture of C1-C4 level with complete lesion of cord
80602	Closed fracture of C1-C4 level with anterior cord syndrome
80603	Closed fracture of C1-C4 level with central cord syndrome
80604	Closed fracture of C1-C4 level with other specified spinal cord injury
80605	Closed fracture of C5-C7 level with unspecified spinal cord injury
80606	Closed fracture of C5-C7 level with complete lesion of cord
80607	Closed fracture of C5-C7 level with anterior cord syndrome
80608	Closed fracture of C5-C7 level with central cord syndrome
80609	Closed fracture of C5-C7 level with other specified spinal cord injury
80610	Open fracture of C1-C4 level with unspecified spinal cord injury
80611	Open fracture of C1-C4 level with complete lesion of cord
80612	Open fracture of C1-C4 level with anterior cord syndrome

Diagnosis Code	Description
80613	Open fracture of C1-C4 level with central cord syndrome
80614	Open fracture of C1-C4 level with other specified spinal cord injury
80615	Open fracture of C5-C7 level with unspecified spinal cord injury
80616	Open fracture of C5-C7 level with complete lesion of cord
80617	Open fracture of C5-C7 level with anterior cord syndrome
80618	Open fracture of C5-C7 level with central cord syndrome
80619	Open fracture of C5-C7 level with other specified spinal cord injury
80620	Closed fracture of T1-T6 level with unspecified spinal cord injury
80621	Closed fracture of T1-T6 level with complete lesion of cord
80622	Closed fracture of T1-T6 level with anterior cord syndrome
80623	Closed fracture of T1-T6 level with central cord syndrome
80624	Closed fracture of T1-T6 level with other specified spinal cord injury
80625	Closed fracture of T7-T12 level with unspecified spinal cord injury
80626	Closed fracture of T7-T12 level with complete lesion of cord
80627	Closed fracture of T7-T12 level with anterior cord syndrome
80628	Closed fracture of T7-T12 level with central cord syndrome
80629	Closed fracture of T7-T12 level with other specified spinal cord injury
80630	Open fracture of T1-T6 level with unspecified spinal cord injury
80631	Open fracture of T1-T6 level with complete lesion of cord
80632	Open fracture of T1-T6 level with anterior cord syndrome
80633	Open fracture of T1-T6 level with central cord syndrome
80634	Open fracture of T1-T6 level with other specified spinal cord injury
80635	Open fracture of T7-T12 level with unspecified spinal cord injury
80636	Open fracture of T7-T12 level with complete lesion of cord
80637	Open fracture of T7-T12 level with anterior cord syndrome
80638	Open fracture of T7-T12 level with central cord syndrome
80639	Open fracture of T7-T12 level with other specified spinal cord injury
8064	Closed fracture of lumbar spine with spinal cord injury
8065	Open fracture of lumbar spine with spinal cord injury
95200	C1-C4 level spinal cord injury, unspecified
95201	C1-C4 level with complete lesion of spinal cord
95202	C1-C4 level with anterior cord syndrome
95203	C1-C4 level with central cord syndrome
95204	C1-C4 level with other specified spinal cord injury
95205	C5-C7 level spinal cord injury, unspecified
95206	C5-C7 level with complete lesion of spinal cord
95207	C5-C7 level with anterior cord syndrome
95208	C5-C7 level with central cord syndrome
95209	C5-C7 level with other specified spinal cord injury
95210	T1-T6 level spinal cord injury, unspecified
95211	T1-T6 level with complete lesion of spinal cord

Diagnosis Code	Description
95212	T1-T6 level with anterior cord syndrome
95213	T1-T6 level with central cord syndrome
95214	T1-T6 level with other specified spinal cord injury
95215	T7-T12 level spinal cord injury, unspecified
95216	T7-T12 level with complete lesion of spinal cord
95217	T7-T12 level with anterior cord syndrome
95218	T7-T12 level with central cord syndrome
95219	T7-T12 level with other specified spinal cord injury

18.2.2.1 Gastrostomy Devices

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

Authorization Requirements

Authorization is required. Documentation supporting medical necessity including, but not limited to, the presence of a gastrostomy (diagnosis code V441) must be submitted on the claim.

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

Procedure Codes				
B4034	B4035	B4036	B4081	B4082
B4083	B4087	B4088		

Procedure code B4035 is limited to a maximum of 31 per month by any provider. 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.

Procedure codes B4087 and B4088 are limited to two per rolling year.

Refer to: Section 4.2, "Authorizations," on page 4-3 for detailed information about authorization requirements.

CSHCN Services Program Prior Authorization Request for Diapers, Pull-ups, Briefs, or Liners Form and Instructions.

Nonobturated Gastrostomy Devices

Nonobturated gastrostomy kits may be reimbursed to physicians, pharmacies, medical suppliers, and home health DME providers. Two devices are considered for reimbursement per year, per client. Additional devices may be considered for reimbursement if the documentation submitted with the claim indicates medical necessity (e.g., failure of the device or infection at the gastrostomy site).

Obturated Gastrostomy Devices

Obturated gastrostomy devices may be reimbursed only to physicians. Two devices may be considered for reimbursement per year, per client.

Refer to: Section 31.2.21, "Gastrostomy Devices," on page 31-69 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 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.

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.*

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.

Chapter

19

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

19.1 Enrollment

Rural health clinics (RHCs), federally qualified health centers (FQHCs), federally qualified look-alikes (FQL), federally qualified satellites (FQS) and rural health clinics can enroll as providers for the Children with Special Health Care Needs (CSHCN) Services Program.

To enroll in the CSHCN Services Program, FQHC and RHC providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the TMHP-CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements.

Out-of-state FQHC and RHC providers must meet all these conditions and be located in the United States within 50 miles of the Texas state border.

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

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

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 25 TAC §38.6(b)(1).

Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1,"Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program enrollment procedures.

19.2 Benefits, Limitations and Authorization Requirements

19.2.1 General Medical Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC providers and billed with a general services modifier:

General Medical Services						
T1015	99381	99382	99383	99384	99385	99386
99387	99391	99392	99393	99394	99395	99396
99397						
General medical services must be billed submitted using one of the appropriate modifiers: AH, AJ, AM, SA, TD, TE, or U7.						

The general medical services modifiers are defined as follows

Modifier	Services Performed
AH	Services Performed By Psychologist
AJ	Services Performed By Social Worker

Modifier	Services Performed
AM	Services Performed By Physician, Team Member Services
SA	Services Performed By Nurse Practitioner In Collaboration With Physician
TD	Services Performed By Registered Nurse
TE	Services Performed By Lpn Or Lvn
U7	Services Performed By Physician Assistant Other Than For Assisant At Surgery

All services provided during an RHC encounter must be submitted using procedure code T1015. The total submitted amount should be the combined charges for all services provided during that encounter.

One of the following modifiers must be reported with procedure code T1015 to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, or U7.

19.2.2 Preventive Care Medical Checkups

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC providers and billed with a general services modifier:

Preventative Care Medical Checkups						
99385	99386	99387	99395	99396	99397	99381
99382	99383	99384	99395	99391		

Refer to: Section 19.2.1,"General Medical Services," on page 19-2 for the list of general medical services modifiers.

Adult preventive care must be billed with diagnosis code V700. Pediatric preventive care must be billed with diagnosis code V202. The provider cannot submit modifier EP for pediatric services.

19.2.3 Behavioral Health Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC or RHC providers are billed with a general services modifier:

Behavioral Health Services				
90847	90853	90865	96101	96118
* The procedure codes indicated by an asterisk (*) are medical examinations and will not be reimbursed to psychologist providers.				

Mental health services must be billed using one of the appropriate general services modifiers as listed and defined below:

Modifier	Services performed
AH	Services performed by psychologist
AJ	Services performed by social worker
AM	Services performed by physician, team member services
U1	Services performed by licensed professional counselor
U2	Services performed by licensed marriage and family therapist
U7	Services performed by physician assistant other than for assistant at surgery

19.2.4 Dental Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC or RHC providers:

Procedure Codes						
D0120	D0140	D0145	D0150	D0160	D0170	D0180
D0330	D0340	D0350	D0470	D1110	D1120	D1206
D1351	D1510	D1515	D1520	D1525	D1555	D2140
D2150	D2160	D2161	D2330	D2331	D2332	D2335
D2390	D2391	D2392	D2393	D2394	D2750	D2751
D2791	D2792	D2930	D2931	D2932	D2933	D2934
D2940	D2950	D2954	D2971	D3220	D3230	D3240
D3310	D3320	D3330	D3346	D3347	D3348	D3351
D3352	D3353	D4341	D4355	D5211	D5212	D5281
D5610	D5630	D5640	D5650	D5660	D5670	D5671
D5720	D5721	D5740	D5741	D5760	D5761	D6549
D7140	D7210	D7220	D7230	D7250	D7270	D7286
D7510	D7550	D7910	D7970	D7971	D7997	D7999
D8050	D8060	D8080	D8210	D8220	D8660	D8670
D8680	D8690	D9110	D9211	D9212	D9215	D9230
D9248	D9330	D9974	D9999			

Procedure codes D8210, D8220, and D8080 must be billed with the appropriate Diagnostic Procedure Code (DPC) remarks codes for correct claims processing:

Procedure Codes						
1000D	1001D	1002D	1003D	1004D	1005D	1006D
1007D	1008D	1010D	1011D	1012D	1013D	1014D
1015D	1016D	1017D	1018D	1019D	1020D	1021D
1022D	1023D	1024D	1025D	1026D	1027D	1028D
1029D	1030D	1031D	1032D	1045D	1046D	1047D
1048D	1049D	1050D	1051D	1052D	1053D	1054D
1055D	1056D	1057D	1058D	1059D	1060D	1061D
1062D	1063D	1064D	1065D	1066D	1067D	1068D
1069D	1070D	1071D	1072D	1073D	1074D	1075D
1076D	1077D	1078D	Z2009	Z2011	Z2012	

19.2.5 Vision Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC or RHC providers:

Procedure Codes						
92002	92004	92012	92014	92015	92020	92025
92060	92065	92081	92082	92083	92100	92140
92225	92226	92230	92235	92240	92250	92260

Procedure Codes						
92265	92270	92275	92285	92286	92287	95930
95933	S0620	S0621				

19.3 Claims Filing

All services require documentation to support the medical necessity of the service rendered. All services provided are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

FQHC and RHC services must be submitted to TMHP in an approved electronic format or on the following paper claim forms:

For FQHC:

Services	Claim Form
Medical services	UB-04 CMS-1450 or CMS-1500 paper claim form
Dental services	American Dental Association (ADA) Dental Claim Form

For RHC:

Services	Claim Form
Medical services	UB-04 CMS-1450 paper claim form

When completing a paper claim form, the provider must include all required information on the claim because information is not keyed from attachments. Super bills or itemized statements are not accepted as claim supplements.

19.4 Reimbursement

CSHCN FQHCs are reimbursed the lower of the billed amount or the Texas Medicaid provider-specific prospective payment system encounter rates.

CSHCN freestanding and hospital-based RHCs are reimbursed the lower of the billed amount or the Texas Medicaid provider-specific per visit rates.

19.5 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.

Chapter

20

Hearing Services

20.1 Enrollment

Appropriately-licensed providers may enroll as CSHCN Services Program providers by completing the provider enrollment application available through the TMHP-CSHCN Services Program. Providers must be actively enrolled as Texas Medicaid providers before enrolling in the CSHCN Services Program. Out-of-state providers must meet all applicable enrollment requirements, and be located in the United States, within 50 miles of the Texas state border.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

20.1.1 Non-Implantable Hearing Aid Devices and Services

A provider of hearing aid fitting and dispensing services must be licensed by the Texas State Committee of Examiners for Speech, Language, Pathology, and Audiology.

Audiologists may enroll with the CSHCN Services Program as individuals or as groups. Hearing aid fitters and dispensers may enroll with the CSHCN Services Program as individuals or as facilities.

Audiologists may enroll as both audiologists and as hearing aid fitters and dispensers by completing an enrollment application for each type of provider (i.e., select "Audiologist" on one application and "Hearing Aid" on the other application).

20.1.2 Implantable Hearing Aid Devices and Services

To enroll in the CSHCN Services Program, hearing services professionals who provide implantable hearing devices and services must be appropriately enrolled according to their licensure and scope of practice.

20.2 Benefits, Limitations, and Authorization Requirements – Non-Implantable Devices and Services

The CSHCN Services Program hearing services benefit includes those services that are medically necessary for clients of any age who have suspected or identified hearing loss that can be improved or ameliorated using a hearing aid device.

Such services may be reimbursed to audiologists or hearing aid fitters and dispensers as follows:

- Audiologist and physician providers may be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss including, but not limited to, the following:
  - Hearing screening
  - Audiometric testing
  - Otological examination
  - Vestibular evaluation
  - Hearing aid evaluation
- Hearing aid fitters and dispensers may be reimbursed for hearing aid devices and accessories, fitting and dispensing visits, and revisits including, but not limited to, the following:
  - Ear molds
  - Hearing aid device
  - Hearing aid fitting
  - Follow-up visits at 30 days (first follow-up) and 60 days (second follow-up)
  - Hearing aid repair
  - Refit and evaluation after repair
  - Hearing aid batteries and supplies

Note: *Hearing-related services that are medically necessary because of a medical condition that cannot be improved or ameliorated using a non-implantable hearing aid device are not considered part of the CSHCN Services Program hearing services benefit. Providers may refer to the other CSHCN Services Program Provider Manual chapters for benefit and limitation information about other hearing-related services.*

All services provided to CSHCN Services Program clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations noted in this chapter. Providers must request prior authorization for medically necessary services that exceed benefit limitations and for those services for which prior authorization is required.

Note: *CSHCN Services Program clients who are 17 years of age or older who are legal residents of the state of Texas, and who are employable, may be eligible for assistance from the Department of Assistive and Rehabilitative Services (DARS). The CSHCN Services Program may request that clients who meet these requirements apply to DARS, as the CSHCN Services Program is the payor of last resort.*

20.2.1 Hearing Screening

A hearing screening that is provided due to client concern, or at the provider's discretion, is a benefit for clients of any age when the client is referred by a CSHCN Services Program-enrolled physician, and the screening is provided by a CSHCN Services Program-enrolled provider that is licensed to perform these services.

20.2.2 Abnormal Hearing Screens

Clients with abnormal hearing screens must be referred to a CSHCN Services Program-enrolled licensed audiologist or physician that provides audiology services.

Clients who are birth through 35 months of age with suspected or confirmed hearing loss must be referred to Early Childhood Intervention (ECI) as soon as possible but no longer than 7 days after identification, even if the client is also referred to an appropriate provider for further testing.

20.2.3 Hearing Testing, Examination, and Evaluation Services

20.2.3.1 Audiometric Testing

A basic comprehensive audiometry survey is a benefit of the CSHCN Services Program and includes the following tests:

- Tympanometry and reflex threshold measurements
- Screening test, pure tone, air only
- Pure tone audiometry
- Speech audiometry threshold
- Comprehensive audiometry threshold evaluation and speech recognition

The following procedure codes may be reimbursed for a basic comprehensive audiometry survey:

Procedure Codes						
92550	92551	92552	92553	92555	92556	92557

The following additional audiometric tests may also be reimbursed by the CSHCN Services Program:

Procedure Codes						
92558	92563	92564	92565	92567	92568	92570
92571	92572	92575	92576	92577	92579	92582
92583	92584	92585	92586	92587	92588	

20.2.3.2 Otological Examination

An otological examination is a benefit of the CSHCN Services Program when it is medically necessary and provided by a CSHCN Services Program-enrolled physician licensed to perform this service.

Procedure codes 92502 and 92504 may be reimbursed for otological examination.

An otological examination may also include physician evaluation and management services that are provided to diagnose or treat medical conditions.

Refer to: Section 31.2.18, "Evaluation and Management (E/M) Services," on page 31-49 for more information about about medically necessary physician evaluation and management services.

20.2.3.3 Vestibular Evaluations

A vestibular evaluation is a benefit of the CSHCN Services Program when it is medically necessary and provided by a CSHCN Services Program-enrolled physician, and the screening is provided by a CSHCN Services Program-enrolled provider licensed to perform these services.

The following procedure codes may be reimbursed for vestibular evaluations:

Procedure Codes						
92531	92532	92533	92534	92540	92541	92542
92543	92544	92545	92546	92547		

20.2.3.4 Authorization/Documentation Requirements

Authorization is not required for hearing services for the evaluation and diagnosis of hearing loss. Documentation of medical necessity must be maintained by the provider in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

20.2.3.5 Limitations

Procedure codes 92553 and 92556 are not reimbursed on the same day by the same provider. If these procedure codes are billed for the same date of service, they are denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Procedure codes 92551, 92252 and 92553 for pure tone audiometry are limited to one of any of these procedure codes per day, any provider.

Evoked response testing (procedure codes 92558, 92585, 92586, 92587, and 92588) is considered a bilateral procedure. If separate charges are billed for left- and right-sided tests of the same type, the tests are combined and reimbursed as a quantity of one.

Procedure code 92547 is an add-on code, and must be billed with the primary procedure code (92541, 92542, 92543, 92544, 92545, or 92546) with the same date of service by the same provider in order to be considered for reimbursement.

Procedure codes 92620, 92621, and 92625 may be reimbursed by the CSHCN Services Program.

Tympanometry (impedance testing) procedure code 92567 may be reimbursed as an objective diagnostic test of middle ear disease and is limited to three services per rolling year by any provider.

Acoustic reflex testing procedure code 92568 is limited to the following diagnosis codes:

Diagnosis Codes				
2251	3510	3511	3518	3519
38600	38601	38602	38603	38604
38610	38611	38612	38619	3862
38630	38631	38632	38633	38634
38635	38640	38641	38642	38643
38648	38650	38651	38652	38653
38654	38655	38656	38658	3868
3869	3870	3871	3872	3878
3879	3882	38830	38831	38832
38840	38841	38842	38843	38844
38845	3885	38905	38906	38910
38911	38912	38913	38914	38915
38916	38917	38918	38920	38921
38922	3898	3899	7443	7804

Procedure code 92591 may be reimbursed for a hearing screening or other hearing aid examination.

Two hearing aid revisits may be reimbursed per calendar year. Procedure code 92592 may be reimbursed for the first and second revisits for monaural hearing aid fittings. Procedure code 92593 may be reimbursed for the first and second revisits for binaural hearing aid fittings.Testing and evaluation procedure codes are subject to National Correct Coding Initiative (NCCI) relationships with the following exceptions.

20.2.4 Hearing Aid Devices and Accessories

Nonimplantable hearing aid devices and accessories are benefits of the CSHCN Services Program.

Important: *TMHP does not supply the hearing aid devices, supplies, and accessories. Providers must purchase equipment directly from the manufacturers of their choice and submit claims to TMHP for reimbursement using the appropriate procedure codes.*

The CSHCN Services Program may reimburse hearing aid fitters and dispensers for the following services:

Service	Limitation
Hearing aid devices	**Limitation:** 1 per ear every 5 years. One of the following may be reimbursed: • If only one ear requires a hearing aid device, one monaural hearing aid procedure code with the appropriate modifier LT or RT may be reimbursed without prior authorization once every 5 years from the dispensing date of the initial services. • If within the same 5-year period, the other ear requires a hearing aid device, a second monaural hearing aid device procedure code with the appropriate modifier LT or RT may be reimbursed without prior authorization and a separate 5-year period will begin for the second device. • If both ears require a hearing aid device at the same time, one binaural hearing aid procedure code may be reimbursed once every 5 years from the dispensing date of the initial services without prior authorization. For binaural procedure codes, bill a quantity of 1. Replacement hearing aid devices that are required within the same 5-year period must be prior authorized. Repairs or modifications may be reimbursed once per year after the 1-year warranty period has lapsed if the requested repair or modification is a better alternative than a new purchase. If repairs are required more than once per year, additional repairs or modifications may be reimbursed with prior authorization if medical necessity can be demonstrated. **Procedure codes:** See below for monaural and binaural procedure codes. Procedure code V5014 may be reimbursed for repairs and modifications.
Hearing aid devices *(continued)*	**Date of service:** The date of service for the initial hearing aid device is the date the client successfully completes the 30-day trial period and accepts the hearing aid device. The date of service for the repair or modification is the date the client receives the repaired or modified hearing aid device. ***Warranty note:*** *During the warranty period, the CSHCN Services Program may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. The CSHCN Services Program will not reimburse hearing aid repairs or modifications that are rendered during the 12-month manufacturer's warranty period. Providers must follow the manufacturer's repair process as outlined in their warranty contract.*

Service	Limitation
Hearing aid accessories	**Limitation:** As often as is medically necessary with prior authorization. ***Note:*** *Hearing aid accessories that are not part of the hearing aid package include, but are not limited to, chin straps, clips, boots, and headbands. The items are not supplied by TMHP; the accessories must be purchased from a vendor of the provider's choice.* **Procedure code:** V5267 **Date of service:** The date of service is the date the client successfully completes the 30-day trial period and accepts the hearing aid device, or the date the client receives the replacement accessory item.
Ear impression	**Limitation:** 1 each per hearing aid device as follows: • For monaural procedure codes, bill a quantity of 1. • For binaural procedure codes, bill a quantity of 2. Replacement ear molds may be reimbursed as often as is medically necessary. **Procedure codes:** V5275 **Date of service:** The date of service for the ear impression is the date the ear impression is taken.
Ear molds	**Limitation:** For clients who are 20 years of age or younger - as medically necessary. (Documentation that supports medical necessity must be maintained in the client's medical record.) For clients who are 21 years of age or older - custom ear molds are limited to 3 ear molds per ear, per rolling year, any provider; disposable ear molds are limited to 4 ear molds per ear, per rolling month, any provider. **Procedure codes:** V5264 and V5265 (billed with modifier LT or RT) **Date of service:** The date of service for the ear mold is the date the ear mold was taken.
Batteries (replacement only)	**Limitation:** Replacement batteries may be reimbursed as often as is medically necessary when a hearing aid device has been previously reimbursed by the CSHCN Services Program. If a hearing aid has not been reimbursed by the CSHCN Services Program in the last 5 years, the replacement batteries may be reimbursed on appeal with a statement that documents medical necessity. **Procedure code:** V5266 **Date of service:** The date of service is the date the client receives the replacement batteries. ***Warranty note:*** *Replacement batteries that are supplied as part of the manufacturer's warranty will not be reimbursed separately by the CSHCN Services Program.*

The following monaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements when they are billed with the appropriate modifier LT or RT to indicate for which ear the hearing aid device was purchased and fitted:

Procedure Codes				
V5030	V5040	V5170	V5180	V5244
V5245	V5246	V5247	V5254	V5255
V5256	V5257	V5298		

The following binaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements:

Procedure Codes				
V5100	V5210	V5220	V5249	V5250
V5251	V5252	V5253	V5258	V5259
V5260	V5261	V5298		

20.2.4.1 Documentation Requirements

Monaural hearing aids may be reimbursed for clients who have no medical contraindication for using a hearing aid and who have documentation of medical necessity. The following documentation of medical necessity must be maintained in the client's medical record:

- Hearing loss in the better ear of 35 dBHL or greater for the pure tone average of 500, 1000, and 2000 Hz.
- A spondee threshold in the better ear of 35 dBHL or greater when pure tone thresholds cannot be established.
- Hearing loss in each ear is less than 35 dBHL at the frequencies below 2000 Hz and thresholds in each ear are greater than 40 dBHL at 2000 Hz and higher.
- Documentation of communication need and a statement that the patient is alert and oriented and able to use the device appropriately by themselves or with assistance.

Clients meet the criteria for binaural aids if they meet the conditions for a monaural hearing aid and have at least a 35-dBHL hearing loss in both ears.

Providers must also include the model number, serial number, and warranty dates of the purchased hearing aid device in the client's medical record.

20.2.4.2 Prior Authorization Requirements

Prior authorization is not required for medically necessary hearing aid devices and supplies that are provided within the limitations outlined in the previous table.

Prior authorization is required for the following:

- Replacement hearing aid devices that are required within the same 5-year period

  A replacement hearing aid device may be considered for prior authorization when loss or irreparable damage has occurred. Replacements will not be authorized when the equipment has been abused or neglected by the client, the client's family, or the caregiver.
- Hearing aid accessories that are not part of the hearing aid package including, but not limited to, chin straps, clips, boots, and headbands

  Requests for prior authorization for hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands will be considered when the requests are submitted with documentation that shows that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.
- Hearing aid devices that are not currently a benefit of the CSHCN Services Program but that are medically necessary.

  The prior authorization request must include:

- The medical necessity for the requested hearing aid device.
- The name of the manufacturer.
- The manufacturer's suggested retail price (MSRP) or the provider's documented invoice cost if the MSRP is not available.
- The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.

- For additional repairs or modifications, requests for prior authorization must include documentation that supports the need for the requested repair or modification.

For services that require prior authorization, prior authorization must be obtained before the services are rendered. The prior authorization number must be included on the claim form when the claim is submitted to TMHP.

Prior authorization requests must be submitted to the TMHP-CSHCN Services Program Authorization Department using the CSHCN Services Program Authorization and Prior Authorization Request Form. Documentation that supports medical necessity for the requested device, service, or supply must be included with the form.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for more information about the authorizations and claims filing processes.

20.2.4.3 Limitations

A hearing aid dispensed through the CSHCN Services Program must meet the following criteria:

- Be a new and current model
- Meet the performance specifications indicated by the manufacturer
- Include, at minimum, a standard 12-month warranty that begins on the dispensing date of the hearing aid.
- Meet the needs of the individual client that receives the device

Providers must dispense each hearing aid reimbursed through the CSHCN Services Program with all necessary hearing aid accessories and supplies, including a 1-month supply of batteries. The reimbursement for monaural and binaural procedure codes includes the required hearing aid package as follows, and no separate reimbursement will be made for these items:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts have been deducted)
- Manufacturer's postage and handling charges
- All necessary hearing aid accessories or supplies
- Instructions for care and use
- A 1-month supply of batteries

Note: *The client, client's family, or caregiver(s) must agree to accept the responsibility for, and be trained in, the proper use of the hearing aid device.*

Procedure code V5298 may be reimbursed with prior authorization for hearing aid devices that are not currently a benefit of the CSHCN Services Program but that are medically necessary.

Procedure code V5251 may be reimbursed with prior authorization.

A monaural hearing aid device procedure code and a binaural hearing aid device procedure code will not be reimbursed within the same 5-year period.

20.2.5 Hearing Aid Services

The CSHCN Services Program may reimburse hearing aid fitters and dispensers for the following services:

Service	Limitation
Hearing aid examination and evaluation	**Limitation:** As often as is medically necessary. **Procedure code:** 92590, 92591, 92594, and 92595 **Date of service:** The date of service is the date the service is rendered to the client.
Hearing aid assessment	**Limitation:** As often as is medically necessary. **Procedure code:** V5010 **Date of service:** The date of service is the date the service is rendered to the client.
Fitting and dispensing visits	**Limitation:** 1 fitting per hearing aid procedure code, regardless of the number of times a device is returned as unacceptable during a 30-day trial period. **Procedure code:** V5011 **Date of service:** The date of service for the fitting, orientation, and checking visit is the date the client successfully completes the 30-day trial period and accepts the hearing aid device. The post-fitting check of the hearing aid must be performed within 5 weeks of the initial fitting, and is included in the reimbursement for the dispensing procedure. No separate reimbursement will be made. **Limitation:** 1 dispensing fee each time a hearing aid is dispensed and a new 30-day trial period begins. **Procedure codes:** V5090, V5110, V5160, V5200, V5240, and V5241 **Date of service:** The date of service for the dispensing visit is the date the client receives the hearing aid device and a new 30-day trial period begins. The dispensing fee may be reimbursed separately from the fitting of the hearing aid.
Revisit(s)	**Limitation:** 2 per calendar year when billed by any provider. **Procedure codes:** 92592 (first and second revisits for monaural fittings) and 92593 (first and second revisits for binaural fittings) **Date of service:** The date of service is the date the service is rendered to the client.

20.2.5.1 Documentation Requirements

Client Acknowledgement Statement (created by the provider)-To confirm that the client was evaluated and offered an appropriate hearing aid that meets the client's hearing need, the client must sign an acknowledgment statement before the provider dispenses the hearing aid device

and supplies. The statement must be maintained in the client's medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the device, service, or supply.

30-Day Trial Period Certification Statement (created by the provider)-To confirm that the client was allowed a 30-consecutive-day trial period that began with the dispensing date, the hearing aid fitter/dispenser must provide the client with a written agreement that includes the beginning and ending dates of the 30-day trial period. The contract agreement must include all charges and fees associated with the trial period as well as the name, address, and telephone number of the State Board of Examiners for Speech-Language Pathology and Audiology. The client must receive a copy of this agreement and a copy must also be maintained in the client's medical record.

A new certification statement must be provided each time a new trial period begins.

The fitter/dispenser must allow 30 days to elapse from the hearing aid dispensing date before completing the 30-day trial period certification statement, which indicates that the client has completed the trial period and has accepted the dispensed hearing aid. The certification statement must be maintained by the provider in the client's medical record.

For hearing aids that are dispensed in a provider's office, if a client fails to return by the end date of the trial period, the provider must contact the client. After 3 attempts have been made, if the client does not return to the provider's office, the provider must document all contact attempts with the client and maintain this documentation in the client's file. Retrospective review may be performed to ensure documentation supports the contact attempts and the client's failure to return to the provider's office.

20.2.5.2 Prior Authorization Requirements

Prior authorization is not required for fitting and dispensing visits and revisits.

20.2.5.3 Limitations

The following hearing aid visits may be reimbursed by the CSHCN Services Program:

- The fitting and dispensing visits that encompass a 30-day trial period and include a post-fitting check 5 weeks after the trial period has been successfully completed
- A first revisit as needed after the post-fitting check
- A second revisit as needed after the first revisit

The fitting visit includes the fitting, dispensing, and post-fitting check of the hearing aid.

After the hearing aid has been dispensed, the client must be allowed a 30-consecutive-day trial period that begins with the dispensing date to determine satisfaction with a purchased hearing aid. During the 30-day trial period, if the client is not satisfied with the purchased hearing aid or if hearing is not improved with the use of the purchased hearing aid, the client may return it to the provider. Providers may dispense additional hearing aids as medically necessary until the client is satisfied with the results of a hearing aid or until the provider determines that the client cannot benefit from the dispensing of an additional hearing aid. A new trial period begins with the dispensing date of each hearing aid.

The hearing aid provider must use the appropriate fitting and dispensing procedure code for services rendered during the trial period. No additional fees may be charged to the client or to the CSHCN Services Program during this period.

The licensed audiologist or fitter/dispenser must perform a post-fitting check of the hearing aid within 5 weeks of the initial fitting.

20.3 Benefits, Limitations, and Authorization Requirements – Implantable Devices and Services

Implantable hearing devices, including the cochlear implant device, the auditory brainstem implant (ABI), and the bone-anchored hearing aid (BAHA), are benefits of the CSHCN Services Program for clients of all ages.

20.3.1 Bone-Anchored Hearing Aid (BAHA)

A bone-anchored hearing aid (BAHA) may be reimbursed by the CSHCN Services Program for clients who are five years of age or older and who meet the medical necessity criteria. The following procedure codes may be reimbursed with prior authorization for the BAHA and related components:

Procedure Codes				
L8690	L8691	L8692	L8693	69711
69714	69715	69717	69718	V5266

Electromagnetic Bone Conduction Hearing Device

Removal or repair of an electromagnetic bone conduction hearing device may be reimbursed using procedure code 69711. This service is limited to two procedures per lifetime when billed by any provider.

The implantation or replacement of an electromagnetic bone conduction hearing device is not a benefit.

20.3.1.1 Prior Authorization Requirements

Prior authorization is required and may be granted if the client is five years of age or older and all of the following documentation is provided:

- Previous attempts at hearing aids and why these devices are inadequate or have failed.
- Scores on hearing tests for bone conduction thresholds and on maximum speech discrimination.
- Audiological testing showing good inner ear function.
- Assessment that shows the client is motivated, is able to follow given instructions, and is willing to participate in follow-up therapy.
- Appropriate diagnosis including, but not limited to, the following:

Diagnosis Code	Description
1601	Malignant neoplasm of auditory tube, middle ear, and mastoid air cells
1710	Malignant neoplasm of connective and other soft tissue of head, face, and neck
17320	Unspecified malignant neoplasm of skin of ear and external auditory canal
17321	Basal cell carcinoma of skin of ear and external auditory canal
17322	Squamous cell carcinoma of skin of ear and external auditory canal
17329	Other specified malignant neoplasm of skin of ear and external auditory canal
20931	Merkel cell carcinoma of the face
20932	Merkel cell carcinoma of the scalp and neck
2120	Benign neoplasm of nasal cavities, middle ear, and accessory sinuses
2150	Other benign neoplasm of connective and other soft tissue of head, face, and neck
2162	Benign neoplasm of ear and external auditory canal
2322	Carcinoma in situ of skin of ear and external auditory canal
38032	Acquired deformities of auricle or pinna
38110	Simple or unspecified chronic serous otitis media
38120	Simple or unspecified chronic mucoid otitis media
3813	Other and unspecified chronic nonsuppurative otitis media
3823	Unspecified chronic suppurative otitis media
3829	Unspecified otitis media

Diagnosis Code	Description
3870	Otosclerosis involving oval window, nonobliterative
3871	Otosclerosis involving oval window, obliterative
3872	Cochlear otosclerosis
3878	Other otosclerosis
3879	Unspecified otosclerosis
38901	Conductive hearing loss, external ear
38902	Conductive hearing loss, tympanic membrane
38906	Conductive hearing loss, bilateral
38908	Conductive hearing loss of combined types
38915	Sensorineural hearing loss, unilateral
74401	Congenital absence of external ear causing impairment of hearing
74402	Other congenital anomaly of external ear causing impairment of hearing
7560	Congenital anomalies of skull and face bones

20.3.1.2 Limitations

Replacement batteries for the BAHA may be reimbursed without prior authorization as follows:

- Using procedure code V5266
- Limited to clients with a previously-paid BAHA device

Replacement batteries for clients who did not receive the hearing device through the CSHCN Services Program may be reimbursed on appeal with a physician's statement documenting medical necessity.

The BAHA is Food and Drug Administration (FDA)-approved for clients who are 5 years of age or older. Clients who are younger than 5 years of age do not have sufficient bone density for implantation of the device.

BAHA 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 procedure codes in Column B:

Column A (Denied)	Column B
L8691, L8692, L8693	L8690

20.3.2 Cochlear Implants

Cochlear implants, auditory brain implants (ABIs), and auditory rehabilitation are benefits of the CSHCN Services Program.

20.3.2.1 Device, Implantation and Supplies

Procedure codes 69930 and S2235 may be reimbursed for the cochlear implant and the ABI devices and implantation.

The following procedure codes may be reimbursed for equipment and batteries:

Procedure Codes				
L7368	L8499	L8614	L8615	L8616
L8617	L8618	L8619	L8621	L8622
L8623	L8624	L8627	L8628	L8629

Procedure codes 92601, 92602, 92603, and 92604 may be reimbursed for diagnostic analysis and subsequent programming of the implant.

20.3.2.2 Auditory Rehabilitation

Auditory rehabilitation may be a benefit of the CSHCN Services Program when medically necessary for clients who have received a surgically implanted hearing device, or clients who have prelingual or postlingual hearing loss if the treating physician has determined that auditory rehabilitation would be beneficial.

The following procedure codes may be reimbursed for auditory rehabilitation services:

Procedure Codes			
92626	92627	92630	92633

Procedure code 92627 is an add-on procedure and must be billed with primary procedure code 92626 in order to be considered for reimbursement

The benefit for auditory rehabilitation is one evaluation and 12 visits per six rolling month period, without prior authorization. Additional therapy services may be available through the speech therapy benefit.

Refer to: Chapter 36, "Speech-Language Pathology (SLP) Services," on page 36-1 for additional information about the CSHCN Services Program speech therapy benefit.

20.3.2.3 Frequency Modulation (FM) Systems

An FM system may be a benefit of the CSHCN Services Program for clients who are 12 months of age and older when it is needed as an assistive listening device for use with a cochlear implant and the following criteria are met:

- At least three months have elapsed since the surgical implantation of the cochlear device
- The client is unable to obtain the FM device through any other source.

The assistive listening device (FM system) for use with a cochlear implant may be reimbursed with prior authorization using procedure code V5273.

Replacement or repair of an FM system will not be considered for coverage during the manufacturer's warranty period.

20.3.2.4 Authorization Requirements

All implants must be prior authorized. The following information must accompany the request for prior authorization:

- Documentation from the audiologist and otolaryngologist that indicates the client is a good candidate for the procedure and meets the requirements outlined earlier in this chapter.
- Documentation that a referral to an appropriate auditory rehabilitation provider is in place.
- Documentation from the client's primary physician, neurologist, or school diagnostician that the client has the cognitive ability to use the implant.

The prior authorization request will not be granted if one or more of the following situations exist:

- The client has an active ear infection.
- The client is deaf due to lesions of the acoustic nerve or central auditory pathways.
- There is radiological documentation of absent cochlear development.
- The client or the client's parents lack the cognitive ability or willingness to complete auditory rehabilitation.

Replacement of rechargeable AA batteries must be prior authorized. A total of 12 replacement rechargeable AA batteries may be prior authorized per year.

The purchase, replacement, or repair of an assistive listening device (FM system) for use with a cochlear implant must be prior authorized.

Auditory rehabilitation services beyond the limit of 12 visits per six-month period must be prior authorized and will be considered for clients who are 12 months of age through 20 years of age with documentation that supports the medical necessity of continued services.

20.3.2.5 Limitations

Clients must meet the following criteria:

- The client is 12 months of age or older.
- The client has a profound, bilateral, sensorineural hearing loss.
- The client who requests the cochlear implant has had limited or no benefit from a trial with appropriately fitted hearing aids. A trial of three to six months is required for clients who do not have previous experience with hearing aids unless there is a documented reason that hearing aids will not work for that particular client.
- The client has the cognitive ability to use auditory cues.
- The client or parents are willing and able to comply with auditory rehabilitation.
- The client is assessed by both an audiologist and an otolaryngologist experienced in the implantation of cochlear implants or ABIs and who indicate that the client is a good candidate for the procedure.

ABI is an adaptation of a cochlear implant and may be reimbursed for services rendered to clients who are 12 years of age or older when submitted with diagnosis code 23772.

The cochlear implant or ABI device must be approved by the FDA and must be age-appropriate for the client.

The device and separate components include the following:

- Cochlear device
- Headpiece or headset
- Microphone
- Transmitting coil
- Transmitter cable
- External speech processor
- Zinc air batteries
- Alkaline AA batteries
- Recharger units
- Rechargeable AA batteries.

Replacement equipment and components are also a benefit of the CSHCN Services Program. Replacement equipment includes batteries, sound processors, cables, coils, headsets, and microphones.

Up to a maximum of 15 zinc air or a maximum of 31 alkaline batteries may be reimbursed per month without prior authorization.

Prior authorization is required for replacement of external sound processors and rechargeable AA batteries for a cochlear implant or ABI device.

20.3.2.6 Sound Processor Replacement Guidelines

Unless ordered by a physician, a processor must be used for 12 months before the replacement of a unit is considered for reimbursement. The replacement of a sound processor requires prior authorization with adjustment to reimbursement based on the manufacturer's trade-in policy. The physician must submit documentation of medical necessity when requesting prior authorization for the replacement of the sound processor.

20.4 Claims Information

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

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements. To avoid claim denials, providers billing as a group must use the performing provider identifier number on their claims.

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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

20.4.1 Claims Filing for Non-Implantable Hearing Devices and Services

Audiology services must be billed using the audiology provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Audiologist." Hearing aid fitting and dispensing services must be billed with the hearing aid provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Hearing Aid."

20.4.1.1 Claims Filing for Non-implantable Hearing Aid Devices

To be reimbursed for a non-implantable hearing aid device, providers must submit paper claims with documentation that shows the provider's cost for the hearing aid device. The documentation submitted with the claim must be a manufacturer invoice that shows the net acquisition cost of the non-implantable hearing aid device.

An invoice printed from an email or the Internet will not be accepted and should not be

submitted with the claim as documentation to show the net acquisition cost of the hearing aid device unless the invoice shows the actual price the provider paid for the hearing aid device.

Providers are required to submit non-implantable hearing aid claims using the CMS-1500 paper claim form because electronic claim submission does not allow for the submission of attachments.

As the amount billed on a claim, providers must use the net acquisition cost, which is the actual price the provider paid for the device, including the wholesale cost plus sales tax, shipping and handling, and any reductions resulting from discounts or rebates. Providers must not use usual and customary fees as the amount billed.

Note: *The requirement to submit the net acquisition cost of the hearing aid device applies only to non-implantable monaural and binaural hearing aid devices including, but not limited to, procedure code V5298.*

20.4.2 Claims Filing for Implantable Hearing Devices and Services

Claims for implantable hearing devices must be billed using the appropriate provider number and benefit code (for electronic claims only, if applicable).

20.5 Reimbursement

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

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

20.5.1 Reimbursement for Hearing Tests

The CSHCN Services Program may reimburse physicians or audiologists who provide hearing tests to clients whose hearing is found to be suspect on the routine screening, whether or not hearing is found to be impaired. Services are reimbursed at the lesser of the billed charges or the amount allowed by Texas Medicaid.

20.5.2 Reimbursement for Non-Implantable Hearing Devices and Services

The CSHCN Services Program may reimburse hearing aid devices the lesser of the following:

- The invoice cost of the hearing aid device
- The acquisition cost of the hearing aid device
- The maximum allowable Texas Medicaid fee for the hearing aid device procedure code

Procedure code V5267 is manually priced and may be reimbursed the lower of the billed amount or the MSRP less 18 percent when purchased.

20.5.3 Reimbursement for Implantable Hearing Devices and Services

Cochlear implants or ABIs may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

BAHA devices and services may be reimbursed as follows:

- Noncustom durable medical equipment (DME) may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- Expendable medical supplies may be reimbursed the lower of the billed amount or the amount allowed by CMS, when available, or Texas Medicaid.
- Ambulatory surgical centers (ASCs) may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid based on ASC groupings approved by CMS.
- Inpatient hospital care may be reimbursed at 80 percent of the All Patient Refined Diagnosis Related Groups (APR-DRG) payment.
- Orthotics and prosthetics may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- Physicians and audiologists may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

20.6 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.

Chapter

21

Home Health Services

21.1 Enrollment

To enroll in the CSHCN Services Program, home health agencies providing home health services 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, be a licensed and certified home and community services support agency (HCSSA), and comply with all applicable state laws and requirements. Out-of-state home health providers must meet all these conditions, be located in the United States, within 50 miles of the Texas state border, and be approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

21.2 Benefits, Limitations, and Authorization Requirements

Home health services are a benefit of the CSHCN Services Program for clients requiring services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent, part-time basis.

Home health services are considered medically necessary for a client who:

- Requires individualized, intermittent, and acute skilled care.
- Requires skilled assessment and treatment to improve health status, and if skilled intervention is delayed, it is expected to result in:
  - Deterioration of a chronic condition.
  - Loss of function.
  - Imminent risk to health status due to medical fragility or risk of death.

Providers must be a licensed and certified home health agency enrolled in the CSHCN Services Program and must comply with all applicable federal, state, and local laws and regulations and CSHCN Services Program policies and procedures.

21.2.1 Prior Authorization Requirements for Home Health Services

Home health services require prior authorization. Prior authorization requests must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

A copy of the home health provider's plan of care (POC) must be submitted for documentation of the required information. The POC must be signed by the physician who is ordering home health services and providing ongoing supervision. A copy of the POC with physician's signature must be received within 30 days of the start of care.

All signatures must be current, unaltered, original, and handwritten; computerized or stamped signatures will not be accepted.

Requests must be submitted by fax or mail. Providers must obtain prior authorization within 3 business days of the start of care date for an initial authorization. The initial prior authorization period may not exceed 60 calendar days. For recertifications, providers must obtain prior authorization within 7 business days before the end of the authorization date.

During the prior authorization process, providers are required to deliver the requested services beginning on the start of care date. An updated POC signed by the physician must be submitted with the prior authorization request. The start of care must be documented on the POC.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for additional information about authorization and prior authorization requirements.

21.3 Home Health Aide (HHA) Visits

HHA visits (procedure code G0156) must be provided by a qualified HHA under the supervision of a qualified licensed individual (registered nurse [RN], physical therapist, occupational therapist) who is employed by the home health agency.

The duties of an HHA during a visit include, but are not limited to, the following:

- Obtaining and recording the client's vital signs
- Observation, reporting, and documentation of the client's status and the care or service furnished
- Personal care including, but not limited to:
  - Sponge, tub, or shower bath
  - Shampoo, sink, tub, or bed bath
  - Nail and skin care
  - Oral hygiene
- Toileting and elimination care
- Ambulation
- Exercise
- Range of motion
- Safe transfer
- Positioning
- Assisting with nutrition and fluid intake
- Household services essential to the client's health care at home
- Assistance with medications that are ordinarily self-administered
- Reporting changes in the client's condition and needs
- Completing appropriate documentation

Typically HHA visits last no longer than 2 hours. Providers must submit documentation of medical necessity for services over 2 hours.

21.3.1 Supervision of Home Health Aides

Supervision, as defined by the *Texas Nurse Practice Act*, is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity.

An RN or physical or occupational therapist must provide the HHA with written instructions for all the tasks delegated to the HHA.

The requirements for HHA supervision are as follows:

- When skilled nursing, occupational therapy (OT), or physical therapy (PT) visits are provided in addition to an HHA visit, an RN must make a supervisory visit to the client's residence at least once every two weeks. The supervisory visit must occur when the HHA is providing care to the client.
- When only OT or PT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

21.3.2 Prior Authorization for Home Health Aide (HHA) Visits

A provider requesting prior authorization for HHA services must submit the following documentation:

- A completed client assessment
- A completed POC that must be signed and dated by the assessing RN and signed and dated by the physician or submitted with the signed and dated physician's orders

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time HHA visits that will safely meet the client's needs. The amount and duration of HHA visits requested will be evaluated by TMHP.

The home health agency must ensure that the requested services are supported by the client assessment, POC, and the physician's orders.

21.3.3 Skilled Nursing Services

Skilled nursing visits (procedure code G0154) are limited to procedures performed by an RN or licensed vocational nurse (LVN) licensed to perform these services under the *Texas Nursing Practice Act* and 42 Code of Federal Regulations §§ 409.32, 409.33, and 409.44. These services include the following:

- Direct skilled nursing care, training, and education for parents, guardians, and caregivers
- Skilled nursing observation, assessment, and evaluation by an RN (if a physician specifically requests that a nurse visit the client for this purpose and the physician's order reflects the medical necessity of the visit)

Determining whether a service requires the skill of an RN or LVN is based on the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

If the service can be safely and effectively performed by an average nonclinician without the direct supervision of an RN or LVN, the service is not considered skilled nursing. A service that could be performed by an average nonclinician is not skilled nursing even if there is no competent person to perform it.

Some services are classified as skilled nursing on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters). If these services are reasonable and necessary to the treatment of the client's illness or injury, they may be covered. In some cases, the client's condition may require a service that is ordinarily considered unskilled and falls outside the scope of skilled nursing. This would occur when the client's condition necessitates an RN or LVN to perform the service safely and effectively.

A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be considered skilled nursing even if it is taught to the client, the client's family, or other caregivers. When the client needs the skilled nursing care and there is no one trained, able, and willing to provide it, the services of a nurse may be considered reasonable and necessary.

Skilled nursing must be reasonable and necessary to the diagnosis and treatment of the client's illness or injury within the context of the client's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client's particular

medical needs, and within accepted standards of medical and nursing practice. A client's overall medical condition is a valid factor in deciding whether skilled nursing is needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is skilled nursing or not.

The determination of whether the services are reasonable and necessary should be made in consideration of the physician's determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

21.3.3.1 Limitations for Skilled Nursing Services

Skilled nursing must be provided on a part-time or intermittent basis.

If medically necessary, a maximum combined total of three skilled nursing visits may be prior authorized per day. One visit may last up to a maximum of 2.5 hours. Skilled nursing visits may be provided on consecutive days.

Skilled nursing visits to obtain routine laboratory specimens may be reimbursed when the only alternative to obtain the specimen is to transport the client by ambulance. Collection of the laboratory specimen is considered part of the visit.

Skilled nursing visits requested primarily to provide the following services will not be prior authorized:

- Respite care
- Child care
- Activities of daily living for the client
- Housekeeping services
- Individualized, comprehensive case management beyond the service coordination required by the *Texas Nursing Practice Act*

A parent, guardian, primary caregiver, or alternate caregiver may not be reimbursed for skilled nursing, even if he or she is employed by an enrolled provider.

Total parenteral nutrition (TPN) is not a benefit through home health services.

Refer to: Section 26.6, "Total Parenteral Nutrition (TPN)," on page 26-36 for more detailed information.

21.3.3.2 Prior Authorization for Skilled Nursing Services

A provider requesting prior authorization for skilled nursing services must submit the following documentation:

- A completed client assessment
- A completed POC that must be signed and dated by the assessing RN and signed and dated by the physician or submitted with the signed and dated physician's orders

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time skilled nursing visits that will safely meet the client's needs. The amount and duration of skilled nursing visits requested will be evaluated by TMHP.

21.3.4 Occupational Therapy (OT) and Physical Therapy (PT)

OT (procedure code G0152) and PT (procedure code G0151) are a benefit of the CSHCN Services Program when medically necessary. OT or PT must be prescribed by a physician and provided by a physical therapist or occupational therapist licensed by the state of Texas.

OT is limited to specific, goal-directed activities to achieve a functional level of mobility and communication. OT is intended to prevent further dysfunction within a reasonable length of time, based on the therapist's evaluation and physician's assessment and treatment plan.

PT is limited to the treatment of acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating PT to restore function.

OT or PT are a benefit of the CSHCN Services Program under any of the following conditions:

- The client has a disability, has sustained a traumatic injury, or is experiencing the late effects of a traumatic injury and requires therapy to improve or maintain function, range of motion, strength, or to prevent or decrease the risk of deformity or osteoporosis.
- The client has an exacerbation of chronic illness or condition (e.g., juvenile rheumatoid arthritis, hemophilia, or sickle cell crisis).
- The client requires short-term therapy related to surgery or casting.
- The client or family requires training in the use of equipment, orthotics, or prosthetics.
- The client or family requires instruction in activities for daily living specific to their home environment.
- The client requires an assessment for appropriate equipment, seating braces, orthotics, or prosthetics.

21.3.4.1 Limitations for Occupational Therapy (OT) and Physical Therapy (PT)

The following outpatient OT or PT procedure codes will be denied if billed on the same date of service as procedure code G0152 by any provider:

Procedure Codes				
97012	97016	97018	97022	97024
97026	97028	97032	97033	97034
97035	97036	97110	97112	97113
97116	97124	97140	97537	97760
97761	97762			

Procedure codes 97545 and 97546 are not a benefit of the CSHCN Services Program.

21.3.4.2 Prior Authorization for Occupational Therapy (OT) and Physical Therapy (PT)

OT and PT evaluation visits do not require authorization. Treatment plans require prior authorization.

21.3.5 Speech-Language Pathology (SLP)

SLP (procedure code G0153) is a benefit of the CSHCN Services Program when it is medically necessary. SLP must be prescribed by a physician and provided by a speech-language pathologist licensed by the state of Texas.

SLP services are for acute or subacute pathological or traumatic conditions of the head or neck which affect speech production.

SLP services are a benefit of the CSHCN Services Program when provided to clients experiencing speech-language difficulty because of a disease or trauma, developmental delay, oral motor problem, or congenital anomaly.

SLP services are a benefit for dysphagia and swallowing disorders, cleft palate, or other craniofacial anomalies whether or not the client is school-age and in special education.

Children who have a condition other than cleft palate or craniofacial anomaly may be eligible to receive services if they have a voice articulation or expressive-receptive language disorder, and if they are expected to make measurable progress toward their individual SLP treatment goals.

Prior authorizations may be granted for:

- SLP evaluations—only one is allowed for payment per 6 months without authorization or written documentation of medical necessity. An evaluation will not be reimbursed on the same day as treatment.
- SLP reevaluations—reevaluations may only be reimbursed once per month.
- SLP evaluations of swallowing and oral function for feeding.
- Sessions that do not exceed 1 hour in length.
- Treatment plans (not to exceed 6 months) and extensions.

Clients may receive SLP from both the CSHCN Services Program and other sources (such as school districts) only when the therapy provided by the CSHCN Services Program addresses different client needs. Therapy provided by the CSHCN Services Program is not intended to duplicate, supplement, or replace services that are the legal responsibility of other entities or institutions. The CSHCN Services Program encourages the private therapist to coordinate with other therapy providers to avoid treatment plans that might compromise the client's ability to progress.

21.3.5.1 Prior Authorization for Speech-Language Pathology (SLP)

The initial SLP evaluation does not require prior authorization. Treatment plans require prior authorization.

21.3.6 Medical Nutritional Counseling Services

Medical nutritional counseling services (procedure codes 97802, 97803, and S9470) are a benefit of the CSHCN Services Program when provided in the home by a licensed dietician.

Refer to: Section 26.4.2, "Benefits, Limitations, and Authorization Requirements," on page 26-10 for additional information about medical nutritional counseling services.

21.3.6.1 Prior Authorization for Medical Nutritional Counseling Services

Prior authorization is required for medical nutritional counseling services.

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

21.3.7 Social Work Services

Social work services (procedure code G0155) that are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker are a benefit when the client meets the qualifying criteria:

- The services of these professionals are necessary to resolve social or emotional problems that are expected to be an impediment to the effective treatment of the client's medical condition or rate of recovery.
- The POC indicates why the required services need the skills of a qualified social worker to be performed safely and effectively.

The services provided by the social worker may include, but are not limited to, the following:

- Assessment of the social and emotional factors related to the client's illness, need for care, response to treatment, and adjustment to care
- Assessment of the relationship of the client's medical and nursing requirements to the client's home situation, financial resources, and availability of community resources
- Appropriate action to obtain available community resources to assist in resolving the client's problem
- Counseling services that are required by the client

- Medical social services furnished to the client's family member or caregiver on a short-term basis when the HHA can demonstrate that a brief intervention (i.e., two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the client's medical condition or to the client's rate of recovery (to be considered "clear and direct," the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the client's medical treatment or rate of recovery)

21.3.7.1 Prior Authorization for Social Work Services

Prior authorization is required for social work services.

The following services are not benefits:

- Medical social services to address general problems that do not clearly and directly impede treatment or recovery
- Long-term social services furnished to family members, such as ongoing alcohol counseling

21.4 Claims Information

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

When completing 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 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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form," on page 5-31 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Services and supplies that exceed the 28-items-per-page limitation must be submitted on separate UB-04 CMS-1450 paper claim forms.

21.5 Reimbursement

Skilled nursing visits provided by home health agencies enrolled in the CSHCN Services Program must be billed in 15-minute increments.

One practicing registered nurse skilled nursing visit may be reimbursed every 30 days outside of the prior authorized visits when skilled nursing visits have been authorized for the particular client.

Skilled nursing provided in the day care or school setting will not be reimbursed.

Two medical nutritional counseling visits (procedure code S9470) may be reimbursed per rolling calendar year.

Reimbursement for mileage is not a benefit of the CSHCN Services Program.

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.*

21.6 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.

Chapter

22

Home Health (Skilled Nursing) Care

22.1 Enrollment

To enroll in the CSHCN Services Program, home health agencies providing skilled nursing services 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, be a licensed and certified home and community services support agency (HCSSA), and comply with all applicable state laws and requirements. Out-of-state home health skilled nursing providers must meet all these conditions, be located in the United States, within 50 miles of the Texas state border, and be approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

22.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program may cover up to 200 hours per client, per year of part-time, intermittent skilled nursing services (procedure codes S9123 and S9124). These services must be provided in the home by an HCSSA-registered nurse (RN) or licensed vocational nurse (LVN) enrolled in the CSHCN Services Program.

The admission visit performed by the agency RN may be reimbursed at the same rate as the home visit and counts toward the 200 hours per year. RN visits to perform assessments that are required to complete the plan of care may be reimbursed at the same rate as the home visit and will count toward the 200 hours per year limit.

Skilled nursing services must meet the following conditions for reimbursement by the CSHCN Services Program:

- Prescribed by a physician
- Medically necessary and appropriate
- Provided according to an established plan of care which is reviewed, at a minimum, by the prescribing physician every 60 days
- Authorized

Skilled nursing can include, but is not limited to:

- Periodic nursing assessment of a client.
- Visits for administering medications, including intravenous (IV) medications and chemotherapy.
- Visits for acute illness, postsurgical, and sterile wound care.
- Education of the primary caregiver and client about the illness process and the skills required to care for the client's medical needs.

- Medical treatments that require the skills of a licensed nurse.
- Transition from an inpatient to a community-based home setting.

The CSHCN Services Program covers other services, therapies, supplies, and equipment that may be provided in the home. Refer to Chapter 21, "Home Health Services," on page 21-1 for guidelines.

Skilled nursing services do not include respite care. Families should be referred to the DSHS regional office in their area for respite care services.

Refer to: Chapter 1, "TMHP and DSHS Contact Information," on page 1-1 for a list of DSHS regional offices.

Nursing services are not reimbursed if provided in conjunction with the administration of total parenteral nutrition (TPN). The reimbursement for TPN is an all-inclusive fee.

Refer to: Section 26.6, "Total Parenteral Nutrition (TPN)," on page 26-36 for more detailed information.

Skilled nursing for in-home administration of blood or blood products is not a benefit.

22.2.1 Authorization Requirements

Skilled nursing services must be authorized. The number of skilled nursing hours that may be authorized or reimbursed is limited to 200 hours per calendar year per client.

Requests for skilled nursing hours must be submitted in writing to TMHP within 95 days of the date of service using the CSHCN Services Program Home Health (Skilled Nursing) Referral and Treatment Plan.

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

An additional 200 hours of service per client, per calendar year may be prior authorized with documented justification of medical necessity.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for additional information about authorization and prior authorization requirements.

22.3 Claims Information

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

When completing 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 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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form," on page 5-31 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Services and supplies that exceed the 28-items-per-page limitation must be submitted on separate UB-04 CMS-1450 paper claim forms.

22.4 Reimbursement

Skilled nursing care may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

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.*

22.5 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.

Chapter

23

Hospice

23.1 Enrollment

The Children with Special Health Care Needs (CSHCN) Services Program enrolls hospice organizations and home health agencies licensed to provide hospice services. These agencies are not required to be actively enrolled in Texas Medicaid. However, they must be licensed by the Department of Aging and Disability Services (DADS), 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 hospice providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

23.2 Benefits, Limitations, and Authorization Requirements

Hospice services are benefits of the CSHCN Services Program. Hospice care includes palliative care for clients with a prognosis of 6 months or less.

Services must be related to palliative care for the terminal diagnosis and may include any or all of the following services: direct care, respite, durable medical equipment (DME), supplies, and medications prescribed for the terminal illness.

Direct care services may include:

- Skilled nursing services.
- Social work services.
- Home health aide services.
- Pastoral care services.
- Medical supervision by the hospice medical director.
- Physical therapy and occupational therapy.
- Speech therapy.
- Dietitian services.

The hospice benefit does not cover curative care for the terminal diagnosis.

Coverage for conditions unrelated to the terminal illness is unaffected.

If nutritional supplements are the client's sole source of nutrition, the supplements are included in the per diem rate.

Total parenteral nutrition (TPN) provided to a client on hospice services may be reimbursed separately.

Refer to: Section 26.6.2, "Benefits, Limitations, and Authorization Requirements," on page 26-36 for TPN benefits, limitations, and authorization requirements.

Hospice and home health services may not be reimbursed on the same date of service, with the exception of the initial date of service when the client is being discharged from home health service and admitted to hospice service.

23.2.1 Prior Authorization Requirements

Prior authorization is required for hospice services. The TMHP-CSHCN Services Program medical review staff review requests for hospice services. Hospice services may be prior authorized up to a maximum of 6 months per request.

Providers must submit the CSHCN Services Program Prior Authorization Request for Hospice Services Form or the provider's plan of care (POC) if it includes the same information as the CSHCN Services Program Prior Authorization Request for Hospice Services Form and the provider and physician signatures. All of the fields on the prior authorization form must be completed. A copy of the POC, signed and dated by a physician, must be maintained by the physician and hospice provider in the client's medical record.

The CSHCN Services Program Prior Authorization Request for Hospice Services Form must include the client's demographic information, the requested services, and required provider information and signature as follows:

The client's demographic information

- First and last name
- CSHCN Services Program number/client identifier
- Date of birth
- Hospice diagnosis codes (ICD-9)
- Address

The requested services

- Start of care and end of care dates
- Type of hospice care to be delivered (i.e., routine home care, continuous home care, inpatient hospice care, or respite care)
- The criteria used to assess appropriateness of hospice for this client
- A specific description of all direct care to be provided, durable medical equipment, supplies, and medications anticipated for the care of the client

Required provider information and signature

- Provider name
- CSHCN Services Program Texas and National Provider Identifiers (TPI and NPI)
- Taxonomy and benefit codes
- Telephone and fax numbers
- Address
- Dated signature

If the client requires hospice care beyond the initial 6-month period, authorization for additional 6-month periods may be considered with a new request that includes the following documentation:

- An updated CSHCN Services Program Prior Authorization Request for Hospice Services Form or a POC that includes the same information as the CSHCN Services Program Prior Authorization Request for Hospice Services Form.
- A current date with the hospice provider and the attending physician.

- An updated description of all direct care, DME, supplies, and medications anticipated for the client's care.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

23.3 Claims Information

Claims for hospice services must be billed using the following revenue codes:

Revenue Code	Description
651	Hospice services—home care
652	Hospice services—continuous home care - ½ (at least 8 but less than 16 hrs care)
655	Hospice services—inpatient respite care
656	Hospice services—general inpatient care/non-respite

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

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

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form," on page 5-31 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

23.4 Reimbursement

Hospice services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid up to the maximum allowed per diem rate. The per diem rate does not cover care for conditions or illnesses unrelated to the terminal diagnosis.

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.*

23.5 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.

Chapter

24

Hospital

24.1 Enrollment

To enroll in the CSHCN Services Program, a hospital must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the TMHP-CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state hospitals must meet all of these conditions and be located in New Mexico, Oklahoma, Arkansas, or Louisiana within 50 miles of the Texas state border. Hospital providers must be Medicare-certified.

Freestanding ambulatory surgical centers (ASCs) and hospital ambulatory surgical centers (HASCs) are subject to the same enrollment requirements as hospitals. HASCs must enroll separately from the hospitals in which they are based.

To be eligible for participation in the CSHCN Services Program, a psychiatric hospital or facility must be enrolled in Texas Medicaid as a freestanding inpatient psychiatric facility. Out-of-state psychiatric hospitals or facilities must meet all of these conditions and be located in the United States, within 50 miles of the Texas state border.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA) of 1988.

Refer to: Section 25.1.1, "Clinical Laboratory Improvement Amendments (CLIA) of 1988," on page 25-3 for more information.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

24.1.1 Continuity of Hospital Eligibility Through Change of Ownership

When a hospital changes ownership, the new owner must take the following actions:

- Obtain recertification as a 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.
- Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in a 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 the providers identified by the change of ownership.

24.1.2 Specialty Team or Center

In addition to requiring prior authorization, the following services require that the physicians or facilities be approved by the TMHP-CSHCN Services Program as specialty team or center providers:

- For kidney transplant services, the facility must be specialty center-approved.
- Stem cell transplant services must be provided in 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 provider must attest to compliance with the required criteria when the prior authorization form is completed and submitted. TMHP maintains a current list of approved centers.

Refer to: Section 2.1.7, "Transplant Specialty Centers," on page 2-9 for more information about stem cell and kidney transplant facility designation.

24.2 Inpatient/Outpatient Benefits, Limitations, and Authorization Requirements

Facilities are responsible for knowing which services require authorization or prior authorization and whether they are a benefit in the inpatient or outpatient setting. The services listed below are not all-inclusive. Refer to the appropriate sections of the provider manual for specific benefit information.

The benefits, limitations, and authorization requirements in this section apply to both inpatient and outpatient services. Additional information specific to inpatient services can be found in Section 24.3, "Inpatient Services," on page 24-6. Additional information specific to outpatient services can be found in Section 24.4, "Outpatient Services," on page 24-15 and information on ASCs can be found in Section 24.5, "Ambulatory Surgical Centers," on page 24-22.

Take-home drugs and supplies are not a benefit of the CSHCN Services Program.

Some procedures require prior authorization or specialty team or center approval. If prior authorization is not obtained as required, the procedures or hospital stay are denied. Authorization is a condition of reimbursement; it is not a guarantee of payment. Faxed transmittal confirmations are not accepted as proof of timely authorization submission.

Authorization or prior authorization is not given if the client is not eligible for the CSHCN Services Program benefits when the request is received by the TMHP-CSHCN Services Program. All claims for these services must meet the 95-day filing deadline.

Providers can fax or mail their written requests along with all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for more information, including deadlines and appeal procedures.

24.2.1 Chemotherapy

Inpatient and outpatient hospitals must use revenue code 636 for reimbursement of the technical component. The appropriate chemotherapy procedure code must be listed on the claim.

Refer to: Section 31.2.12, "Chemotherapy," on page 31-24 for additional information.

24.2.2 Cochlear Implants

Cochlear implant devices are payable to the facility where the cochlear implantation surgery takes place. Hospitals must submit procedure code L8614 when billing for cochlear implant devices. ASCs and HASCs must submit procedure code L8614 with modifier NU when billing for cochlear implant devices.

Refer to: Section 20.3.2, "Cochlear Implants," on page 20-13 for additional information.

24.2.3 Electrodiagnostic Testing (Electromyography and Nerve Conduction Studies)

Electromyography (EMG) and nerve conduction studies (NCS) are benefits of the CSHCN Services Program when medically indicated. EMG and NCS are diagnosis restricted and may require prior authorization.

Refer to: Section 31.2.18, "Evaluation and Management (E/M) Services," on page 31-49.

24.2.4 Fluocinolone Acetonide Intravitreal Implant (*Retisert*)

Fluocinolone acetonide intravitreal implant is a corticosteroid indicated for the treatment of chronic noninfectious uveitis affecting the posterior segment of the eye. The surgical implant is designed to release fluocinolone acetonide over approximately 30 months.

Procedure code J7311 is a benefit for the CSHCN Services Program for clients 12 years of age or older in a hospital, HASC, or ASC setting. Procedure code J7311 is only considered for reimbursement with a posterior uveitis (36320) diagnosis of more than 6 months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. Prior authorization is required.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information on prior authorization requirements.

24.2.5 Laboratory Services

Hospital laboratory services are a benefit for inpatient, outpatient, and nonpatient clients. A hospital nonpatient is one who is not registered as an inpatient or an outpatient, but whose laboratory services are performed by the hospital.

All clinical laboratory services may be reimbursed at a percentage of the Medicare rate set by the Centers for Medicare and Medicaid Services (CMS), except for those hospitals that have been identified by Medicare as sole community hospitals. These hospitals may be reimbursed at 103.35 percent of the clinical lab rate.

Outpatient and nonpatient claims for laboratory services must only reflect tests actually performed by the hospital laboratory; however, hospital laboratories may bill for all of the tests performed on a specimen even if a portion of the tests are done by another laboratory on referral from the hospital submitting the claim.

Hospitals may bill a handling fee (procedure code 99001) for collecting and forwarding a specimen collected by venipuncture or catheterization and sent to a receiving laboratory. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories. In order to bill a handling fee, the receiving laboratory's name and address and unique Texas provider identifier (TPI) number must be included on the claim in Blocks 17 and 17B.

To be eligible for reimbursement by the CSHCN Services Program, all laboratories must be certified according to the Clinical Laboratory Improvement Amendments (CLIA) regulations.

Refer to: Chapter 25, "Laboratory Services," on page 25-1.

24.3 Inpatient Services

24.3.1 Benefits, Limitations, and Authorization Requirements

Inpatient hospital services include medically necessary items and services ordinarily furnished by a CSHCN Services Program hospital or by an approved, enrolled, out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Hospital services must be medically necessary, prior authorized, and are subject to the utilization review requirements of the CSHCN Services Program.

Reimbursement to hospitals for inpatient services is limited to 60 days per calendar year and may accrue intermittently or consecutively. Once 60 days of inpatient care are provided, reimbursement for additional inpatient care is not considered until the next calendar year, except as noted below.

Exception: *A benefit of up to 60 additional inpatient days may be granted to a client, to begin on the date of hospital admission, for an approved stem cell transplant.*

Inpatient hospital services include the following items and services:

- Room and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services. Room and board in private accommodations, including meals, special diets, and general nursing services may be reimbursed up to the hospital's charge for the most prevalent semiprivate accommodations. Private accommodations are not subject to the semiprivate rate if they are documented by the physician as medically necessary. The hospital must keep this documentation in the client's record and document the information on the claim.
- Whole blood and packed red blood cells that are reasonable and necessary for the treatment of illness or injury provided they are not available without cost.
- All medically necessary ancillary services and supplies ordered by a physician.
- Medically necessary emergency and non-emergency ambulance transportation of the client during the inpatient stay.

Note: *Items for personal comfort or convenience, such as a telephone or television, are not a benefit of the CSHCN Services Program and are not reimbursed, even if they are ordered by a physician.*

Initial Inpatient Prior Authorization Requests

All inpatient admissions must be prior authorized before the date of service or the entire hospital stay will be denied. Partial approvals for a hospital stay will not be approved. Friday and weekend admissions may be authorized when an emergency exists or when the required medical services will not be delayed due to the timing of the admission. The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only must be completed and submitted to obtain authorization.

All prior authorization request forms must be complete and must include either the surgeon's or the attending physician's name and provider identifier on the authorization request form. These physicians and the hospital must be actively enrolled in the CSHCN Services Program to obtain authorization.

If an initial request for prior authorization of an inpatient hospitalization is received for a CSHCN Services Program-enrolled client from a nonenrolled provider, the request is denied. If that provider subsequently enrolls as a CSHCN Services Program provider and submits a claim for these previously denied services within the 95-day claims filing deadline, then the claim may be considered for reimbursement based on the medical necessity of the services. If a provider does not complete the request, or if an initial request for prior authorization was not received from an enrolled provider, then the claim(s) cannot be considered for payment and are denied. All providers must be enrolled in order to receive reimbursement.

If prior authorization for a nonemergency inpatient admission is not requested and approved before the admission, and if a request for authorization is made subsequently and approved, then only the day of the authorization request and subsequent days that were approved may be paid.

Emergency Inpatient Hospital Admissions

All inpatient admissions must be prior authorized. The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admissions - For Use by Facilities Only Form must be submitted to the claims contractor for review and approval before the date of service, or the entire hospital stay will be denied. Partial approvals for a hospital stay will no longer be reimbursed.

Requests for emergency hospital admissions must be authorized by the next working day after admission date for the coverage of the entire hospital stay. Requests for emergency admissions received after the next business day will be denied for the entire hospital stay.

All applicable information must accompany the request documenting the emergent conditions that necessitated the inpatient admission.

Inpatient Hospital Extensions

Extension of previously authorized inpatient dates of service requires prior authorization. Requests for extension of an inpatient stay must be received on or before the next working day following the last authorized day. Except for previously authorized dates of service, any date requested before the date the request is received is denied.

When requesting an extension that includes a surgical procedure, providers must document the surgical procedure as part of the medical necessity for the extension.

Providers must include all supporting documentation showing medical necessity for the extended inpatient stay.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for detailed information about authorization and prior authorization requirements.

24.3.1.1 Inpatient Behavioral Health

The intent in providing inpatient services is to provide resources for behavioral health crisis stabilization while efforts are made to transfer the clients to a more appropriate outpatient program where they may receive the necessary psychiatric/psychological treatment required. Benefits are limited to inpatient assessment and crisis stabilization and must be followed by referral to the Texas Department of State Health Services (DSHS) or other appropriate behavioral health programs. Inpatient behavioral health services are limited to five days per calendar year, which count toward the inpatient hospital limitation of 60 days per calendar year.

Inpatient Behavioral Health Prior Authorization Requirements

Inpatient admissions for behavioral health crisis stabilization must be prior authorized. A completed CSHCN Services Program Prior Authorization Request for Inpatient Pyschiatric Care Form must be submitted. Requests must be received by the TMHP-CSHCN Services Program before or on the day of the client's admission, unless the admission is after 5 p.m., or on a holiday, or a weekend. In these cases, the TMHP-CSHCN Services Program must receive it by 5 p.m. on the next business day following admission. The TMHP-CSHCN Services Program will notify the provider of the decision in writing by fax. There may be no extensions to the 5-day limit.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information on prior authorization requirements.

Chapter 29, "Outpatient Behavioral Health," on page 29-1 for more information about behavioral health services.

Inpatient psychiatric hospitals may be reimbursed at 80 percent of the TEFRA rate for CSHCN services.

24.3.1.2 Inpatient Rehabilitation Services

Inpatient rehabilitation programs must include medical management, two or more therapies (e.g., respiratory therapy, speech-language pathology [SLP] services, physical therapy [PT], occupational therapy [OT]), and rehabilitation nursing. The CSHCN Services Program may reimburse inpatient rehabilitation services if the client meets one of the following criteria:

- The client is 5 years of age or older, sufficiently alert to respond to interventions and to participate with the rehabilitation team in setting treatment goals, and is an active participant in therapeutic activities.

- The client is 4 years of age or younger, sufficiently alert to respond to interventions and to participate with the rehabilitation team, and the parent or caregiver can actively participate in setting treatment goals and learning therapeutic management.

In addition, at least one of the following criteria must be met for the client to be eligible for reimbursement of inpatient rehabilitation services:

- The client developed a recent onset of illness or trauma (within the last 12 months) without previous comprehensive rehabilitation efforts.
- There is no documentation of previous inpatient comprehensive rehabilitation effort.
- The client experienced a loss of previous level of functional independence through complications or recurrent illness, and the recovery of functional independence is feasible.

The following are examples of conditions that may be considered for coverage of inpatient rehabilitation:

- Spinal cord injuries
- Traumatic amputation of upper or lower extremities
- Rheumatoid arthritis and other inflammatory polyarthropathies
- Burns
- Postpolio syndrome
- Neoplasms
- Head or brain injuries
- Late effects of infections (i.e., Guillain-Barré syndrome)
- Cerebrovascular diseases
- Congenital conditions (e.g., spina bifida and cerebral palsy) may be considered when there is a recent change in medical and functional status, such as postspinal surgery

Inpatient Rehabilitation Prior Authorization Requirements

Prior authorization is required for inpatient rehabilitation services. An inpatient rehabilitation provider must be enrolled in the CSHCN Services Program as an inpatient rehabilitation facility or unit before a prior authorization may be approved.

Prior authorization may be approved in 14-day increments, not to exceed a maximum of 90 days per calendar year. Requests must be submitted in writing with documentation of medical necessity, including the diagnosis or condition of the client and progress toward goals (request for additional days) along with a copy of the treatment plan. The CSHCN Services Program Prior Authorization Request for Inpatient Rehabilitation Admission must be submitted for the initial request and each extension. Providers must include all supporting documentation showing medical necessity for the extended inpatient stay.

A statement explaining the medical necessity of inpatient versus outpatient rehabilitation services must be included with the documentation submitted for prior authorization. The justification must state the client's current condition and why inpatient rehabilitation, as opposed to outpatient therapy, is required for optimal care. The client's need for daily, intense, focused, team-directed therapy must be substantiated by the circumstances of the case.

If the prior authorization request for additional days documents that the client has made progress toward treatment goals, an additional 14 days may be approved up to a maximum of 90 days per calendar year.

Requests for additional days must be received for prior authorization before the last inpatient rehabilitation day previously prior authorized.

Requests for extensions are *not* approved if one of the following conditions applies:

- The client has met treatment goals, as determined by the rehabilitation team or the CSHCN Services Program medical director or designee.
- The client has failed to make progress toward remaining treatment goals during the currently authorized period.

- The client no longer requires inpatient rehabilitation, and therapeutic goals can be met on an outpatient basis.
- The request was received after the last prior authorized inpatient day.
- The 90-day calendar maximum is exhausted.

Treatment for Acute Medical Episodes

If a client has been admitted for inpatient rehabilitation and develops an acute medical condition that prevents participation in rehabilitation program activities, then the CSHCN Services Program must not be billed for inpatient rehabilitation services. Acute care services (whether inpatient or outpatient) that are a benefit of the CSHCN Services Program may require authorization or prior authorization and must be billed as acute care services.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information on prior authorization requirements.

24.3.1.3 Renal (Kidney) Transplants

Renal transplants will only be approved for reimbursement when performed in a Medicaid-approved, CSHCN Services Program-enrolled transplant facility by a Medicaid-approved, CSHCN-enrolled transplant team. All transplant facilities who wish to perform transplants for CSHCN Services Program clients must have current certification and be in continuous compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN). The Centers for Medicare & Medicaid Services maintains a list of certified and approved Texas transplant facilities (www.cms.hhs.gov/ApprovedTransplantCenters).

The CSHCN Services Program may reimburse renal transplants when the projected costs of the transplant and follow-up care is less than continuing dialysis treatments. The estimated cost of the renal transplant over a 1-year period versus the cost of renal dialysis for 1 year at the requesting facility must be both documented and reviewed. Clients who have not previously applied for Medicare and Kidney Health Care coverage and are anticipating the need for a renal transplant must apply for Medicare and Kidney Health Care coverage.

For any client who is 18 years of age or older, the transplant team must also provide a plan of care to be implemented after the client reaches 21 years of age and is no longer eligible for services through the CSHCN Services Program.

Renal transplants must be prior authorized, and approval is subject to the availability of funds. Only one initial and one subsequent renal transplant may be reimbursed per lifetime.

Some renal transplant procedure codes are subject to a global surgical period of 90 days, with postoperative care included in the reimbursement of the surgical fee.

Refer to: Section 31.2.37.6, "Global Fees," on page 31-110.

If the transplant is not prior authorized, services directly related to the transplant within 3 days preoperative and during the 6-week postoperative period will be denied for the surgeon, assistant surgeon, and facility. The anesthesiologist may be reimbursed.

Reimbursement for Renal Transplants

A maximum amount of $200,000 per client may be reimbursed for a renal transplant hospitalization. Hospitals may be reimbursed 80 percent of the All Patient Refined Diagnosis Related Groups (APR-DRG) payment rate, up to the maximum of $200,000. All hospital charges, including donor costs, are included in the $200,000 limit.

Reimbursement for renal transplants includes:

- The cost of the transplant services.
- One of the following:
  - The cost of the procurement of a cadaveric organ and services associated with the organ procurement, when the organ is obtained from an organ procurement organization designated by the U.S. Department of Health and Human Services. Documentation validating the organ's source must accompany the claim.
  - The cost associated with living donors. The donor costs must be included on the client's inpatient hospital claim and may be reimbursed only if another source of payment is not

available. Donor costs for CSHCN Services Program clients who also have Medicaid benefits are not reimbursed.

The costs related to the donor-matching process will not be reimbursed.

If the cost related to a living donor will be paid by the client's other insurance carrier, the Other Insurance information must be completed on the claim form. If these costs will be paid by the donor's insurance carrier, the claim must be submitted using a paper claim form with attachments documenting the donor's insurance information.

Refer to: Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form," on page 5-31.

Renal transplant recipients are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge for the renal transplant.

Renal Transplant Authorization Requirements

Prior authorization must be obtained by both the facility and the physician.

Documentation supporting the transplant prior authorization request must include:

- The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant form
- A recent and complete history and physical.
- A statement of the client's status, including why a transplant is being recommended at this time.
- Documentation of the cost effectiveness of the transplant vs. continued dialysis.

Nationally, stays for renal transplants in hospital are 5 to 10 days followed by outpatient follow-up; therefore, no additional hospital days beyond the 60 per year allowed by the CSHCN Services Program are authorized without an appeal documenting medical necessity.

24.3.1.4 Transplants - Nonsolid Organ

The CSHCN Services Program may cover only autologous and matched related and matched nonrelated allogenic transplants.

Stem cell transplants include the initial transplant and one subsequent retransplant. This allows a total of two transplants per lifetime regardless of payer. The subsequent transplant must be prior authorized separately from the initial transplant.

Indications for re-transplantation will include the following:

- Relapse of disease
- Failure to engraft or poor graft function
- Graft rejection

Services must be provided in 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). TMHP maintains a current list of approved centers.

If a stem cell transplant has been prior authorized, a maximum of 60 days of inpatient hospital services may be a benefit beginning with the actual first day of the transplant. Any days remaining from the standard 60 inpatient day limit may be added to the 60 days for the transplant if the $200,000 limit for the transplant maximum amount has not been exceeded. This 60-day period is considered a separate inpatient hospital admission for reimbursement purposes.

A maximum amount of $200,000 per client may be reimbursed for a stem cell transplant hospitalization. All hospital charges for patient care and donor costs (inpatient hospital only) during the time of the hospital stay are applied to the $200,000 limit. Donor costs must be included on the client's inpatient hospital claim for the transplant. Donor costs will not be considered by the CSHCN Services Program when another third-party resource is available to reimburse the transplant.

When a second stem cell transplant is prior authorized an additional maximum of $200,000 may be reimbursed for the second prior authorization period. All hospital charges for patient care and donor cost (inpatient hospital only) will be applied to the additional $200,000 limit. Donor cost

must be included on the client's inpatient hospital claim for the transplant. Donor cost will not be considered by the CSHCN Services Program when another third-party resource is available to reimburse the transplant.

If a second cell transplant has been prior authorized, a maximum of 60 days of inpatient hospital services may be a benefit beginning with the actual first day of the second transplant.

Claims are accumulated systematically and payments that exceed $200,000 are cut back, denied, or recouped.

Clients receiving a stem cell transplant are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge for the stem cell transplant event. This includes reimbursement for anti-rejection drugs.

Stem Cell Transplant Prior Authorization Requirements

Prior authorization is required for all stem cell transplants and must be obtained by both the facility and the physician.

Refer to: Section 31.2.39.2, "Transplants - Nonsolid Organ," on page 31-130for additional benefit information.

24.3.2 Hospital Reimbursement

The reimbursement methodology for many CSHCN Services Program facilities that are reimbursed based on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) has changed to the prospective payment methodology based on All Patient Refined Diagnosis Related Groups (APR-DRG) payment system.

Hospitals that are enrolled in the CSHCN Services Program must first be enrolled in Texas Medicaid. The CSHCN Services Program reimbursement methodology has changed from TEFRA to APR-DRG. The reimbursement methodology for hospitals that are reimbursed by Texas Medicaid using APR-DRG also applies for the CSHCN Service Program.

The reimbursement method will not affect inpatient benefits and limitations. Inpatient admissions will continue to require prior authorization.

Note: *The 20 percent payment reduction that is currently applied to inpatient claims by the CSHCN Services Program will remain in effect.*

24.3.3 Prospective Payment Methodology

The prospective payment methodology is based on a diagnosis related groups (DRG) payment system. Reimbursement based on DRG includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. Claims may not be submitted for technical services.

The CSHCN Services Program does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, providers may submit only one claim for each inpatient stay. The claim must include appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 claim form or electronic equivalent, to be considered for payment.

The number of days of care charged for a client for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for reporting purposes even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a client returns from leave of absence, counts as a full day. However, the day of discharge, death, or day on which a client begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (January 1 through December 31) for clients who are 21 years of age and older. Claims may be subject to retrospective review, which may result in recoupment. Hospital reimbursement is made in accordance with TAC §38.10 (6).

24.3.4 Client Transfers

24.3.4.1 Admission Dates

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date on which the client was admitted into each facility in Block 12 on the UB-04 CMS-1450.

24.3.4.2 Continuous Stays - Client Transfers and Readmissions

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The CSHCN Services Program does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be submitted as one admission under the provider identifier. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Admissions submitted inappropriately are identified and denied during the UR process and may result in intensified review.

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of either the mean length of stay for the DRG or the eligible days in the facility. The DRG modifier, PT, on the R&S Report indicated per diem pricing related to a client transfer. Services must be medically necessary and are subject to the CSHCN Services Program's UR requirements.

The claims contractor performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date that the client was admitted into each facility in Block 12 on the UB-04 CMS- 1450. Inpatient authorization requirements are based on the requirements that are specified by the program in which the client is enrolled on the date of the original admission. Providers must adhere to the authorization requirements for claims to be considered for reimbursement. Providers are reimbursed at the rate in effect on the date of admission.

24.3.5 Observation Status to Inpatient Admission

When a client's status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. This rule always applies regardless of the length of time the client was in observation (less than 48 hours) or whether the date of inpatient admission is the following day. All charges including the observation room are submitted on the inpatient claim (TOB 111).

24.3.6 Outlier Ajustments

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients who are 21 years of age or younger as of the date of the inpatient admission. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Providers can view their day and cost outlier payment information for inpatient hospital claims on the Electronic Remittance and Status (ER&S) Report. The ER&S Report reflects the outlier reimbursement payment and defines the type of outlier paid. To view the day and cost outlier payment information, providers, facilities, and third party vendors may need to update their 835 electronic file format. For information about how to update the 835 electronic file format, refer to the revised electronic data exchange (EDI) companion guide (ANSI ASC X12N 835 Healthcare Claim Payment/Advice-Acute Care Companion Guide) on this website.

24.3.6.1 24.3.5.1 Day Outliers

The following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the DRG day threshold for the specific DRG.
- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 60 percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length to stay for the DRG.

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

24.3.7 Payment Window Reimbursement Guidelines

The following payment window reimbursement guidelines apply to services that are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

CSHCN Services Program inpatient hospital providers must submit, as part of the client's inpatient hospital claim, all related professional and outpatient services that were rendered on the date of the client's inpatient admission or one of the following dates immediately before the client's inpatient admission:

- Within three calendar days before the client's inpatient admission for hospitals that receive DRG reimbursement
- Within one calendar day before the client's inpatient admission for hospitals that receive reimbursement other than DRG

Professional and outpatient services that must be submitted as part of the inpatient hospital claim include the following services if they are rendered by the hospital or an entity that is wholly owned or operated by the hospital:

- **Diagnostic services.** Diagnostic services include outpatient laboratory and radiology services that are related to the inpatient admission and submitted by physician and outpatient hospital providers. Affected services will include the total and technical components. The professional interpretation component will not be included in the payment windows identified above.
- **Non-diagnostic services.** Non-diagnostic services include surgeries and other non-diagnostic procedures and services that are related to the inpatient admission and submitted by physician, outpatient hospital, or other providers.

Important: *Related professional and outpatient services that were rendered within one day of the inpatient admission and related to the inpatient admission must be submitted on the inpatient hospital claim and not on an outpatient hospital claim. An outpatient hospital claim for these services will be denied as part of the payment for the inpatient hospital stay.*

Exceptions

The following services are excluded from the payment window and may be submitted and reimbursed separately from the inpatient admission:

- Services rendered by federally qualified health center (FQHC) providers
- Services rendered by rural health center (RHC) providers
- Professional services that are rendered in the inpatient hospital setting (place of service 3)
- Non-emergency and emergency ambulance services

The outpatient emergency and maintenance renal dialysis procedure codes in the tables below are also exceptions to the one-day payment window reimbursement guidelines:

Emergency Renal Dialysis Services Procedure Codes
G0257

Maintenance Renal Dialysis Services Procedure Codes							
ESRD Physician Services							
90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966
90967	90968	90969	90970				
Physician Services for Hemodialysis or Other Dialysis Procedures							
71010	71020	78300	78305	78306	80069	81050	82040
82310	82374	82435	82565	83615	83735	84075	84100
84132	84155	84295	84450	84520	85004	85007	85008
85014	85018	85025	85027	85041	85345	85347	85610
87340	90935	90937	90945	90947	93005		
Equipment and Supplies							
A4216	A4217	A4651	A4652	A4657	A4660	A4663	A4670
A4680	A4690	A4706	A4707	A4708	A4709	A4714	A4719
A4720	A4721	A4722	A4723	A4724	A4725	A4726	A4730
A4736	A4737	A4740	A4750	A4755	A4760	A4765	A4766
A4772	A4773	A4774	A4802	A4860	A4911	A4913	A4918
A4927	A4928	A4929	A4930	A4931	A4932	E0424	E0431
E0434	E0439	E0441	E0442	E0443	E0444	E1510	E1520
E1530	E1540	E1550	E1560	E1570	E1575	E1580	E1590
E1592	E1594	E1600	E1620	E1630	E1632	E1635	E1637
E1639	E1699	J0360	J1160	J1200	J1265	J1642	J1644
J1720	J1800	J1955	J2150	J2720	Q4081	36000	36430
36591	36593	49421	93040	93041			

Professional and Outpatient Claims for Services Related to the Inpatient Admission

Professional and outpatient services that are rendered on the date of admission or within one calendar day of the admission date by the hospital, or an entity that is wholly owned or operated by the hospital, are considered part of the inpatient stay. Professional and outpatient claims submitted for services that are related to the inpatient admission will be denied or recouped if they are submitted with the specified payment window.

When modifier PD is appended to a professional or outpatient service, the modifier indicates that the service is related to the inpatient admission. The total and technical components for professional and outpatient services that are related to the inpatient admission will be denied when submitted with modifier PD.

Note: *The professional interpretation component for professional and outpatient services that are related to the inpatient stay may be reimbursed separately even if accompanied by PD modifier.*

Professional and Outpatient Claims for Services Unrelated to the Inpatient Admission

Professional and outpatient services that are rendered within the specified timeframe by the hospital or an entity that is wholly owned or operated by the hospital may be reimbursed if they are identified as unrelated to the inpatient admission as follows:

- Professional and outpatient claims for diagnostic services that are unrelated to the inpatient admission must be submitted with modifier U4, which indicates the service is unrelated to the inpatient admission.
- Professional claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the professional claim to the principal inpatient diagnosis. Professional services must be submitted with modifier U4 if the services are unrelated and the referenced professional diagnosis is a three-digit match to the principal inpatient diagnosis.
- Outpatient claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the outpatient claim to the principal inpatient diagnosis. The outpatient services must be submitted with condition code 51 if the services are unrelated and the referenced outpatient diagnosis is a three-digit match to the principal inpatient diagnosis.

Unrelated services that are denied as part of the inpatient admission can be appealed with modifier U4 or condition code 51, which indicates that the service is unrelated to the inpatient admission.

Note: *Claims that are submitted with modifier U4 or condition code 51 will be subject to retrospective review and may be recouped if there is not sufficient documentation to indicate the service was unrelated to the inpatient admission.*

These benefit changes do not impact services rendered by providers that are not wholly owned or operated by the hospital.

24.4 Outpatient Services

24.4.1 Benefits, Limitations, and Authorization Requirements

Outpatient services are ambulatory services provided to an individual who is in a hospital, but not admitted for inpatient care. Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services provided on an outpatient basis that are deemed medically necessary and are provided by a CSHCN Services Program hospital or under the direction of a physician. Supplies provided by a hospital supply room for use in physician's offices in the treatment of clients are not reimbursable as outpatient services.

24.4.1.1 Blood Factor Products

Authorization of hemophilia blood factor products is not required.

Blood factor product procedure codes must be submitted with the National Drug Code (NDC) that identifies the product used and one of the following diagnosis codes as indicated:

- Procedure codes J7185, J7190, J7192, and J7198 are limited to diagnosis code 2860, 2861, 2862, 2863, or 28652.
- Procedure codes J7186 and J7187 are limited to diagnosis code 2860 or 2864.
- Procedure code J7189 is limited to diagnosis code 2860, 2861, 2863, 28652, 2867, 2869, or V8302.

- Procedure codes J7193, J7194, and J7195 are limited to diagnosis code 2861.
- Procedure codes Q9975 and J7201 are limited to diagnosis codes 2860 and 2863.
- Procedure codes J7181 and J7200 are limited to diagnosis code 2863.

Exceptions to the diagnosis codes indicated above will be considered with medical review. Medical review is conducted on all authorization requests that include a diagnosis code other than one listed above.

Medical review is required for approval of blood factor products for any diagnosis other than those listed above.

Claims must be submitted with the quantity and number of units of blood factor products that were provided.

- On electronic claims, enter the following information
  - Quantity Billed field - Enter a quantity of 1 for the blood factor procedure code.
  - NDC QTY field - Indicate the number of units provided.
- On paper CMS-1450 claim forms, enter the number of blood factor units in Box 46.

Outpatient hospitals are reimbursed a percentage of the amount billed.

Refer to: Section 31.2.9, "Blood Factor Products," on page 31-20 for additional information.

24.4.1.2 Hospital-Based Outpatient Behavioral Health Services

Outpatient behavioral health services are limited to no more than 30 encounters by all providers per eligible client per calendar year. Laboratory and radiological services do not count toward the 30 outpatient encounters. The CSHCN Services Program does not provide outpatient behavioral health benefits for clients who are also enrolled in the Texas Medicaid, the Medicaid Comprehensive Care Program (CCP), or Children's Health Insurance Program (CHIP).

Hospitals may be reimbursed for psychological testing (procedure code 96101) and neuropsychological testing (procedure code 96118) in the outpatient setting. Psychological and neuropsychological testing is limited to a total of 4 hours per day and 8 hours per calendar year, per client, by any provider. Interpretation and documentation time, including time to document test results in the client's medical record, is included in procedure code 96101 or 96118, and is not reimbursed separately. Procedure code 96101 will be denied if performed on the same day as procedure code 96118.

Authorization is not required.

Refer to: Chapter 29, "Outpatient Behavioral Health," on page 29-1.

24.4.1.3 Hospital-Based Emergency Services Department

The CSHCN Services Program may cover emergency room visits for program eligible clients when provided in a CSHCN-enrolled facility. An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week.

According to the federal *Emergency Medical Transportation and Labor Act* (EMTALA), if any individual presents at the hospital emergency department requesting an examination or treatment the hospital must provide for an appropriate medical screening examination and stabilization services within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in placing an individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The medical records must reflect continued monitoring according to the client's needs and must continue until the client is discharged, stabilized, or appropriately transferred.

EMTALA medical screening revenue code 451 may be considered for reimbursement when billed as a stand alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement when billed with revenue code 451. Services beyond screening can be billed with the appropriate corresponding emergency services revenue code 450, 456, 459, 761, or 762.

Hospital-Based Emergency Services Authorization

Authorization is not required for emergency medical services. Emergency department services are subject to retroactive review.

24.4.1.4 Outpatient Observation

Outpatient observation services are a benefit of the CSHCN Services Program and do not require prior authorization. Observation care is defined by the Centers for Medicare & Medicaid Services (CMS) as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital's nursing or other ancillary staff to evaluate the client's condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services are a benefit only when medically necessary and when provided under a practitioner's order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
  - Laboratory, radiology, or other testing is necessary to assess the client's need for an inpatient admission.
  - The treatment plan is not established or, based on the client's condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.
  - The medical necessity for inpatient treatment is unclear, that is:
  - The client's medical condition requires monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary.
  - There is a delayed or slow progression of the client's signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.
  - The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.

Medically necessary services that do not meet the definition of observation care should be submitted separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner's expectation of the care that the client will require.

Direct Outpatient Observation Admission

A client may be directly admitted to outpatient observation from the evaluating practitioner's office without being seen in the emergency room by a hospital-based practitioner. The practitioner's order should clearly specify that the practitioner wants the client to be admitted to outpatient observation status. An order for "direct admission" will be considered an inpatient admission unless otherwise specified by the practitioner's orders.

Brief observation periods following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., a breathing treatment) would be more appropriately coded as a treatment room visit.

Observation Following Emergency Room

A client may be admitted to outpatient observation through the emergency room if the client presents to the facility with an unstable medical condition and the evaluating practitioner determines that outpatient observation is medically necessary to determine a definitive treatment plan. An unstable medical condition is defined as one of the following:

- A variance in laboratory values from what is considered the generally accepted, safe values for the individual client.
- Clinical signs and symptoms that are above or below those of normal range and that require extended monitoring and further evaluation.
- Changes in the client's medical condition are anticipated, and further evaluation is necessary.

If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be submitted on a separate detail on the same claim as the observation room charges.

Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit

Observation Following Outpatient Day Surgery

If a medical condition or complication of a scheduled day surgery requires additional care beyond the routine recovery period, the client may be placed in outpatient observation. The observation period should be submitted as an outpatient claim.

Reimbursement for outpatient observation after a scheduled day surgery is limited to situations in which the client exhibits an unusual reaction to the surgical procedure and requires monitoring or treatment beyond what is normally provided in the immediate post-operative period. Examples include, but are not limited to:

- Difficulty in awakening from anesthesia.
- A drug reaction.
- Other post-surgical complications.

Observation Following Outpatient Diagnostic Testing or Therapeutic Services

A client may be admitted to outpatient observation if the client develops a significant adverse reaction to a scheduled outpatient diagnostic test or to a therapeutic service, such as chemotherapy, that requires further monitoring. Observation services begin when the reaction occurred and end when the practitioner determines that the client is stable for discharge, or that an inpatient admission is appropriate.

Documentation Requirements for Outpatient Observation

Documentation that supports the medical necessity of the outpatient observation services must be maintained by the facility in the client's medical record. Documentation must include:

- The order of the ordering practitioner for admission to observation care, which must be dated and timed.

- The practitioner's admission and progress notes, which must be dated and timed, confirm the need for observation care, and outline the client's condition, treatment, and response to treatment.
- Nurse's notes, which must be dated and timed, reflect the time at which the client was admitted to the observation bed, and the reason for the observation stay.
- All supporting diagnostic and ancillary testing reports, including orders for the testing or any preadmission testing.
- Procedure notes and operative notes that address any complication that would support admission to observation status and must be dated and timed.
- Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must be dated and timed and detail orders and any complications that require admission to observation status.
- Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.
- All of the client education that was provided during the observation stay.
- The order for discharge from observation care, which must be signed, dated, and timed.
- The discharge notes, including nurse's notes that reflect the date and time at which the client was discharged from observation.

The client must be in the care of a practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are dated, timed, written, and signed by the practitioner.

Claims submitted for outpatient procedures in which the original intention was to keep the client for an extended period of time, such as overnight or for a 24-hour period, will be denied unless significant medical necessity is documented.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the outpatient observation services. Medical records will be evaluated to determine whether the practitioner's order (practitioner intent) and the services that were actually provided were consistent.

The medical records must clearly support the medical necessity of the outpatient observation services and must include a timed order for observation services that will support the number of hours that the client was under observation care and the hours that were submitted for payment.

Reporting Hours of Observation

Providers must submit the number of observation hours the client was under observation care.

Observation time begins at the clock time documented in the client's medical record. This time should coincide with the time that the client is placed in a bed for the purpose of initiating observation care in accordance with the practitioner's order.

Observation time ends when all medically necessary services related to observation care are completed. The end time of observation services may coincide with the time the client is actually discharged from the hospital or is admitted as an inpatient.

Hospitals should round clock times for the beginning and end of observation to the nearest hour and submit the total number of hours for the observation stay on the claim. For the purposes of submitting claims for observation services, one unit equals one hour. Partial units or hours should be rounded up or down to the nearest hour. Claims submitted with observation room units exceeding 48 hours will be denied.

Any service that was ordered within the observation period may be included on the outpatient claim if a practitioner's order for the service was made within the observation period time frame but hospital scheduling limitations prevented the service from being performed before the 48 hours expired. Any services ordered after 48 hours must not be included on the outpatient claim nor billed to the client. If a period of observation spans more than one calendar day (i.e., extends past midnight), all of the hours for the entire period of observation must be included on a single line, and the date of service for that line is the date on which the observation care began.

Observation time may include medically necessary services and follow-up care that is provided after the time the practitioner writes the discharge order, but before the client is discharged. Reported observation time does not include the time the client remains in the observation area after treatment is completed for reasons such as waiting for transportation home.

Observation services must not be submitted concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure. Time spent for the diagnostic or therapeutic procedure must not be included in the total amount of observation time submitted on the claim.

Recovery room hours that are associated with an outpatient procedure must not be submitted simultaneously with hours of observation time.

Revenue code 761 will be denied if it is submitted for the same date of service by the same provider as revenue code 760, 762, or 769.

Client Status Change

If a practitioner determines that a client in observation status meets criteria for an inpatient admission, the observation service becomes part of the inpatient stay and is not separately reimbursed.

Both the outpatient observation service (revenue code 760) and the inpatient admission must be submitted as separate details on the same inpatient claim. When a client's status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. The practitioner's order for a change in client status from outpatient observation to inpatient admission must be written, dated, and timed before the outpatient observation claim is submitted for reimbursement.

When a client is admitted to the hospital as an inpatient and a subsequent internal utilization review (UR) determines that the services did not meet inpatient criteria, the hospital may change the client's status from inpatient to outpatient observation. The order to change from an inpatient to outpatient observation admission is effective for the same date and time as the inpatient order. This practice is acceptable under the CSHCN Services Program if all of the following conditions are met:

- The change in client status is made before the claim is submitted.
- The hospital has not submitted a claim for the inpatient admission.
- The practitioner responsible for the care of the client concurs with the hospital UR determination to change to outpatient status.
- The practitioner's concurrence with the UR determination is documented in the client's medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be submitted as an outpatient episode of care.

Outpatient Observation Authorization

Authorization is not required for outpatient observation services. Prior authorization is required in the following situations:

- An outpatient observation stay is converted to an inpatient hospitalization.
- For the practitioner's professional services related to a diagnostic, therapeutic, or surgical procedure performed during the time the client is in observation status.

Observation Services that are Not a Benefit

Outpatient observation services that are not medically necessary or appropriate are not benefits of the CSHCN Services Program, including, but not limited to, services provided under the following circumstances:

- As a substitute for an inpatient admission.
- Without a practitioner's order, including services ordered as inpatient services by the ordering practitioner, but submitted as outpatient by the billing office.
- For clients awaiting transfer to another facility.
- For clients with lack of or delay in transportation.

- As a convenience to the client, client's family, the practitioner, hospital, or hospital staff.
- For routine preparation before, or recovery after, outpatient diagnostic or surgical services.
- When an overnight stay is planned before diagnostic testing.
- To medically stable clients who need diagnostic testing or outpatient procedures that are routinely provided in an outpatient setting.
- Following an uncomplicated treatment or procedure.
- As standing orders for observation following outpatient surgery.
- For postoperative monitoring during a standard recovery period of four to six hours, which is considered part of the recovery room service.
- For outpatient blood or chemotherapy administration and concurrent services.
- For services that would normally require an inpatient admission.
- Beyond 48 hours from the time of the observation admission.

Outpatient Observation Authorization

Authorization is not required for outpatient observation services.

Important: *All inpatient admissions require prior authorization. Providers must submit the prior authorization request immediately upon determining that the patient's status is changing from observation to inpatient.*

24.4.1.5 Sleep Studies

Polysomnography, multiple sleep latency tests, and pediatric pneumograms may be a benefit of the CSHCN Services Program.

Sleep facilities that perform services for CSHCN Services Program clients must be accredited with the American Academy of Sleep Medicine (AASM) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Documentation of accreditation must be maintained in the facility and be available for review. Sleep facilities must also follow current AASM practice parameters and clinical guidelines. Providers may refer to the AASM website at www.aasmnet.org for AASM facility certification requirements or to the JCAHO website at www.jointcommission.org for JCAHO facility accreditation information.

Sleep facility technicians and technologists must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

The sleep facility must have one or more supervision physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of the non-physician staff who use the equipment.

Refer to: Section 31.2.36, "Sleep Studies," on page 31-103.

24.4.1.6 Hyperbaric Oxygen Therapy (HBOT)

Hyperbaric oxygen therapy services may be a benefit of the CSHCN Services Program when reimbursed in the outpatient setting to hospital providers when using procedure code G0277. Procedure code G0277 requires prior authorization.

Claims for procedure code G0277 must be submitted with revenue code 413 on the same claim. Claims that are submitted without revenue code 413 will be denied.

The number of billable units that may be submitted for procedure code G0277 will be based on the length of time during which the patient receives treatment with hyperbaric oxygen.

The number of billable units of procedure code G0277 is based upon the time that the patient receives treatment with hyperbaric oxygen. In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, airbrakes and ascent, (in minutes), as follows:

- The first unit is for the time spent in the chamber receiving hyperbaric oxygen and must be for a minimum of 16 minutes.
- To bill for a second (or subsequent unit), all previous units of time must have been for the full 30 minutes, and the last unit must be for 16-30 minutes.

Refer to: Section 31.2.23, "Hyperbaric Oxygen Therapy (HBOT)," on page 31-71 for more information on benefit and prior authorization criteria.

24.4.2 Reimbursement Information

Outpatient hospital services may be reimbursed 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate. The CSHCN Services Program does not have a separate cost settlement process.

Nonemergent and nonurgent evaluation and management (E/M) services rendered in the emergency room may be reimbursed 125 percent of the adult, physician office visit fee for procedure code 99202.

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

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

Refer to: Section 24.4.1.1, "Blood Factor Products," on page 24-15 for more information on blood factor products.

24.4.2.1 Hospital-Based Emergency Services Department

Hospital-based emergency departments may be reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Texas Medicaid cost settlement report. The reasonable cost is reduced by a percentage determined by the state.

24.4.2.2 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.

Refer to: Section 24.3.7, "Payment Window Reimbursement Guidelines," on page 24-13 for additional information about the one-day payment window reimbursement guidelines.

24.5 Ambulatory Surgical Centers

24.5.1 Benefits, Limitations, and Authorization Requirements

Covered services in a freestanding surgical center (ASC) or a hospital ambulatory surgical center (HASC) are billed as one inclusive charge. It is not appropriate to bill separately for any supplies or other services related to the surgery. Routine X-ray and laboratory services directly related to the surgical procedure are not reimbursed separately. All nonroutine laboratory and X-ray services should be billed separately using the hospital's full care provider identifier.

Day surgery payment represents a global payment. Physician services must be billed separately.

Day surgery services include prosthetic devices, such as an intraocular lens (IOL), when supplied by the day surgery facility and implanted, inserted, or otherwise applied during a surgical procedure that is a benefit. Certain devices, such as cochlear implants and neurostimulator devices, may be reimbursed separately from the global rate.

24.5.1.1 Freestanding Surgical Centers

To be considered for payment, all surgeries performed in a freestanding surgical center must meet the following requirements:

- Child must be 24 months of age or older.
- The client's current state of health, using the American Society of Anesthesiologists (ASA) physical state classification, must be Level I or II:
  - ASA I or P1: a normal health patient.
  - ASA II or P2: a patient with mild systemic disease.

Services for a client with physical status P3, P4, P5, or P6 cannot be authorized in a freestanding surgical center.

ASA Designation	Physical Status Modifier
ASA I	P1
ASA II	P2
ASA III	P3
ASA IV	P4
ASA V	P5
ASA VI	P6

Documentation of the client's physical status must be on the surgery authorization request form.

A CSHCN Services Program-enrolled provider must perform the surgical procedure.

24.5.2 Reimbursement Information

Reimbursement of ASC procedures, whether HASC or free-standing, is based on the Centers for Medicare & Medicaid Services (CMS)-approved Ambulatory Surgical Code Groupings (Groups 1 through 9 per CMS and group 10 per the Texas Health and Human Services Commission [HHSC]) payment schedule. ASC and HASC procedure code group information can be obtained from the fee schedules on the TMHP website at www.tmhp.com. When two or more procedures are performed at the same surgical event, reimbursement is based on the procedure with the highest group payment.

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

24.6 Claims Information

Inpatient, outpatient, and HASC claims must be submitted to TMHP in an approved electronic format or on a UB-04-CMS-1450 paper claim form. Freestanding ASC claims must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase UB-04 CMS-1450 or CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

The total number of details allowed for a UB-04 CMS-1450 paper claim form is 28. The TMHP claims processing system accepts a total of 61 details, and merges like revenue codes together to reduce the lines to 28 or less. If the merge function is unable to reduce the lines to 28 or less, the claim will be denied, and the provider will need to reduce the number of details and resubmit the claim.

All claims that require prior authorization must include the prior authorization number.

When completing the 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 CMS NCCI web page at

www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for additional information about claims filing.

Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims filing.

Important: *All CSHCN Services Program paper hospital claims must include benefit code CSN.*

24.6.1 Inpatient Claims

Hospitals are not required to submit itemized charge tickets with their UB-04 CMS-1450 paper claim forms for inpatient stays. The itemized charges must be retained by the facility for a period of at least 5 years from the date of service.

Medical or surgical supplies (e.g., infusion pumps, traction setups, and crutches only for inpatient use) must be itemized on Block 42-43 of the UB-04 CMS-1450 paper claim form. If provided to all admitted clients, admission kits should be billed using revenue code 270. If laboratory work is sent out, the name and address or provider identifier of the laboratory where the work was forwarded must be entered in Block 80 of the UB-04 CMS-1450 paper claim form or in Block 32 of the CMS-1500 paper claim form.

The date of admission must reflect the date that the client was admitted to the hospital as an inpatient.

The from date of service must reflect the date that the client first presented at the hospital for services including but not limited to, emergency room, observation, labor and delivery, or inpatient services.

If services that are rendered before the inpatient admission must be submitted on the inpatient claim, the number of pre-admission days that are related to the inpatient admission cannot exceed the days allowed for the rendered services:

Services	Days Allowed	Units
Emergency Room (ER) services	One day (24 hours) before the inpatient admission	Submitted per day
Observation Services	Up to two days (48 hours) before the inpatient admission	Submitted in hours
Labor and Delivery	Up to three days before the inpatient admission	Submitted per day

Diagnosis-Related Group (DRG) hospital claims allow for a total of three days of pre-admit services. Non-DRG hospital claims are allowed one day of pre-admit services and a second day if additional observations hours occurred.

24.6.2 Outpatient Claims

Medical or surgical supplies (e.g., infusion pumps and traction setups) must be itemized on Block 42-43 of the UB-04 CMS-1450 paper claim form. If provided to all admitted clients, admission kits should be billed using revenue code 270. If laboratory work is sent out, the name and address or provider identifier of the laboratory where the work was forwarded must be entered in Block 80 of the UB-04 CMS-1450 paper claim form or in Block 32 of the CMS-1500 paper claim form.

Emergency department services by facilities for the room charges may be billed using the following revenue codes:

Revenue Code	Description
450	Emergency room
451	Emergency room - EMTALA
456	Emergency room, urgent care
459	Emergency room, other
761	Treatment or observation room, treatment room
762	Treatment or observation room, observation room

Emergency room ancillary services by facilities include laboratory services, radiology services, respiratory therapy services, and diagnostic studies such as electrocardiogram (EKG), computed tomography (CT) scans, and supplies. Facilities billing outpatient claims (claim type 023) bill for ancillary services must use the appropriate procedure code such as the CPT code or the HCPCS code that indicates the procedure or service performed.

If the client visits the emergency room more than once in a day, the time must be given for each visit. The time of the first visit must be identified in Block 18 of the UB-04 CMS-1450 paper claim form, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.

Drugs administered in the outpatient setting must be billed with modifier SH. The drug description must include the name, strength, and quantity of the drug. Take home drugs and supplies are not a benefit of the CSHCN Services Program.

24.6.2.1 Revenue Code and Procedure Code Requirements for All Outpatient Services

The *Health Insurance Portability and Accountability Act* (HIPAA) of 1996, requires that a revenue code be billed for outpatient services that are submitted on the CMS-1450 UB-04 paper claim form or electronic equivalent. All revenue codes (except for those in the table below) must be billed with the most appropriate corresponding procedure code.

Claims must be submitted with the revenue code in Block 42 and the corresponding procedure code in Block 44 for each line item submitted. The revenue code and corresponding procedure code must be on the same line for the claim to process correctly. The procedure code and revenue code combination that is submitted on the claim must reflect the services that were provided to the client. All claims are subject to retrospective review.

Revenue Codes That Require a Procedure Code

The following revenue codes must be billed with an applicable procedure code:

Revenue Codes That Require Procedure Code							
220	278	279	300	301	302	303	304
305	306	307	309	310	311	312	314
319	320	321	322	323	324	329	330
331	332	333	335	339	340	341	342
349	350	351	352	359	380	381	382
383	384	385	386	387	389	400	401
402	403	404	409	419	420	421	422
423	424	429	430	431	432	433	434
439	440	441	442	443	444	449	450*

* For revenue codes 450, 452, 456, and 459, refer to Section 5.8.5, "Physician Services in Hospital Outpatient Setting," on page 5-49 for additional information about the 40-percent reduction for non-emergent and non-urgent services rendered in the emergency room.

Revenue Codes That Require Procedure Code							
452*	456*	459*	460	469	470	471	472
479	480	481	482	483	489	550	551
552	559	560	561	562	569	570	571
572	579	580	581	582	589	610	611
612	619	620	630	631	632	633	634
635	636	730	731	732	739	740	749
770	771	779	920	921	922	923	924
925	929	943					

* For revenue codes 450, 452, 456, and 459, refer to Section 5.8.5, "Physician Services in Hospital Outpatient Setting," on page 5-49 for additional information about the 40-percent reduction for non-emergent and non-urgent services rendered in the emergency room.

Claims that are submitted with a revenue code in the above table will be priced based on the procedure code pricing methodology. All limitations, guidelines, and pricing that apply to the procedure code will be applied to the line item. If the procedure code is not a benefit when rendered by outpatient hospital providers, the line item will be denied. The procedure code must be a benefit when rendered by outpatient hospital providers, and the provider must follow the benefit guidelines and restrictions for the procedure code in order to be reimbursed.

The following list provides examples of claim submissions and appropriate processing:

- Example 1: If the provider bills a revenue code from the above table and chooses a procedure code that requires a modifier, the appropriate modifier must be billed with the revenue code/procedure code combination.
- Example 2: If the provider bills a revenue code from the above table and chooses a procedure code that is not a benefit when rendered by outpatient hospital providers, the line item will be denied.
- Example 3: If the provider bills a revenue code from the above table and chooses a procedure code that must be submitted to the client's other insurance, the line item will be denied with an indication that the other insurance must be billed first.
- Example 4: If the provider bills a revenue code from the above table and chooses a procedure code with a CMS MUE limitation, the line item will be processed to determine whether the limitation for the procedure code has been exceeded.

Refer to: Section 24.4.1.1, "Blood Factor Products," on page 24-15 for more information on blood factor products.

The following revenue codes are the only codes that providers can submit without a corresponding procedure code:

Revenue Codes Exceptions List					
250	251	252	254	255	257
258	259	260	261	262	263
264	269	270	271	272	275
276	280	289	360	361	369
370	371	372	374	379	390
410	412	413	451	510	511
512	513	514	515	516	517
519	520	523	526	529	621
622	623	650	651	652	655
656	657	659	700	709	710
719	720	721	722	723	724

Revenue Codes Exceptions List					
729	750	759	760	761	762
769	881				

Clarification for Non-Hospital Facility Claims

Claims that are submitted on the CMS-1450 UB-04 paper claim form or electronic equivalent by non-hospital facility or other non-hospital providers must be submitted with a revenue code for correct processing. The following guidelines apply to determine reimbursement based on the information submitted on the claim.

Claims submitted with one of the following revenue codes on the same detail line as the procedure code will be reimbursed based on the submitted procedure code:

Revenue Codes that Require a Procedure Code							
278	279	300	301	302	303	304	305
306	307	309	310	311	312	314	319
320	321	322	323	324	329	330	331
332	333	335	339	340	341	342	349
350	351	352	359	380	381	382	383
403	404	409	419	420	421	422	423
424	429	430	431	432	433	434	439
440	441	442	443	444	449	460	469
470	471	472	479	480	481	482	483
489	550	551	552	559	560	561	562
569	570	571	572	579	580	581	582
589	610	611	612	619	620	630	631
632	633	634	635	636	730	731	732
739	740	749	770	771	779	920	921
922	923	924	925	929	943		

Claims that are submitted with a revenue code in the above table will be processed and priced based on the procedure code processing guidelines and pricing methodology. The reimbursement for the line item will not reflect the submitted revenue code even though the revenue code is required for correct claims processing. All limitations, guidelines, and pricing that apply to the procedure code will be applied to the line item.

For all revenue codes that are not in the above table, the following reimbursement guidelines will apply:

- If the revenue code is submitted without a procedure code, the claim will process using the limitations, guidelines, and pricing for the submitted revenue code.
- If the revenue code is submitted with a procedure code (i.e., on the same line item as the revenue code), the claim will process using the limitations, guidelines, and pricing for the submitted procedure code.

Note: *If the submitted procedure code is not a benefit when rendered by the provider that submits the claim, the line item will be denied. The procedure code must be a benefit when rendered by the provider that submits the claim, and the provider must following the benefit guidelines and restrictions for the procedure code in order to be reimbursed.*

Refer to: The Online Fee Lookup (OFL) on this website to determine whether a procedure code is a benefit when rendered by the provider that submits the claim.

24.6.3 HASC Claims

All surgical procedures performed in an ASC or HASC must be billed using the appropriate national procedure code. Day surgery payment represents a global payment. Physician services must be billed separately.

Claims for scheduled outpatient day surgeries performed in an HASC must be filed using the HASC provider identifier and type of bill (TOB) 131 for outpatient hospitals in Block 4 of the UB-04 CMS-1450 paper claim form. Surgical procedures performed in the hospital's outpatient departments (emergency room, treatment rooms) are to be billed under the hospital's provider identifier and not under the ASC provider identifier.

Claims for emergency, unscheduled outpatient surgical procedures should be filed with separate charges for all services using TOB 131 and the hospital's outpatient provider identifier. If a client is admitted for a day surgery procedure, whether scheduled or emergency, and has either an ASA Classification of Physical Status of III, IV, or V or Classification of Heart Disease IV, the surgical procedure must be considered an inpatient procedure and billed on an inpatient claim (TOB 111) using the full care provider identifier. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the surgical procedure must be included on one inpatient claim.

Refer to: Section 24.6.2.1, "Revenue Code and Procedure Code Requirements for All Outpatient Services," on page 24-25 for more information about the revenue code and procedure code claim requirements for outpatient services.

24.6.4 Inpatient Stays Following Scheduled Day Surgeries

If a client suffers a complication following an elective day surgery procedure and requires an inpatient admission, the surgery must be billed as an outpatient service. All inpatient charges must be submitted on a second claim as inpatient services. The diagnosis on the inpatient claim must be the complication that resulted in the admission. The ambulatory surgical procedure must not be listed on the inpatient claim. All inpatient admissions require prior authorization.

Providers must bill the scheduled day surgery using the ASC or HASC provider identifier. If a condition of the scheduled day surgery requires additional care beyond the recovery period, the patient may be placed in outpatient observation (stay less than 24 hours). This outpatient observation stay must be billed using the hospital provider identifier. Care required beyond the outpatient observation period (stay of 24 hours or more) must be billed as an inpatient stay. The admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement must be included on the claim. The principal diagnosis to be used is the complication of surgery that necessitated the extended stay.

24.6.5 Inpatient Stays Following Unscheduled (Emergency) Day Surgeries

Providers must bill the unscheduled day surgery as an outpatient claim using the hospital's provider identifier. If a complication occurs, the same guidelines presented in Section 24.6.4, "Inpatient Stays Following Scheduled Day Surgeries," on page 24-28, must be followed with the following exception: the date of admission on the outpatient claim must reflect the date of first contact with the client.

Take-home drugs and supplies are not a benefit of the CSHCN Services Program. Drugs administered in the outpatient setting must be billed with modifier SH. The drug description must include the name, strength, and quantity.

24.7 TMHP-CSHCN Services Program Contact Center

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

Chapter

25

Laboratory Services

25.1 Enrollment

To enroll in the CSHCN Services Program, laboratories 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, be certified according to the Clinical Laboratory Improvement Amendments (CLIA) of 1988, and comply with all applicable state laws and requirements. Out-of-state laboratory providers must meet all of these conditions and be located in the United States within 50 miles of the Texas state border.

The following laboratories are eligible for enrollment in the CSHCN Services Program:

- A physician's office
  - Meets staff, equipment, and testing capability standards for certification by the Department of State Health Services (DSHS)
  - Medicare-certified and enrolled as a Medicaid provider
  - Providers must also submit a current copy of their permit or license and a copy of the approval letter from DSHS

Note: *If a physician performs more than 100 laboratory tests per year for other providers in their laboratory, the laboratory must be certified by Medicare, and the provider must enroll as an independent laboratory with TMHP.*

- A hospital laboratory for inpatient, outpatient, and nonpatient client claims (a hospital nonpatient is one who is not registered as an inpatient or an outpatient but whose laboratory services are performed by the hospital laboratory)
  - Meets staff, equipment, and testing capability standards for certification by the Department of State Health Services (DSHS)
  - Medicare-certified and enrolled as a Medicaid provider
  - Providers must also submit a current copy of their permit or license and a copy of the approval letter from DSHS
- An independent (freestanding) laboratory
  - An independent (freestanding) laboratory enrolled in the CSHCN Services Program is defined as a facility that meets all of the following criteria:
  - Facility independent from a physician's office, ASC, or hospital
  - Meets staff, equipment, and testing capability standards for certification by the Department of State Health Services (DSHS)
  - Medicare-certified and enrolled as a Medicaid provider
  - Providers must also submit a current copy of their permit or license and a copy of the approval letter from 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

25.1.1 Clinical Laboratory Improvement Amendments (CLIA) of 1988

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

- Enroll with the Centers for Medicare & Medicaid Services (CMS).
- Receive a CLIA registration and certification number by contacting DSHS at 1-512-834-6792 or access CLIA information at www.dshs.state.tx.us/facilities/clia.aspx or at www.cms.hhs.gov/clia.

Submit CLIA applications to the following address:

Texas Department of State Health Services
Patient Quality Care, MC-1979/E 30000
1100 West 49th Street
Austin, TX 78756

Notify TMHP of the assigned CLIA number by fax at 1-512-514-4214 or by mail at the following address:

Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78720–0795

CMS implemented CLIA. The CLIA regulations were published in the February 28, 1992, *Federal Register* and have been amended several times since.

Copies of the CLIA rules and regulations are located at the CMS website at www.cms.hhs.gov. These regulations concern all laboratory testing used for the assessment of human health or the diagnosis, prevention, or treatment of disease. CLIA regulations set standards designed to improve quality in all laboratory testing and include specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing. Under CLIA 88, all clinical laboratories (including those located in physician's offices), regardless of location, size, or type of laboratory must meet standards based on the complexity of the test(s) they perform.

Important: *The CSHCN Services Program monitors claims submitted by clinical laboratories for CLIA numbers. Claims submitted for laboratory services are denied if there is not a CLIA number on file with the CSHCN Services Program.*

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

25.1.1.1 Waiver and Physician-Performed Microscopy Procedure (PPMP) Certificates

Providers are responsible for practicing within the limits of their certificates and maintaining awareness of the most current information regarding enforcement of CLIA provisions.

Note: *Providers may refer to the CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for a list of waived test and provider-performed microscopy procedures (PPMP) procedure codes.*

CSHCN Services Program bills must accurately reflect only those services authorized by CLIA regulations.

25.2 Benefits, Limitations, and Authorization Requirements

Authorization is not required for laboratory services.

The CSHCN Services Program may reimburse the following laboratories for services when the laboratory is certified according to the CLIA regulations and enrolled in the CSHCN Services Program:

- A hospital laboratory for outpatient and nonpatient client claims
- A physician's office
- An independent laboratory

Providers must bill the most specific diagnosis and procedure codes that describes the services provided.

Laboratory tests generally performed as a panel and performed on the same day by the same provider, must be billed as a panel, regardless of the method used to perform the tests (automated or manual).

The CSHCN Services Program pays only the amount allowed for the total component for the same procedure, same client, same date of service, and any provider.

- Providers who perform both the technical service and interpretation must bill for the total component.
- Providers who perform only the technical service must bill for the technical component.
- Providers who perform only the interpretation must bill for the interpretation component.

Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, are denied.

Claims are paid based on the order in which they are received. For example, if a claim is received for the total component, and if payment has been made for the technical and interpretation component for the same procedure, same dates of service, same client, from any provider, the claim for the total component is denied as previously paid to another provider. The same is true if a total component is paid and subsequent claims are received for the individual components.

The following table summarizes procedure code limitations for laboratory services. The procedure codes in Column A are denied as part of another service when submitted with the same date of service by the same provider as any of the procedure codes in Column B.

Column A	Column B
Laboratory	
G0306	85025 (Laboratory)
G0307	85025, 85027 (Laboratory)
82374, 82435, 84132, 84295	80047, 80048, 80051, 80053, 80069 (Laboratory)
80051, 82565, 82947, 84520	80047, 80048, 80053, 80069 (Laboratory)
82310	80048, 80053, 80069 (Laboratory)
80048	80047, 80053, 80069 (Laboratory)
82330	80047 (Laboratory)
80047	80053, 80069 (Laboratory)
80069, 80076, 82040, 82247, 84075, 84155, 84450, 84460	80053 (Laboratory)
82465, 83718, 83721, 84478	80061 (Laboratory)
82040, 84100	80069 (Laboratory)
86705, 86709, 86803, 83740	80074 (Laboratory)
82040, 82247, 82248, 84075, 84155, 84450, 84460	80076 (Laboratory)

Column A	Column B
Consultation	
80500	80502 (Consultation)

25.2.1 Hospital Laboratory Services

Hospital laboratory services are a benefit for inpatient, outpatient, and nonpatient clients. A hospital nonpatient is one who is not registered as an inpatient or an outpatient but whose laboratory services are performed by the hospital laboratory.

Outpatient and nonpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory. However, hospital laboratories may bill for all of the tests performed on a specimen even if a portion of the tests are done by another laboratory on referral from the hospital submitting the claim. If the specimen is collected by venipuncture or catheterization, hospitals may bill procedure code 99001 for collecting and forwarding a specimen to a receiving laboratory. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more laboratories.

In order to bill a handling fee, the receiving laboratory's name and address and unique Texas provider identifier (TPI) number must be included on the claim in Blocks 17 and 17B.

In order to bill nonpatient claims for laboratory services, the complete name and address and unique TPI of the attending, ordering, designated, or performing (freestanding ASCs only) provider must be included on the claim in Blocks 17 and 17B.

25.2.2 Independent Laboratory Services

Independent laboratories that provide laboratory tests to clients registered as hospital inpatients or hospital outpatients are not directly reimbursed. Reimbursement must be obtained from the hospital.

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may not bill for laboratory tests. An independent laboratory may bill the CSHCN Services Program for tests referred to another laboratory (independent or hospital) only if the independent laboratory performs at least one test and forwards a portion of the same specimen to another laboratory to have one or more tests performed. In this instance, the referring laboratory may bill for tests it performs and all tests the receiving laboratory performs on the specimen. In both instances, an independent laboratory that forwards a specimen to another laboratory may bill a handling fee (procedure code 99001) for collection and forwarding the specimen if the specimen is collected by venipuncture or catheterization.

In order to bill a handling fee, the receiving laboratory's name and address and unique TPI number must be included on the claim in Blocks 17 and 17B.

The CSHCN Services Program covers professional and technical services that an independent laboratory is certified by Medicare to perform.

25.2.3 Physician-Owned Laboratory Services

The CSHCN Services Program reimburses laboratory services ordered by a physician and provided under the provider's personal supervision in a setting other than an inpatient or outpatient hospital.

25.2.3.1 Other Physician Laboratory-Related Services

Physicians may only bill for those laboratory tests that are actually performed in their offices. Clinical laboratory services performed in a physician's office may be reimbursed at 60 percent of the prevailing charge levels. A laboratory handling fee (procedure code 99000) may be billed if the specimen is obtained by venipuncture or catheterization and sent to an outside laboratory. Only one lab handling fee per day, per client, may be billed, unless multiple specimens are obtained and sent to different laboratories.

In order to bill a handling fee, the receiving laboratory's name and address and unique TPI number must be included on the claim in Blocks 17 and 17B.

Laboratory services must be documented in clients' medical records as medically necessary and reference an appropriate diagnosis.

Laboratory tests generally performed as a panel (chemistries, complete blood counts [CBCs], or urinalyses [UAs]) and performed on the same day by the same provider must be billed as a panel regardless of the method used to perform the test.

Interpretation of laboratory tests for the physician's patients in the hospital, office, or emergency rooms are considered part of the physician's professional services and should not be billed separately.

25.2.4 Clinical Pathology Services

Clinical pathology consultations are a benefit when performed by a clinical pathologist or geneticist. A geneticist may submit claims for procedure codes 80500 and 80502 using their physician provider identifier.

Independent laboratories may submit claims for procedure codes 80500 and 80502 when services are performed in the independent laboratory setting.

Routine conversations between a consultant and an attending physician about test orders or results are not considered consultations.

The service does not qualify as a consultation if the information could ordinarily be furnished by a non-physician laboratory specialist.

Claims for clinical pathology consultations must be submitted with the following documentation:

- The name and address, or the CSHCN Services Program provider identifier for the physician requesting the consultation, must be included on the claim. The NPI of the physician requesting the consultation should also be included, if known.
- A copy of the written narrative report describing the consultation findings.
- Documented interaction that clearly outlines that the consultant interpreted the test results and made specific recommendations to the ordering physician.

Important: *If the claim does not include all of this information, the clinical pathology consultation will be denied.*

25.2.5 Other Laboratory Procedures

Procedure Codes				
1 per day when billed by any provider				
82013	82105	82127	82128	82131
82136	82139	82164	82657	82677
83080	84702	88240	88241	88267
88269				
1 per provider per day				
80500	80502	83788	83789	83915
83916	83918	83919	88291	
5 per provider per day				
88280				
10 per provider per day				
83516	83518	83519	83520	88273
88274	88275			
50 per provider per day				
88271				
1 per lifetime				
S3840	S3841	S3842	S3844	S3846
S3849	S3850	S3853		

Procedure codes 82105 and 84702 may be reimbursed once per day to physician, hospital, and independent laboratories when billed with diagnosis code 1550, 1580, 1640, 1649, 1830, 1860, 1869, or 1910.

25.2.5.1 Cytogenetics Testing

When billed with an appropriate diagnosis code, cytogenetics testing procedure codes have the following limitations:

Procedure Code	Quantity Allowed
Tissue Culture	
88230	1 per day, any provider
88233	1 per day, any provider
88235	1 per day, any provider
88237	1 per day, any provider
88239	1 per day, any provider
Chromosome Analysis	
88245	1 per day, any provider
88248	1 per day, any provider
88249	1 per day, any provider
88261	1 per day, any provider
88262	1 per day, any provider
88263	1 per day, any provider
88264	1 per day, any provider
88280	5 per day, any provider

Procedure Code	Quantity Allowed
88283	1 per day, any provider
88285	1 per day, any provider
88289	1 per day, any provider
Molecular Cytogenetics	
88271	50 per provider, per day
88272	10 per provider, per day
88273	10 per provider, per day
88274	10 per provider, per day
88275	10 per provider, per day
Interpretation and Report	
88291	Cytogenetics and molecular cytogenetics, interpretation and report

Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

Diagnosis Code	Description
20030	Marginal zone lymphoma, unspecified site, extranodal and solid organ sites
20031	Marginal zone lymphoma, lymph nodes of head, face, and neck
20032	Marginal zone lymphoma, intrathoracic lymph nodes
20033	Marginal zone lymphoma, intra-abdominal lymph nodes
20034	Marginal zone lymphoma, lymph nodes of axilla and upper limb
20035	Marginal zone lymphoma, lymph nodes of inguinal region and lower limb
20036	Marginal zone lymphoma, intrapelvic lymph nodes
20037	Marginal zone lymphoma, spleen
20038	Marginal zone lymphoma, lymph nodes lymph nodes of multiple sites
20040	Mantle cell lymphoma, unspecified site, extranodal and solid organ sites
20041	Mantle cell lymphoma, lymph nodes of head, face, and neck
20042	Mantle cell lymphoma, intrathoracic lymph nodes
20043	Mantle cell lymphoma, intra-abdominal lymph nodes
20044	Mantle cell lymphoma, lymph nodes of axilla and upper limb
20045	Mantle cell lymphoma, lymph nodes of inguinal region and lower limb
20046	Mantle cell lymphoma, intrapelvic lymph nodes
20047	Mantle cell lymphoma, spleen
20048	Mantle cell lymphoma, lymph nodes of multiple sites
20050	Primary central nervous system lymphoma, unspecified site, extranodal and solid organ sites
20051	Primary central nervous system lymphoma, lymph nodes of head, face, and neck
20052	Primary central nervous system lymphoma, intrathoracic lymph nodes
20053	Primary central nervous system lymphoma, intra-abdominal lymph nodes
20054	Primary central nervous system lymphoma, lymph nodes of axilla and upper limb
20055	Primary central nervous system lymphoma, lymph nodes of inguinal region and lower limb

Diagnosis Code	Description
20056	Primary central nervous system lymphoma, intrapelvic lymph nodes
20057	Primary central nervous system lymphoma, spleen
20058	Primary central nervous system lymphoma, lymph nodes of multiple sites
20060	Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites
20061	Anaplastic large cell lymphoma, lymph nodes of head, face, and neck
20062	Anaplastic large cell lymphoma, intrathoracic lymph nodes
20063	Anaplastic large cell lymphoma, intra-abdominal lymph nodes
20064	Anaplastic large cell lymphoma, lymph nodes of axilla and upper limb
20065	Anaplastic large cell lymphoma, lymph nodes of inguinal region and lower limb
20066	Anaplastic large cell lymphoma,
20067	Anaplastic large cell lymphoma, spleen
20068	Anaplastic large cell lymphoma, lymph nodes of multiple sites
20070	Large cell lymphoma, unspecified site, extranodal and solid organ sites
20071	Large cell lymphoma, lymph nodes of head, face and neck
20072	Large cell lymphoma, intrathoracic lymph nodes
20073	Large cell lymphoma, intra-abdominal lymph nodes
20074	Large cell lymphoma, lymph nodes of axilla and upper limb
20075	Large cell lymphoma, lymph nodes of inguinal region and lower limb
20076	Large cell lymphoma, intrapelvic lymph nodes
20077	Large cell lymphoma, spleen
20078	Large cell lymphoma, lymph nodes of multiple sites
20270	Peripheral T-cell lymphoma, unspecified site, extranodal and solid organ sites
20271	Peripheral T-cell lymphoma, lymph nodes of head, face and neck
20272	Peripheral T-cell lymphoma, intrathoracic lymph nodes
20273	Peripheral T-cell lymphoma, intra-abdominal lymph nodes
20274	Peripheral T-cell lymphoma, lymph nodes of axilla and upper limb
20275	Peripheral T-cell lymphoma, lymph nodes of inguinal region and lower limb
20276	Peripheral T-cell lymphoma, intrapelvic lymph nodes
20277	Peripheral T-cell lymphoma, spleen
20278	Peripheral T-cell lymphoma, lymph nodes of multiple sites
20280	Lymphoma (malignant)
20281	Other malignant lymphomas involving lymph nodes of head, face, and neck
20282	Other malignant lymphomas involving intrathoracic lymph nodes
20283	Other malignant lymphomas involving intra-abdominal lymph nodes
20284	Other malignant lymphomas involving lymph nodes of axilla and upper limb
20285	Other malignant lymphomas involving lymph nodes of inguinal region and lower limb
20286	Other malignant lymphomas involving intrapelvic lymph nodes
20287	Other malignant lymphomas involving spleen
20288	Other malignant lymphomas involving lymph nodes of multiple sites

Diagnosis Code	Description
20290	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites
20291	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of head, face, and neck
20292	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrathoracic lymph nodes
20293	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intra-abdominal lymph nodes
20294	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of axilla and upper limb
20295	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of inguinal region and lower limb
20296	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrapelvic lymph nodes
20297	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving spleen
20298	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of multiple sites
20312	Plasma cell leukemia, in relapse
20382	Other immunoproliferative neoplasms, in relapse
20400	Acute lymphoid leukemia, without mention of having achieved remission
20401	Acute lymphoid leukemia, in remission
20402	Acute lymphoid leukemia, in relapse
20410	Chronic lymphoid leukemia, without mention of having achieved remission
20411	Chronic lymphoid leukemia, in remission
20412	Chronic lymphoid leukemia, in relapse
20420	Subacute lymphoid leukemia, without mention of having achieved remission
20421	Subacute lymphoid leukemia, in remission
20422	Subacute lymphoid leukemia, in relapse
20480	Other lymphoid leukemia, without mention of having achieved remission
20481	Other lymphoid leukemia, in remission
20482	Other lymphoid leukemia, in relapse
20490	Unspecified lymphoid leukemia, without mention of having achieved remission
20491	Unspecified lymphoid leukemia, in remission
20492	Unspecified lymphoid leukemia, in relapse
20500	Acute myeloid leukemia, without mention of having achieved remission
20501	Acute myeloid leukemia, in remission
20502	Acute myeloid leukemia, in relapse
20510	Chronic myeloid leukemia, without mention of having achieved remission
20511	Chronic myeloid leukemia, in remission
20512	Chronic myeloid leukemia, in relapse
20520	Subacute myeloid leukemia, without mention of having achieved remission
20521	Subacute myeloid leukemia, in remission

Diagnosis Code	Description
20522	Subacute myeloid leukemia, in relapse
20530	Myeloid sarcoma, without mention of having achieved remission
20531	Myeloid sarcoma, in remission
20532	Myeloid sarcoma, in relapse
20580	Other myeloid leukemia, without mention of having achieved remission
20581	Other myeloid leukemia, in remission
20582	Other myeloid leukemia, in relapse
20590	Unspecified myeloid leukemia, without mention of having achieved remission
20591	Unspecified myeloid leukemia, in remission
20592	Unspecified myeloid leukemia, in relapse
20600	Acute monocytic leukemia, without mention of having achieved remission
20601	Acute monocytic leukemia, in remission
20602	Acute monocytic leukemia, in relapse
20610	Chronic monocytic leukemia, without mention of remission
20611	Chronic monocytic leukemia, in remission
20612	Chronic monocytic leukemia, in relapse
20620	Subacute monocytic leukemia, without mention of having achieved remission
20621	Subacute monocytic leukemia, in remission
20622	Subacute monocytic leukemia, in relapse
20680	Other monocytic leukemia, without mention of having achieved remission
20681	Other monocytic leukemia, in remission
20682	Other monocytic leukemia, in relapse
20690	Unspecified monocytic leukemia, without mention of having achieved remission
20691	Unspecified monocytic leukemia in remission
20692	Unspecified monocytic leukemia, in relapse
20700	Acute erythremia and erythroleukemia, without mention of having achieved remission
20701	Acute erythremia and erythroleukemia, in remission
20702	Acute erythremia and erythroleukemia, in relapse
20710	Chronic erythremia, without mention of having achieved remission
20711	Chronic erythremia in remission
20712	Erythroleukemia, in relapse
20720	Megakaryocytic leukemia, without mention of having achieved remission
20721	Megakaryocytic leukemia, in remission
20722	Megakaryocytic leukemia, in relapse
20780	Other specified leukemia, without mention of having achieved remission
20781	Other specified leukemia, in remission
20782	Other specified leukemia, in relapse
20800	Acute leukemia of unspecified cell type, without mention of having achieved remission

Diagnosis Code	Description
20801	Acute leukemia of unspecified cell type, in remission
20802	Acute leukemia of unspecified cell type, in relapse
20810	Chronic leukemia of unspecified cell type, without mention of having achieved remission
20811	Chronic leukemia of unspecified cell type, in remission
20812	Chronic leukemia of unspecified cell type, in relapse
20820	Subacute leukemia of unspecified cell type, without mention of having achieved remission
20821	Subacute leukemia of unspecified cell type, in remission
20822	Other leukemia of unspecified cell type, in relapse
20880	Other leukemia of unspecified cell type, without mention of having achieved remission
20881	Other leukemia of unspecified cell type, in remission
20822	Other leukemia of unspecified cell type, in relapse
20890	Unspecified leukemia, without mention of having achieved remission
20891	Unspecified leukemia, in remission
20892	Unspecified leukemia, in relapse
23773	Schwannomatosis
2533	Pituitary dwarfism
2572	Other testicular hypofunction
2590	Delay in sexual development and puberty, not elsewhere classified
2594	Dwarfism, not elsewhere classified
27501	Hereditary hemochromatosis
27549	Other disorders of calcium metabolism
27911	DiGeorge's syndrome
29900	Autistic disorder, current or active state
29901	Autistic disorder, residual state
31400	Attention deficit disorder of childhood without mention of hyperactivity
31401	Attention deficit disorder of childhood with hyperactivity
31500	Developmental reading disorder, unspecified
31501	Alexia
31502	Developmental dyslexia
31509	Other specific developmental reading disorder
31534	Speech and language developmental delay due to hearing loss
3151	Mathematics disorder
3152	Other specific developmental learning difficulties
31531	Expressive language disorder
31532	Mixed receptive-expressive language disorder
31539	Other developmental speech disorder
3154	Developmental coordination disorder
3155	Mixed development disorder
3158	Other specified delays in development

Diagnosis Code	Description
3159	Unspecified delay in development
317	Mild intellectual disabilities
3180	Moderate intellectual disabilities
3181	Severe intellectual disabilities
3182	Profound intellectual disabilities
319	Unspecified intellectual disabilities
37641	Hypertelorism of orbit
44770	Aortic ectasia, unspecified site
44771	Thoracic aortic ectasia
44772	Abdominal aortic ectasia
44773	Thoracoabdominal aortic ectasia
52400	Unspecified major anomaly of jaw size
52401	Maxillary hyperplasia
52402	Mandibular hyperplasia
52403	Maxillary hypoplasia
52404	Mandibular hypoplasia
52405	Macrogenia
52406	Microgenia
52407	Excessive tuberosity of jaw
52409	Other specified major anomaly of jaw size
61182	Hypoplasia of breast
7400	Anencephalus
7401	Craniorachischisis
7402	Iniencephaly
74100	Spina bifida with hydrocephalus, unspecified region
74101	Spina bifida with hydrocephalus, cervical region
74102	Spina bifida with hydrocephalus, dorsal (thoracic) region
74103	Spina bifida with hydrocephalus, lumbar region
74190	Spina bifida without mention of hydrocephalus, unspecified region
74191	Spina bifida without mention of hydrocephalus, cervical region
74192	Spina bifida without mention of hydrocephalus, dorsal (thoracic) region
74193	Spina bifida without mention of hydrocephalus, lumbar region
7420	Encephalocele
7421	Microcephalus
7422	Congenital reduction deformities of brain
7423	Congenital hydrocephalus
7424	Other specified congenital anomalies of brain
74251	Diastematomyelia
74253	Hydromyelia
74259	Other specified congenital anomaly of spinal cord
7428	Other specified congenital anomalies of nervous system

Diagnosis Code	Description
7429	Unspecified congenital anomaly of brain, spinal cord, and nervous system
74300	Unspecified clinical anophthalmos
74303	Cystic eyeball, congenital
74306	Cryptophthalmos
74310	Unspecified microphthalmos
74311	Simple microphthalmos
74312	Microphthalmos associated with other anomalies of eye and adnexa
74320	Unspecified buphthalmos
74321	Simple buphthalmos
74322	Buphthalmos associated with other ocular anomaly
74330	Unspecified congenital cataract
74331	Congenital capsular and subcapsular cataract
74332	Congenital cortical and zonular cataract
74333	Congenital nuclear cataract
74334	Congenital total and subtotal cataract
74335	Congenital aphakia
74336	Congenital anomalies of lens shape
74337	Congenital ectopic lens
74339	Other congenital cataract and lens anomalies
74341	Congenital anomaly of corneal size and shape
74342	Congenital corneal opacities, interfering with vision
74343	Other congenital corneal opacity
74344	Specified congenital anomalies of anterior chamber, chamber angle, and related structures
74345	Aniridia
74346	Other specified congenital anomaly of iris and ciliary body
74347	Specified congenital anomaly of sclera
74348	Multiple and combined congenital anomalies of anterior segment of eye
74349	Other congenital anomaly of anterior segment of eye
74351	Vitreous anomalies, congenital
74352	Fundus coloboma
74353	Congenital chorioretinal degeneration
74354	Congenital folds and cysts of posterior segment of eye
74355	Congenital macular change
74356	Other congenital retinal changes
74357	Specified congenital anomalies of optic disc
74358	Vascular anomalies, congenital
74359	Other congenital anomalies of posterior segment of eye
74361	Congenital ptosis of eyelid
74362	Congenital deformity of eyelids
74363	Other specified congenital anomaly of eyelid
74364	Specified congenital anomaly of lacrimal gland

Diagnosis Code	Description
74365	Specified congenital anomaly of lacrimal passages
74366	Specified congenital anomaly of orbit
74369	Other congenital anomalies of eyelids, lacrimal system, and orbit
7438	Other specified congenital anomalies of eye
7439	Unspecified congenital anomaly of eye
74400	Unspecified congenital anomaly of ear causing impairment of hearing
74401	Congenital absence of external ear causing impairment of hearing
74402	Other congenital anomaly of external ear with impairment of hearing
74403	Congenital anomaly of middle ear, except ossicles, causing impairment of hearing
74404	Congenital anomalies of ear ossicles
74405	Congenital anomalies of inner ear
74409	Other congenital anomalies of ear causing impairment of hearing
7441	Congenital anomalies of accessory auricle
74421	Congenital absence of ear lobe
74422	Macrotia
74423	Microtia
74424	Specified congenital anomaly of Eustachian tube
74429	Other congenital anomaly of ear
7443	Unspecified congenital anomaly of ear
74441	Congenital branchial cleft sinus or fistula
74442	Congenital branchial cleft cyst
74443	Congenital cervical auricle
74446	Congenital preauricular sinus or fistula
74447	Congenital preauricular cyst
74449	Other congenital branchial cleft cyst or fistula; preauricular sinus
7445	Congenital webbing of neck
74481	Macrocheilia
74482	Microcheilia
74483	Macrostomia
74484	Microstomia
74489	Other specified congenital anomaly of face and neck
7449	Unspecified congenital anomaly of face and neck
7450	Bulbus cordis anomalies of cardiac septal closure, common truncus
74510	Complete transposition of great vessels
74511	Transposition of great vessels, double outlet right ventricle
74512	Corrected transposition of great vessels
74519	Other transposition of great vessels
7452	Tetralogy of Fallot
7453	Bulbus cordis anomalies and anomalies of cardiac septal closure, common ventricle
7454	Ventricular septal defect

Diagnosis Code	Description
7455	Ostium secundum type atrial septal defect
74560	Unspecified type congenital endocardial cushion defect, unspecified type
74561	Ostium primum defect
74569	Other congenital endocardial cushion defects
7457	Cor biloculare
7458	Other bulbus cordis anomalies and anomalies of cardiac septal closure
7459	Unspecified congenital defect of septal closure
74600	Unspecified congenital pulmonary valve anomaly
74601	Congenital atresia of pulmonary valve
74602	Congenital stenosis of pulmonary valve
74609	Other congenital anomalies of pulmonary valve
7461	Congenital tricuspid atresia and stenosis
7462	Ebstein's anomaly
7463	Congenital stenosis of aortic valve
7464	Congenital insufficiency of aortic valve
7465	Congenital mitral stenosis
7466	Congenital mitral insufficiency
7467	Hypoplastic left heart syndrome
74681	Congenital subaortic stenosis
74682	Cor triatriatum
74683	Congenital infundibular pulmonic stenosis
74684	Congenital obstructive anomalies of heart, not elsewhere classified
74685	Congenital coronary artery anomaly
74686	Congenital heart block
74687	Congenital malposition of heart and cardiac apex
74689	Other specified congenital anomaly of heart
7469	Unspecified congenital anomaly of heart
7470	Patent ductus arteriosus
74710	Coarctation of aorta (preductal) (postductal)
74711	Congenital interruption of aortic arch
74720	Unspecified congenital anomaly of aorta
74721	Congenital anomalies of aortic arch
74722	Congenital atresia and stenosis of aorta
74729	Other congenital anomaly of aorta
74732	Pulmonary arteriovenous malformation
74740	Congenital anomaly of great veins, unspecified
74741	Total congenital anomalous pulmonary venous connection
74742	Partial congenital anomalous pulmonary venous connection
74749	Other congenital anomalies of great veins
7475	Congenital absence or hypoplasia of umbilical artery
74760	Congenital anomaly of the peripheral vascular system, unspecified site

Diagnosis Code	Description
74761	Congenital gastrointestinal vessel anomaly
74762	Congenital renal vessel anomaly
74763	Congenital upper limb vessel anomaly
74764	Congenital lower limb vessel anomaly
74769	Congenital anomaly of other specified sites of peripheral vascular system
74781	Congenital anomaly of cerebrovascular system
74782	Congenital spinal vessel anolmaly
74783	Persistent fetal circulation
74789	Other specified congenital anomaly of circulatory system
7479	Unspecified congenital anomaly of circulatory system
7480	Congenital choanal atresia
7481	Other congenital anomaly of nose
7482	Congenital web of larynx
7483	Other congenital anomaly of larynx, trachea, and bronchus
7484	Congenital cystic lung
7485	Congenital agenesis, hypoplasia, and dysplasia of lung
74860	Unspecified congenital anomaly of lung
74861	Congenital bronchiectasis
74869	Other congenital anomaly of lung
7488	Other specified congenital anomaly of respiratory system
7489	Unspecified congenital anomaly of respiratory system
74900	Unspecified cleft palate
74901	Unilateral cleft palate complete
74902	Unilateral cleft palate incomplete
74903	Bilateral cleft palate complete
74904	Bilateral cleft palate incomplete
74910	Unspecified cleft lip
74911	Unilateral cleft lip complete
74912	Unilateral cleft lip incomplete
74913	Bilateral cleft lip complete
74914	Bilateral cleft lip incomplete
74920	Unspecified cleft palate with cleft lip
74921	Unilateral cleft palate with cleft lip complete
74922	Unilateral cleft palate with cleft lip incomplete
74923	Bilateral cleft palate with cleft lip complete
74924	Bilateral cleft palate with cleft lip incomplete
74925	Other combinations of cleft palate with cleft lip
7500	Tongue tie
75010	Congenital anomaly of tongue, unspecified
75011	Aglossia
75012	Congenital adhesions of tongue

Diagnosis Code	Description
75013	Congenital fissure of tongue
75015	Macroglossia
75016	Microglossia
75019	Other congenital anomaly of tongue
75021	Congenital absence of salivary gland
75022	Congenital accessory salivary gland
75023	Congenital atresia, salivary duct
75024	Congenital fistula of salivary gland
75025	Congenital fistula of lip
75026	Other specified congenital anomalies of mouth
75027	Congenital diverticulum of pharynx
75029	Other specified congenital anomaly of pharynx
7503	Congenital tracheoesophageal fistula, esophageal atresia and stenosis
7504	Other specified congenital anomaly of esophagus
7505	Congenital hypertrophic pyloric stenosis
7506	Congenital hiatus hernia
7507	Other specified congenital anomalies of stomach
7508	Other specified congenital anomalies of upper alimentary tract
7509	Unspecified congenital anomalies of upper alimentary tract
7510	Meckel's diverticulum
7511	Congenital atresia and stenosis of small intestine
7512	Congenital atresia and stenosis of large intestine, rectum, and anal canal
7513	Hirschsprung's disease and other congenital functional disorders of colon
7514	Congenital anomalies of intestinal fixation
7515	Other congenital anomalies of intestine
75160	Unspecified congenital anomaly of gallbladder, bile ducts, and liver
75161	Congenital biliary atresia
75162	Congenital cystic disease of liver
75169	Other congenital anomaly of gallbladder, bile ducts, and liver
7517	Congenital anomalies of pancreas
7518	Other specified congenital anomalies of digestive system
7519	Unspecified congenital anomaly of digestive system
7520	Congenital anomalies of ovaries
75210	Unspecified congenital anomaly of fallopian tubes and broad ligaments
75211	Embryonic cyst of fallopian tubes and broad ligaments
75219	Other congenital anomaly of fallopian tubes and broad ligaments
7522	Congenital doubling of uterus
75231	Agenesis of uterus
75232	Hypoplasia of uterus
75240	Unspecified congenital anomaly of cervix, vagina, and external female genitalia
75241	Embryonic cyst of cervix, vagina, and external female genitalia

Diagnosis Code	Description
75242	Imperforate hymen
75243	Cervical agenesis
75425	Vaginal agenesis
75249	Other congenital anomaly of cervix, vagina, and external female genitalia
75251	Undescended testis
75252	Retractile testis
75261	Hypospadias
75262	Epispadias
75263	Congenital chordee
75264	Micropenis
75265	Hidden penis
75269	Other penile anomalies
7527	Indeterminate sex and pseudohermaphroditism
75281	Scrotal transposition
75289	Other specified anomalies of genital organs
7529	Unspecified congenital anomaly of genital organs
7530	Congenital renal agenesis and dysgenesis
75310	Unspecified congenital cystic kidney disease
75311	Congenital single renal cyst
75312	Congenital polycystic kidney, unspecified type
75313	Congenital polycystic kidney, autosomal dominant
75314	Congenital polycystic kidney, autosomal recessive
75315	Congenital renal dysplasia
75316	Congenital medullary cystic kidney
75317	Congenital medullary sponge kidney
75319	Other specified congenital cystic kidney disease
75320	Unspecified obstructive defect of renal pelvis and ureter
75321	Congenital obstruction of ureteropelvic junction
75322	Congenital obstruction of ureterovesical junction
75323	Congenital ureterocele
75329	Other obstructive defect of renal pelvis and ureter
7533	Other specified congenital anomalies of kidney
7534	Other specified congenital anomalies of ureter
7535	Exstrophy of urinary bladder
7536	Congenital atresia and stenosis of urethra and bladder neck
7537	Congenital anomalies of urachus
7538	Other specified congenital anomaly of bladder and urethra
7539	Unspecified congenital anomaly of urinary system
7540	Congenital musculoskeletal deformities of skull, face, and jaw
7541	Congenital musculoskeletal deformity of sternocleidomastoid muscle
7542	Congenital musculoskeletal deformity of spine

Diagnosis Code	Description
75430	Congenital dislocation of hip, unilateral
75431	Congenital dislocation of hip, bilateral
75432	Congenital subluxation of hip, unilateral
75433	Congenital subluxation of hip, bilateral
75435	Congenital dislocation of one hip with subluxation of other hip
75440	Congenital genu recurvatum
75441	Congenital dislocation of knee (with genu recurvatum)
75442	Congenital bowing of femur
75443	Congenital bowing of tibia and fibula
75444	Congenital bowing of unspecified long bones of leg
75450	Congenital talipes varus
75451	Congenital talipes equinovarus
75452	Congenital metatarsus primus varus
75453	Congenital metatarsus varus
75459	Other congenital varus deformity of feet
75460	Congenital talipes valgus
75461	Congenital pes planus
75462	Talipes calcaneovalgus
75469	Other congenital valgus deformity of feet
75470	Unspecified talipes
75471	Talipes cavus
75479	Other congenital deformity of feet
75481	Pectus excavatum
75482	Pectus carinatum
75489	Other specified nonteratogenic anomalies
75500	Polydactyly, unspecified digits
75501	Polydactyly of fingers
75502	Polydactyly of toes
75510	Syndactyly of multiple and unspecified sites
75511	Syndactyly of fingers without fusion of bone
75512	Syndactyly of fingers with fusion of bone
75513	Syndactyly of toes without fusion of bone
75514	Syndactyly of toes with fusion of bone
75520	Congenital unspecified reduction deformity of upper limb, congenital
75521	Congenital transverse deficiency of upper limb
75522	Congenital longitudinal deficiency of upper limb, not elsewhere classified
75523	Congenital longitudinal deficiency, combined, involving humerus, radius, and ulna (complete or incomplete)
75524	Congenital longitudinal deficiency, humeral, complete or partial (with or without distal deficiencies, incomplete)
75525	Congenital longitudinal deficiency, radioulnar, complete or partial (with or without distal deficiencies, incomplete)

Diagnosis Code	Description
75526	Congenital longitudinal deficiency, radial, complete or partial (with or without distal deficiencies, incomplete)
75527	Congenital longitudinal deficiency, ulnar, complete or partial (with or without distal deficiencies, incomplete)
75528	Congenital longitudinal deficiency, carpals or metacarpals, complete or partial (with or without incomplete phalangeal deficiency)
75529	Congenital longitudinal deficiency, phalanges, complete or partial
75530	Congenital unspecified reduction deformity of lower limb, congenital
75531	Congenital transverse deficiency of lower limb
75532	Congenital longitudinal deficiency of lower limb, not elsewhere classified
75533	Congenital longitudinal deficiency, combined, involving femur, tibia, and fibula (complete or incomplete)
75534	Congenital longitudinal deficiency, femoral, complete or partial (with or without distal deficiencies, incomplete)
75535	Congenital longitudinal deficiency, tibiofibular, complete or partial (with or without distal deficiencies, incomplete)
75536	Congenital longitudinal deficiency, tibia, complete or partial (with or without distal deficiencies, incomplete)
75537	Congenital longitudinal deficiency, fibular, complete or partial (with or without distal deficiencies, incomplete)
75538	Congenital longitudinal deficiency, tarsals or metatarsals, complete or partial (with or without incomplete phalangeal deficiency)
75539	Congenital longitudinal deficiency, phalanges, complete or partial
7554	Congenital reduction deformities, unspecified limb
75550	Unspecified congenital anomaly of upper limb
75551	Congenital deformity of clavicle
75552	Congenital elevation of scapula
75553	Radioulnar synostosis
75554	Madelung's deformity
75555	Acrocephalosyndactyly
75556	Accessory carpal bones
75557	Macrodactylia (fingers)
75558	Congenital cleft hand
75559	Other congenital anomaly of upper limb, including shoulder girdle
75561	Congenital coxa valga
75562	Congenital coxa vara
75563	Other congenital deformity of hip (joint)
75565	Macrodactylia of toes
75566	Other congenital anomaly of toes
75567	Congenital anomalies of foot, not elsewhere classified
75569	Other congenital anomalies of lower limb, including pelvic girdle
7558	Other specified congenital anomalies of unspecified limb
7559	Unspecified congenital anomaly of unspecified limb
7560	Congenital anomalies of skull and face bones

Diagnosis Code	Description
75610	Congenital anomaly of spine, unspecified
75611	Congenital spondylolysis, lumbosacral region
75612	Congenital spondylolisthesis
75613	Congenital absence of vertebra
75614	Hemivertebra
75615	Congenital fusion of spine (vertebra)
75616	Klippel-Feil syndrome
75617	Spina bifida occulta
75619	Other congenital anomaly of spine
7562	Cervical rib
7563	Other congenital anomaly of ribs and sternum
7564	Chondrodystrophy
75650	Unspecified congenital osteodystrophy
75651	Osteogenesis imperfecta
75652	Osteopetrosis
75653	Osteopoikilosis
75654	Polyostotic fibrous dysplasia of bone
75655	Chondroectodermal dysplasia
75656	Multiple epiphyseal dysplasia
75659	Other congenital osteodystrophy
7566	Congenital anomaly of diaphragm
75670	Unspecified congenital anomaly of abdominal wall
75671	Prune belly syndrome
75679	Other congenital anomalies of abdominal wall
75681	Congenital absence of muscle and tendon
75682	Accessory muscle
75683	Ehlers-Danlos syndrome
75689	Other specified congenital anomaly of muscle, tendon, fascia, and connective tissue
7569	Other and unspecified congenital anomaly of musculoskeletal system
7570	Hereditary edema of legs
7571	Ichthyosis congenita
7572	Dermatoglyphic anomalies
75731	Congenital ectodermal dysplasia
75732	Congenital vascular hamartomas
75733	Congenital pigmentary anomaly of skin
75739	Other specified congenital anomaly of skin
7574	Specified congenital anomalies of hair
7575	Specified congenital anomalies of nails
7576	Specified congenital anomalies of breast
7578	Other specified congenital anomalies of the integument
7579	Unspecified congenital anomaly of the integument

Diagnosis Code	Description
7580	Down's syndrome
7581	Patau's syndrome
7582	Edwards' syndrome
75831	Cri-du-chat syndrome
75832	Velo-cardio-facial syndrome
75833	Autosomal deletion syndromes, other microdeletions
75839	Autosomal deletion syndromes, other autosomal deletions
7584	Balanced autosomal translocation in normal individual
7585	Other conditions due to autosomal anomalies
7586	Gonadal dysgenesis
7587	Klinefelter's syndrome
75881	Other conditions due to sex chromosome anomalies
75889	Other conditions due to chromosome anomalies
7589	Conditions due to anomaly of unspecified chromosome
7590	Congenital anomalies of spleen
7591	Congenital anomalies of adrenal gland
7592	Congenital anomalies of other endocrine glands
7593	Situs inversus
7594	Conjoined twins
7595	Tuberous sclerosis
7596	Other congenital hamartoses, not elsewhere classified
7597	Multiple congenital anomalies, so described
75981	Prader-Willi syndrome
75982	Marfan's syndrome
75983	Fragile's X syndrome
75989	Other specified congenital anomalies, so described
7599	Unspecified congenital anomaly
V184	Family history of intellectual disabilities
V195	Family history of congenital anomalies
V198	Family history of other condition
V2631	Testing of female for genetic disease carrier status
V2632	Other genetic testing of female
V2633	Genetic counseling

25.2.5.2 Genetic Testing for Colorectal Cancer

Genetic testing for colorectal cancer is provided to clients that have a known predisposition (having a first-or-second degree relative) to colorectal cancer. Results of the testing may indicate whether the individual has an increased risk of developing colorectal cancer. A first-degree relative is defined as: sibling, parent, or offspring. A second-degree relative is defined as: uncle, aunt, grandparent, nephew, niece, or half-sibling.

Genetic test results, when informative, may influence clinical management decisions. Documentation in the medical record must reflect that the client and/or family member has been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions prior to the genetic testing.

Providers must bill the following procedure codes for genetic testing for colorectal cancer:

Procedure Codes				
81201	81202	81203	81210	81275
81288	81292	81293	81294	81295
81296	81297	81298	81299	81300
81301	81317	81318	81319	

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results. Interpretation of gene mutation analysis results is not separately reimbursable. Interpretation is part of the Physical Evaluation and Management (E/M service).

Genetic testing for colorectal cancer is limited to once per lifetime. Additional tests will not be authorized.

Authorization Requirements

Prior authorization is required for genetic testing for colorectal cancer.

A completed CSHCN Services Program Authorization and Prior Authorization Request form, signed and dated by the referring providers, must be submitted:

- Any provider's signature, including the prescribing provider's, on a submitted document indicates the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate and complete.
- All documentation submitted with a hand-written provider's signature must have a hand-written date next to the signature and must be kept in the client's medical record.
- Stamped and digitalized signatures will not be accepted.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the services requested. The client's medical record must include documentation of formal pre-test counseling, including assessment of the client's ability to understand the risks and limitations of the test, and the client's informed choice to proceed with the genetic testing for colorectal cancer. The medical record is subject to retrospective review.

Requisition forms from the laboratory are not sufficient documentation for verification of the personal and family history. Medical documentations submitted by the physician must verify the client's diagnosis or family history.

Familial Adenomatous Polyposis (FAP)

Prior authorization for testing Familial Adenomatous Polyposis (FAP) (procedure codes 81201, 81202, and 81203) may be offered to individuals who have well defined hereditary cancer syndromes and for which either a positive or negative result will change medical care.

Documentation must include one of the following:

- Client with greater than 20 polyps.
- Client with a first-degree relative with FAP and a documented mutation.
- Clients who are seven years of age or younger must have rationale for testing and documentation of medical necessity included in the client's medical record and submitted with the prior authorization request.

Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

The following procedure codes require prior authorization for testing Hereditary Nonpolyposis Colorectal Cancer (HNPCC) to determine whether an individual has an increased risk for colorectal cancer or other HNPCC-associated cancers, including Lynch Syndrome:

Procedure Codes				
81292	81293	81294	81295	81296
81297	81298	81299	81300	81301
81317	81318	81319		

Results of the test may influence clinical management decisions

Documentation of medical necessity must include one of the following:

- Client has three or more family members (one of whom is a first-degree relative) with colorectal cancer and two successive generations are affected and one or more of the colorectal cancers were diagnosed at 50 years of age or younger and FAP has been ruled out.
- A client has had two HNPCC cancers.
- A client has colorectal cancer and a first-degree relative with either colorectal cancer or HNPCC extracolonic cancer at 50 years of age or younger.
- A client has had colorectal cancer or endometrial cancer at 50 years of age or younger.
- A client has had right-sided colorectal cancer with an undifferentiated pattern or histology at 50 years of age or younger.
- A client has had signet-cell type colorectal cancer at 50 years of age or younger.
- A client has had colorectal adenoma at 40 years of age or younger.
- A client is an asymptomatic individual with a first or second-degree relative with a documented HNPCC mutation.
- A client has a family history of malignant neoplasm in the gastrointestinal tract.

Clients who are twenty years of age or younger must have a clear rationale for testing and documentation of medical necessity from the client's record must be submitted with the prior authorization request.

25.2.5.3 Genetic Testing for Hereditary Breast and Ovarian Cancers

Genetic testing for hereditary breast and ovarian cancers is provided to clients who are at least 18 years of age with an inherited increased risk (having a first-, second- or third-degree relative) for developing breast and certain other cancers.

Genetic testing of mutations in BRCA1 and BRCA2, the genes associated with hereditary breast and ovarian cancer, is based on the National Comprehensive Cancer Network (NCCN) guidelines. These guidelines highly recommend genetic counseling to clients when genetic testing is offered and after test results are disclosed.

Genetic test results, when informative, may influence clinical management decisions. Documentation in the medical record must reflect that the client and/or family member has been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions prior to the genetic testing.

Providers must bill the following procedure codes genetic testing for hereditary breast and ovarian cancers:

Procedure Codes				
81211	81212	81213	81214	81215
81216	81217			

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results only if the test results will affect treatment decisions or provide prognostic information. Interpretation of genetic testing results is not separately reimbursable. Interpretation is part of the physician evaluation and management (E/M) service.

BRCA uncommon, large rearrangement testing (procedure code 81213) may be considered for reimbursement with submission of the following evidence:

- The client is at an exceptionally high risk for hereditary breast or ovarian cancers, and
- The client has undergone comprehensive, full sequence analysis of both BRCA1 and BRCA2 and the results of the test (procedure code 81211) are negative.

Genetic testing for hereditary breast and ovarian cancers is limited to once per lifetime. Additional tests will not be authorized.

Genetic testing for hereditary breast and ovarian cancer predisposition is not covered as a screening test in the general population.

Authorization Requirements

Prior authorization is not required for uncommon, large rearrangement testing of the BRCA1 and BRCA2 genes (procedure code 81213) when submitted with a negative test result for procedure code 81211.

Prior authorization is required for all other BRCA1/BRCA2 genetic testing for susceptibility to breast and ovarian cancer.

A completed CSHCN Services Program Genetic Testing for Hereditary Breast and Ovarian Cancers Prior Authorization Request form, signed and dated by the ordering practitioner, must be submitted and approved prior to the date of service. The form must include:

- The physician's signature on a submitted document that indicates that the physician certifies, to the best of the physician's knowledge, the information in the document is true, accurate, and complete.
- All documentation must be submitted with a hand-written physician's signature with a handwritten date next to the signature and must be kept in the client's medical record.
- No stamped or digitalized signatures will be accepted.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the service(s) requested. Documentation supporting the medical need for genetic testing of hereditary breast and ovarian cancers must include:

- The client’s diagnosis and prognosis, including the age of onset and the specific location of cancer
- The client’s family history, if applicable, including the specifics about the relationship to the client, cancer site, and the age of cancer diagnosis
- The NCCN criterion met supporting the need for the specific test requested
- Documentation of how the result of the test will directly impact the plan of treatment delivered to the client.

Requisition forms from the laboratory are not sufficient documentation for verification of the personal and family history.

To complete the prior authorization process, the provider must complete and submit the prior authorization request and required documentation to the TMHP CSHCN Services Program Authorization Department.

If the service is medically necessary and is provided after hours or on a recognized holiday or weekend, the service may be authorized when the request is submitted on the next business day. A completed CSHCN Services Program Genetic Testing for Hereditary Breast and Ovarian Cancers Prior Authorization Request form and supporting documentation must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines are not given by the CSHCN Services Program for providers to correct incomplete PA requests.

The client's medical record must include a copy of the prior authorization request, all submitted documentation, and an assessment of the client's ability to understand the risks and limitations of the test as well as the client's informed choice to proceed with the genetic testing. The medical record is subject to retrospective review.

25.2.6 Cytopathology of Vaginal, Cervical, and Uterine Sites

Because of the technical nature of processing and interpreting a Pap smear or specimen for cytopathology, pathologists are the only physician specialty reimbursed with the following exception:

Exception: *Other physician specialties equipped to perform Pap smears in their offices must have modifier SU on the claim form.*

Procurement and handling of the Pap smear or specimen for cytopathology is considered part of the evaluation and management of the client and is not reimbursed separately.

A pathologist must report the place of service (POS) according to where the Pap smear is interpreted: office (POS 1), inpatient (POS 3), outpatient (POS 5), or independent laboratory (POS 6).

The following procedure codes are payable for gynecological cytopathology services and may be reimbursed only to pathologists and CLIA-certified laboratories whose directors providing technical supervision of cytopathology services are pathologists:

Procedure Codes				
88142	88143	88147	88148	88150
88152	88153	88154	88155	88164
88165	88166	88167	88174	88175

Procedure codes 88155 is an add-on code to be used in conjunction with the following cytopathology procedure codes:

Procedure Codes				
88142	88143	88147	88148	88150
88152	88153	88154	88164	88165
88166	88167	88174	88175	

The interpretation portion of any gynecological cytopathology test must be reported using only procedure code 88141 and type of service "I." Reimbursement is restricted to laboratories and pathologists. The interpretation portion may be reimbursed in addition to the following cytopathology procedure codes:

Procedure Codes				
88142	88143	88147	88148	88150
88152	88153	88154	88164	88165
88166	88167	88174	88175	

25.2.7 Cytopathology Studies Other Than Vaginal, Cervical, or Uterine

Procurement and handling of the specimen is not reimbursed separately for cytopathology of sites other than vaginal, cervical, or uterine and is considered part of the evaluation and management of the client. These procedures may be reimbursed according to the POS where the cytopathology smear is interpreted.

Procedure codes 88160, 88161, and 88162 are payable for the total component and technical component in the office (place of service [POS] 1), outpatient setting (POS 5), or independent laboratory (POS 6). Procedure codes 88160, 88161, and 88162 are payable for the interpretation in the inpatient (POS 3) or outpatient (POS 5) settings.

Procedure codes 88160, 88161, and 88162 are payable to a pathologist for the interpretation in the inpatient hospital (POS 3) and outpatient (POS 5) settings.

Procedure codes 88160 or 88161 total components and interpretations are denied as part of the total component and interpretation for procedure code 88162.

Procedure code 88160 total component and interpretation is denied as part of the total component and interpretation for procedure code 88161.

Reimbursement for the total component or interpretation and technical component for procedure codes 88160, 88161, and 88162 is limited to pathologists (doctor of medicine [MD] and doctor of osteopathy [DO]) and laboratories (CLIA-certified to provide pathology services).

25.2.8 Evocative and Suppression Testing

Evocative and suppression testing is a benefit when billed for the total component.

Providers must bill the following procedure codes for evocative suppression testing:

Procedure Codes							
80400	80402	80406	80408	80410	80412	80414	80415

Procedure Codes							
80416	80417	80418	80420	80422	80424	80426	80428
80430	80432	80434	80435	80436	80438	80439	

25.2.9 Helicobacter pylori (H. pylori)

H. pylori testing is a benefit. Serology testing for H. pylori is a noninvasive diagnostic procedure preferred for initial diagnosis but is not indicated once a diagnosis is made.

H. pylori testing is not indicated or a benefit for any of the following:

- New onset uncomplicated dyspepsia
- New onset dyspepsia that is responsive to conservative treatment (e.g., withdrawal of nonsteroidal anti-inflammatory drugs [NSAIDs] or use of antisecretory agents) (If conservative treatment does not eliminate the symptoms, further testing may be indicated to determine the presence of H. pylori.)
- Screening for H. pylori in asymptomatic clients
- Dyspeptic clients who require endoscopy and biopsy
- A negative endoscopy in the previous 90 days
- A planned endoscopy
- New onset H. pylori that is still being treated

Serology testing is not indicated or a benefit for monitoring response to therapy.

The following procedure codes may be reimbursed by the CSHCN Services Program:

- Serology testing, procedure codes 83009 and 86677
- Stool testing, procedure code 87338
- Breath testing, procedure codes 78267, 78268, 83013, and 83014

These procedure codes are considered a clinical lab service and must be billed using type of service (TOS) 5. The interpretation/professional component TOS I is not separately reimbursed.

H. pylori testing may be indicated for symptomatic clients with a documented history of chronic or recurrent duodenal ulcers, gastric ulcers, or chronic gastritis. The history should delineate the failed conservative treatment for the condition.

Only one of the following procedure codes may be reimbursed once per lifetime when billed by any provider: 83009 or 86677. A second test may be considered on appeal with documentation submitted indicating the original test result was negative for H. pylori.

If a follow-up breath or stool test is used to document the eradication of H. pylori, the medical record should contain evidence of one of the following:

- The patient remains symptomatic after a treatment regimen for H. pylori.
- The patient is asymptomatic after H. pylori eradication therapy but has a history of hemorrhage, perforation, or outlet obstruction from peptic ulcer disease.
- The patient has a history of ulcer on chronic nonsteroidal anti-inflammatory drug (NSAID) or anticoagulant therapy.

Providers cannot be reimbursed for testing for the eradication of H. pylori, procedure codes 78267, 78268, 83013, 83014, and 87338 within 35 days of the initial test.

H. pylori testing will be denied if it is performed within 90 days of the following procedure codes:

Procedure Codes									
43200	43201	43202	43216	43217	43228	43231	43232	43234	43235
43236	43237	43238	43239	43241	43242	43250	43251	43257	43258
43259									

Procedure codes 78267, 78268, 83013, 83014, and 87338 may be reimbursed within 90 days of the procedure codes in the preceding table if the provider submits documentation that indicates the client was tested for eradication after treatment.

25.2.10 Laboratory Panel Tests

Panels are specific laboratory tests that are combined together under a problem-oriented classification. The organ and disease panels include all tests as indicated in Current Procedural Terminology (CPT) that must be performed in order to bill the panel code. Individual laboratory tests considered part of a specific panel are denied when billed with a panel code on the same day, by the same provider. Modifier 91 or additional times must be indicated on the claim if a panel code or an individual component of a panel code is billed more than one time per day. Additional times may also be included on accompanying documentation. No distinction is made between the method of testing, whether manual or automated; the test must be billed as a panel. Tests performed in addition to those specifically indicated for a particular panel should be reported separately and in addition to the panel code.

25.2.10.1 Organ or Disease Panels

The panels listed below include those components delineated in CPT and are those panels that may be reimbursed by the CSHCN Services Program. To bill the panel code, all the laboratory tests must be included.

The organ or disease panels are specific laboratory tests that may be reimbursed by the CSHCN Services Program have distinct procedures codes that are further detailed in the table below and include the following:

Procedure Codes					
80047 must include the following:					
82330	82374	82435	82565	82947	84132
84295	84520				
80048 must include the following:					
82310	82374	82435	82565	82947	84132
84295	84520				
80050 must include the following:					
80053, 84443, and either					
85025 or (85027 and 85004) *or*					
85027 and *either* 85004, 85007, or 85009					
80051 must include the following:					
82374	82435	84132	84295		
80053 must include the following:					
82040	82247	82310	82374	82435	82565
82947	84075	84132	84155	84295	84450
84460	84520				
80061 must include the following:					
82465	83718	84478			
80069 must include the following:					
82040	82310	82374	82435	82565	82947
84100	84132	84295	84520		
80074 must include the following:					
86705	86709	86803	87340		

Procedure Codes					
80076 must include the following:					
82040	82247	82248	84075	84155	84450
84460					

Do not report 80047 in conjunction with 80053.

Individual laboratory tests considered part of a specific panel will be denied when billed with a panel code on the same day by the same provider. Modifier 91 or additional times must be indicated on the claim if a panel code or an individual component of a panel code is billed more than one time per day. Additional times may also be included on accompanying documentation. No distinction is made between the method of testing, whether manual or automated; the test must be billed as a panel. If tests in addition to those specifically indicated for a particular panel are performed, those tests should be reported separately in addition to the panel code.

25.2.10.2 Complete Blood Count (CBC)

Blood counts must be billed using the most comprehensive code that describes all the services rendered on that day. If individual components of a blood count test are performed on the same day, they may not be billed separately. If two or more of the components are performed on the same day, they must be combined and billed with the blood count code that most accurately reflects the test provided.

Procedure code 85008 can be billed the same day of service by the same provider as procedure code 85014 (HCT).

Procedure codes 85044, 85045, and 85046 may be reimbursed in addition to a CBC when performed on the same day.

25.2.10.3 Ferritin and Iron Studies

The CSHCN Services Program may reimburse procedure codes 82728, 83540, 83550, 84466, and 85536 when billed with any of the following diagnosis codes:

Diagnosis Code	Description
2750	Disorders of iron metabolism
2800	Iron deficiency anemia secondary to blood loss (chronic)
2801	Iron deficiency anemia secondary to inadequate dietary iron intake
2808	Other specified iron deficiency anemias
2809	Unspecified iron deficiency anemia
2810	Pernicious anemia
2811	Other vitamin B12 deficiency anemia
2812	Folate-deficiency anemia
2819	Unspecified deficiency anemia
28241	Sickle-cell thalassemia without crisis
28242	Sickle-cell thalassemia with crisis
28249	Other thalassemia
28264	Sickle-cell/Hb-C disease with crisis
28268	Other sickle-cell disease without crisis
2828	Other specified hereditary hemolytic anemias
2829	Unspecified hereditary hemolytic anemia
2839	Unspecified acquired hemolytic anemia
2850	Sideroblastic anemia

Diagnosis Code	Description
28521	Anemia in chronic kidney disease
28522	Anemia in neoplastic disease
28529	Anemia of other chronic illness
2859	Unspecified anemia
5360	Achlorhydria
5728	Other sequelae of chronic liver disease
5738	Other specified disorders of liver
5739	Unspecified disorder of liver
5793	Other and unspecified postsurgical nonabsorption
5798	Other specified intestinal malabsorption
5799	Unspecified intestinal malabsorption
5851	Chronic kidney disease, stage I
5852	Chronic kidney disease, stage II (mild)
5853	Chronic kidney disease, stage III (moderate)
5854	Chronic kidney disease, stage IV (severe)
5855	Chronic kidney disease, stage V
5856	End-stage renal disease
5859	Chronic kidney disease, unspecified
586	Unspecified renal failure
70900	Dyschromia, unspecified dialysis
V560	Encounter for extracorporeal
V5631	Encounter for adequacy testing for hemodialysis
V5632	Encounter for adequacy testing for peritoneal dialysis
V568	Encounter other dialysis

25.2.11 Urinalysis

Urinalysis must be billed using the most comprehensive code that describes the urinalysis test rendered on that day. If individual components of a urinalysis are performed on the same day, they may not be billed separately. If two or more of the components are performed on the same day, they must be combined and billed with the urinalysis procedure code that most accurately reflects the test provided.

If procedure codes 84578 (urobilinogen, qualitative) or 84583 (urobilinogen, semiquantitative) are billed on the same day by the same provider as procedure codes 81000, 81001, 81002, 81003, 81005, or 81020, procedure codes 84578 or 84583 will deny as part of another procedure.

25.2.12 Other Laboratory Services

Laboratory and interpretation procedure codes 86077, 86078, and 86079 should be used when blood bank physician services are needed.

The following procedure codes are denied for pathologists as noncovered for specialty type:

Procedure Codes				
Surgery				
36430	36440	36455		

Procedure Codes				
Consultation				
99251	99252	99253	99254	99255

Payment may be considered on appeal if the pathologist can document the medical necessity of performing the procedures.

25.2.13 Repeated Procedures

25.2.13.1 Modifier 91

Modifier 91 must be used for clinical diagnostic laboratory tests performed more than one time per day as follows:

- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 91, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures must be documented on the appeal.
- Modifier 91 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

Certain procedure codes have been removed from modifier 91 auditing. These are procedure codes that have been identified as routinely being performed at the same time, more than twice per day for each analyte. Documentation of time is required. If no time documentation is received, the claim will be denied. Providers may appeal claims that have been denied for documentation of time. Most procedure codes initially requiring modifier 91 continue to be audited for modifier 91.

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier including documentation of times for each repeated procedure.

Refer to: Chapter 7, "Appeals and Administrative Review," on page 7-1.

25.2.14 Receiving Labs and Lab Handling Fees

An independent laboratory may not bill for laboratory tests when the specimen is forwarded to another laboratory without performing any tests on that specimen. An independent laboratory may bill the CSHCN Services Program for tests referred to another laboratory (independent or hospital) only if the independent laboratory performs at least one test and forwards a portion of the same specimen to another laboratory (receiving laboratory) to have one or more tests performed. In this instance, the receiving laboratory may bill for tests it performs and all tests the receiving laboratory performs on the specimen. When billing, the *YES* box in Block 20 of the CMS-1500 paper claim form must be marked, the complete name, provider identifier, address, and ZIP code of the outside receiving laboratory where the specimen was forwarded must be entered in Block 32, and the TPI of the receiving laboratory must be indicated in Block 24j next to each procedure to be performed by the receiving laboratory. Enter the TPI in the shaded area of the field. Enter the NPI in the unshaded area of the field.

Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories.

In order to bill a handling fee, the receiving laboratory's name and address and unique TPI number must be included on the claim in Blocks 17 and 17B.

In both situations, if a specimen is collected by venipuncture or catheterization, an independent laboratory that forwards a specimen to another laboratory (independent or hospital) may bill a handling fee (procedure code 99001) for collecting and forwarding the specimen to the other laboratory.

When billing for laboratory services, providers should use the date the specimen is collected as the date of service. If the specimen is sent to a receiving laboratory and the client is an inpatient, the hospital is responsible for payment of these services to the receiving laboratory.

25.3 Claims Information

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

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

Laboratory services providers must indicate the specific laboratory procedure codes that are being submitted for claims filing.

The Healthcare Common Procedure Coding System (HCPCS)/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 CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement,"on page 5-1 for general information about claims filing.

Chapter 5, "CMS-1500 Paper Claim Form Instructions,"on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

25.3.1 Modifiers To Use When Billing Laboratory Procedures

Providers may use an appropriate modifier to bill for laboratory procedures as needed.

Providers may refer to the CMS website at www.cms.gov for guidelines on which modifier to use when submitting claims for laboratory services.

25.4 Reimbursement

In compliance with state and federal law, the CSHCN Services Program reimburses laboratories for most services according to maximum fees established by federal law, Medicare, or HHSC. Clinical laboratory services may be reimbursed the lower of the national fee schedule amount, the billed amount, or the amount allowed by Texas Medicaid. Some services (e.g., anatomical pathology) may be reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM). For automated lab tests, the fees that are paid are calculated by compiling the number of automated tests on the date of service and assigning an automated test panel payment code.

Physicians may be reimbursed for laboratory services the lower of the billed amount or the amount allowed by Texas Medicaid. Outpatient hospitals may be reimbursed for laboratory services at 72 percent of the rate equivalent to the hospital's Medicaid interim rate.

As the result of the *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982, independent laboratories are not directly reimbursed by the CSHCN Services Program when providing tests to clients registered as hospital inpatients or hospital outpatients. Reimbursement must be obtained from the hospital. These services cannot be billed to the client.

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.*

25.4.1 Clinical Laboratory Fee Schedule

The *Deficit Reduction Act* (DEFRA) of 1984 requires clinical diagnostic laboratory tests that are performed in a physician's office by an independent laboratory or a hospital laboratory for its outpatients be reimbursed on the basis of maximum fee schedules. The Texas Medicare carrier publishes the fee schedules on an annual basis. By federal law, the CSHCN Services Program payment *cannot* exceed that allowed by Medicare.

25.4.2 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," on page 24-13 for additional information about the one-day payment window reimbursement guidelines.

25.5 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.

Chapter

26

Medical Nutrition Services

26.1 Enrollment

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

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical foods are in Section 26.3.1, "Enrollment," on page 26-8.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical nutritional counseling services are in Section 26.4.1, "Enrollment," on page 26-10.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical nutrition products are in Section 26.5.1, "Enrollment," on page 26-12.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of total parenteral nutrition are in Section 26.6.1, "Enrollment," on page 26-36.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

26.2 Vitamins and Minerals

26.2.1 Enrollment

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

Refer to: Section 17.1, "Enrollment," on page 17-3 for more detailed information about CSHCN Services Program provider enrollment procedures for DME and Custom DME providers and Section 21.1, "Enrollment," on page 21-2 for more detailed information about CSHCN Services Program provider enrollment procedures for home health providers

26.2.2 Benefits, Limitations, and Authorization Requirements

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

The following procedure codes for vitamin and mineral products, which will be manually priced, will be a benefit when prior authorized and submitted with the corresponding procedure code and state modifier:

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

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

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

Vitamin or Mineral	Condition
Beta-carotene	• Vitamin A deficiency • Cystic fibrosis • Disorders of porphyrin metabolism • Intestinal malabsorption
Biotin	• Biotin deficiency • Biotinidase deficiency • Carnitine deficiency • Cystic fibrosis
Boric acid	• Recalcitrant vulvovaginitis
Calcium	• Calcium deficiency • Disorders of calcium metabolism • Chronic renal disease • Pituitary dwarfism, isolated growth hormone deficiency • Cystic fibrosis • Intestinal disaccharidase deficiencies and disaccharide malabsorption • Allergic gastroenteritis and colitis
Chloride	• Hypochloremia • Hypercapnia with mixed acid-base disorder
Copper	• Disorders of copper metabolism
Iodine	• Iodine deficiency • Simple and unspecified goiter and nontoxic nodular goiter • Cystic fibrosis
Iron	• Disorders of iron metabolism • Iron deficiency anemia • Cystic fibrosis
Magnesium	• Magnesium deficiency • Hypoparathyroidism • Cystic fibrosis
Phosphorous	• Disorders of phosphorous metabolism
Vitamin A (retinol)	• Vitamin A deficiency • Intestinal malabsorption • Disorders of the biliary tract • Cystic fibrosis
Vitamin B1 (thiamin)	• Vitamin B1 deficiency • Disturbances of branched-chain amino-acid metabolism (e.g. maple syrup urine disease) • Disorders of mitochondrial metabolism • Wernicke-Korsakoff syndrome • Cystic fibrosis

Vitamin or Mineral	Condition
Vitamin B2 (riboflavin)	• Vitamin B2 deficiency • Disorders of fatty acid oxidation • Riboflavin deficiency, ariboflavinosis • Disorders of mitochondrial metabolism • Cystic fibrosis
Vitamin B3 (niacin)	• Vitamin B3 deficiency • Disorders of lipid metabolism (e.g. pure hypercholesterolemia) • Cystic fibrosis
Vitamin B5 (pantothenic acid)	• Vitamin B5 deficiency
Vitamin B6 (pyridoxine, pyridoxal 5 phosphate)	• Vitamin B6 deficiency • Sideroblastic anemia • Cystic fibrosis
Vitamin B9 (folic acid)	• Vitamin B9 deficiency • Folate-deficiency anemia • Combined B12 and folate-deficiency anemia • Disorders of mitochondrial metabolism • Sickle-cell disease • Pernicious anemia • Cystic fibrosis
Vitamin B12 (cyanocobalamin)	• Vitamin B12 deficiency • Disturbances of sulphur-bearing amino-acid metabolism (e.g., homocystinuria and disturbances of metabolism of methionine) • Pernicious anemia • Combined B12 and folate-deficiency anemia • Cystic fibrosis
Vitamin C (asorbic acid)	• Vitamin C deficiency • Anemia due to disorders of glutathione metabolism • Disorders of mitochondrial metabolism • Cystic fibrosis
Vitamin D (ergocalciferol)	• Vitamin D deficiency • Galactosemia • Glycogenosis • Disorders of magnesium metabolism • Intestinal malabsorption • Chronic renal disease • Cystic fibrosis • Disorders of phosphorous metabolism • Hypocalcemia • Disorders of the biliary tract • Hypoparathyroidism • Intestinal disaccharidase deficiencies and disaccharide malabsorption • Allergic gastroenteritis and colitis

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

26.2.3 Prior Authorization Requirements

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

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

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

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

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

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

- Example 1: Vitamin D

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

- Example 2: Multivitamin Tables

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

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

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

- Example 4: Fer-In-Sol Iron Supplement

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

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

26.2.4 Claims Information

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

26.2.5 Reimbursement

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

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

A maximum of $100.00 per 30 days may be reimbursed for all vitamin and mineral products.

26.3 Medical Foods

26.3.1 Enrollment

To enroll in the CSHCN Services Program, providers of medical foods are not required to be actively enrolled in Texas Medicaid. However, they must have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. The Provider Agreement is part of the paper CSHCN Services Program enrollment application. If enrolling in the CSHCN Services Program online, the Provider Agreement must be printed and mailed in separately. The mailing address is available in Section 2.1, "Provider Enrollment," on page 2-2. Out-of-state medical food providers may enroll and must meet all these conditions. The 50-mile within the Texas state border limitation does not apply to providers of medical foods.

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

26.3.2 Benefits, Limitations, and Authorization Requirements

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

Medical foods are defined as:

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

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

Providers must use procedure codes S9434 or S9435 when submitting claims for medical foods. Procedure codes S9434 and S9435 will not require authorization or prior authorization for diagnosis code 36350.

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

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

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

26.3.2.1 Prior Authorization Requirements

Authorization or prior authorization is not required if the client has one of the diagnoses listed below and the request is for covered items. Covered items are foods with nutritional value.

Diagnosis Code	Description
2700	Disturbance of amino-acid transport
2701	Phenylketonuria (PKU)
2702	Other disturbances of aromatic amino-acid metabolism
2703	Disturbances of branched-chain amino acid metabolism
2704	Disturbances of sulphur-bearing amino-acid metabolism
2706	Disorder of urea cycle metabolism
2707	Other disturbances of straight-chain amino-acid metabolism
36350	Hereditary choroidal dystrophy or atrophy, unspecified

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

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

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

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

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

26.3.3 Claims Information

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

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

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

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

The Texas Health and Human Services Commission Texas Medicaid/CHIP Vendor Drug Program website at www.txvendordrug.com for information about the VDP.

26.3.4 Reimbursement

Providers must dispense the most cost-effective product in accordance with a prescription from a licensed physician. Organic products will not be reimbursed unless medical documentation is provided to substantiate the need for that formulation.

The CSHCN Services Program implemented rate reductions for certain services. The Online Fee Lookup (OFL) includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at 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.*

26.4 Medical Nutritional Counseling Services

26.4.1 Enrollment

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

26.4.2 Benefits, Limitations, and Authorization Requirements

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

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

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

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

- Abnormal weight gain
- Cardiovascular disease
- Diabetes or alterations in blood glucose
- Eating disorders
- Gastrointestinal disorders

- Hypertension
- Inherited metabolic disorders
- Kidney disease
- Lack of normal weight gain
- Nutritional deficiencies

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

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

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

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

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

26.4.2.1 Prior Authorization Requirements

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

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

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

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

This form and its instructions have been updated as follows:

- The “Dietician Information and Required Signature” section has been moved above the "Nutritional Products" section and renamed to “Dietician Information and Required Signature for Additional Medical Nutritional Counseling.”
- A new “Dispensing Provider Information” section has been added.

To request medical nutritional services, providers must use the most current form, which is available on the TMHP webiste.

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

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

Refer to: Section 4.3, “Prior Authorizations,” on page 4-5 for detailed information about prior authorization requirements.

26.4.3 Claims Information

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

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

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

26.4.4 Reimbursement

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

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

Procedure Code	Description
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15 minutes
S9470	Nutritional counseling, dietitian visit

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

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

26.5 Medical Nutritional Products

26.5.1 Enrollment

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

26.5.2 Benefits, Limitations, and Authorization Requirements

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

The CSHCN Services Program does not cover the following:

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

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

The procedure codes in the following table may be reimbursed in the home setting to the following provider types:

Procedure Code	Provider Type
B4100, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4162, and B9998	Home Health DME, DME Suppliers, medical supply company, and custom DME providers.
B4158, B4159, B4160, and B4161	Home health DME, DME Suppliers, medical supply company, and custom DME providers.
T1999	Home health DME, DME suppliers, medical supply company, and custom DME providers.

26.5.2.1 Prior Authorization Requirements

Prior authorization is required for medical nutritional products.

Prior authorization is required every six months for medical nutritional products when submitted with any of the diagnosis codes in the table below or diagnosis codes in the table in Section 26.6.2 of this chapter. Appropriate limitations for miscellaneous procedure code B9998 and T1999 are determined on a case-by-case basis through prior authorization.

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV)
1400	Malignant neoplasm of upper lip, vermilion border
1401	Malignant neoplasm of lower lip, vermilion border
1403	Malignant neoplasm of upper lip, inner aspect
1404	Malignant neoplasm of lower lip, inner aspect
1405	Malignant neoplasm of lip, unspecified, inner aspect
1406	Malignant neoplasm of commissure of lip
1408	Malignant neoplasm of other sites of lip
1409	Malignant neoplasm of lip, unspecified vermilion border
1410	Malignant neoplasm of base of tongue
1411	Malignant neoplasm of dorsal surface of tongue
1412	Malignant neoplasm of tip and lateral border of tongue
1413	Malignant neoplasm of ventral surface of tongue
1414	Malignant neoplasm of anterior two-thirds of tongue, part unspecified

Diagnosis Code	Description
1415	Malignant neoplasm of junctional zone of tongue
1416	Malignant neoplasm of lingual tonsil
1418	Malignant neoplasm of other sites of tongue
1419	Malignant neoplasm of tongue, unspecified
1420	Malignant neoplasm of parotid gland
1421	Malignant neoplasm of submandibular gland
1422	Malignant neoplasm of sublingual gland
1428	Malignant neoplasm of other major salivary glands
1429	Malignant neoplasm of salivary gland, unspecified
1430	Malignant neoplasm of upper gum
1431	Malignant neoplasm of lower gum
1438	Malignant neoplasm of other sites of gum
1439	Malignant neoplasm of gum, unspecified
1440	Malignant neoplasm of anterior portion of floor of mouth
1441	Malignant neoplasm of lateral portion of floor of mouth
1448	Malignant neoplasm of other sites of floor of mouth
1449	Malignant neoplasm of floor of mouth, part unspecified
1450	Malignant neoplasm of cheek mucosa
1451	Malignant neoplasm of vestibule of mouth
1452	Malignant neoplasm of hard palate
1453	Malignant neoplasm of soft palate
1454	Malignant neoplasm of uvula
1455	Malignant neoplasm of palate, unspecified
1456	Malignant neoplasm of retromolar area
1458	Malignant neoplasm of other specified parts of mouth
1459	Malignant neoplasm of mouth, unspecified
1460	Malignant neoplasm of tonsil
1461	Malignant neoplasm of tonsillar fossa
1462	Malignant neoplasm of tonsillar pillars (anterior) (posterior)
1463	Malignant neoplasm of vallecula
1464	Malignant neoplasm of anterior aspect of epiglottis
1465	Malignant neoplasm of junctional region of oropharynx
1466	Malignant neoplasm of lateral wall of oropharynx
1467	Malignant neoplasm of posterior wall of oropharynx
1468	Malignant neoplasm of other specified sites of oropharynx
1469	Malignant neoplasm of oropharynx, unspecified site
1470	Malignant neoplasm of superior wall of nasopharynx
1471	Malignant neoplasm of posterior wall of nasopharynx
1472	Malignant neoplasm of lateral wall of nasopharynx
1473	Malignant neoplasm of anterior wall of nasopharynx
1478	Malignant neoplasm of other specified sites of nasopharynx

Diagnosis Code	Description
1479	Malignant neoplasm of nasopharynx, unspecified site
1480	Malignant neoplasm of postcricoid region of hypopharynx
1481	Malignant neoplasm of pyriform sinus
1482	Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
1483	Malignant neoplasm of posterior hypopharyngeal wall
1488	Malignant neoplasm of other specified sites of hypopharynx
1489	Malignant neoplasm of hypopharynx, unspecified site
1490	Malignant neoplasm of pharynx, unspecified
1491	Malignant neoplasm of Waldeyer's ring
1498	Malignant neoplasm of other sites within the lip, and oral cavity
1499	Malignant neoplasm of ill-defined sites within the lip and oral cavity
1500	Malignant neoplasm of cervical esophagus
1501	Malignant neoplasm of thoracic esophagus
1502	Malignant neoplasm of abdominal esophagus
1503	Malignant neoplasm of upper third of esophagus
1504	Malignant neoplasm of middle third of esophagus
1505	Malignant neoplasm of lower third of esophagus
1508	Malignant neoplasm of other specified part of esophagus
1509	Malignant neoplasm of esophagus, unspecified site
1510	Malignant neoplasm of cardia
1511	Malignant neoplasm of pylorus
1512	Malignant neoplasm of pyloric antrum
1513	Malignant neoplasm of fundus of stomach
1514	Malignant neoplasm of body of stomach
1515	Malignant neoplasm of lesser curvature of stomach, unspecified
1516	Malignant neoplasm of greater curvature of stomach, unspecified
1518	Malignant neoplasm of other specified sites of stomach
1519	Malignant neoplasm of stomach, unspecified site
1520	Malignant neoplasm of duodenum
1521	Malignant neoplasm of jejunum
1522	Malignant neoplasm of ileum
1523	Malignant neoplasm of Meckel's diverticulum
1528	Malignant neoplasm of other specified sites of small intestine
1529	Malignant neoplasm of small intestine, unspecified site
1530	Malignant neoplasm of hepatic flexure
1531	Malignant neoplasm of transverse colon
1532	Malignant neoplasm of descending colon
1533	Malignant neoplasm of sigmoid colon
1534	Malignant neoplasm of cecum
1535	Malignant neoplasm of appendix
1536	Malignant neoplasm of ascending colon

Diagnosis Code	Description
1537	Malignant neoplasm of splenic flexure
1538	Malignant neoplasm of other specified sites of large intestine
1539	Malignant neoplasm of colon, unspecified site
1540	Malignant neoplasm of rectosigmoid junction
1541	Malignant neoplasm of rectum
1542	Malignant neoplasm of anal canal
1543	Malignant neoplasm of anus, unspecified site
1548	Malignant neoplasm of other sites of rectum, rectosigmoid junction, and anus
1550	Malignant neoplasm of liver, primary
1551	Malignant neoplasm of intrahepatic bile ducts
1552	Malignant neoplasm of liver, not specified as primary or secondary
1560	Malignant neoplasm of gallbladder
1561	Malignant neoplasm of extrahepatic bile ducts
1562	Malignant neoplasm of ampulla of vater
1568	Malignant neoplasm of other specified sites of gallbladder and extrahepatic bile ducts
1569	Malignant neoplasm of biliary tract, part unspecified site
1570	Malignant neoplasm of head of pancreas
1571	Malignant neoplasm of body of pancreas
1572	Malignant neoplasm of tail of pancreas
1573	Malignant neoplasm of pancreatic duct
1574	Malignant neoplasm of Islets of Langerhans
1578	Malignant neoplasm of other specified sites of pancreas
1579	Malignant neoplasm of pancreas, part unspecified
1580	Malignant neoplasm of retroperitoneum
1588	Malignant neoplasm of specified parts of peritoneum
1589	Malignant neoplasm of peritoneum, unspecified
1590	Malignant neoplasm of intestinal tract, part unspecified
1591	Malignant neoplasm of spleen, not elsewhere classified
1598	Malignant neoplasm of other sites of digestive system and intra-abdominal organs
1599	Malignant neoplasm of ill-defined sites within the digestive organs and peritoneum
1600	Malignant neoplasm of nasal cavities
1601	Malignant neoplasm of auditory tube, middle ear, and mastoid air cells
1602	Malignant neoplasm of maxillary sinus
1603	Malignant neoplasm of ethmoidal sinus
1604	Malignant neoplasm of frontal sinus
1605	Malignant neoplasm of sphenoidal sinus
1608	Malignant neoplasm of other sites of nasal cavities, middle ear, and accessory sinuses

Diagnosis Code	Description
1609	Malignant neoplasm of site of nasal cavities, middle ear, and accessory sinus, unspecified site
1610	Malignant neoplasm of glottis
1611	Malignant neoplasm of supraglottis
1612	Malignant neoplasm of subglottis
1613	Malignant neoplasm of laryngeal cartilages
1618	Malignant neoplasm of other specified sites of larynx
1619	Malignant neoplasm of larynx, unspecified site
1620	Malignant neoplasm of trachea
1622	Malignant neoplasm of main bronchus
1623	Malignant neoplasm of upper lobe, bronchus or lung
1624	Malignant neoplasm of middle lobe, bronchus or lung
1625	Malignant neoplasm of lower lobe, bronchus or lung
1628	Malignant neoplasm of other parts of bronchus or lung
1629	Malignant neoplasm of bronchus and lung, unspecified site
1630	Malignant neoplasm of parietal pleura
1631	Malignant neoplasm of visceral pleura
1638	Malignant neoplasm of other specified sites of pleura
1639	Malignant neoplasm of pleura, unspecified site
1640	Malignant neoplasm of thymus
1641	Malignant neoplasm of heart
1642	Malignant neoplasm of anterior mediastinum
1643	Malignant neoplasm of posterior mediastinum
1648	Malignant neoplasm of other parts of mediastinum
1649	Malignant neoplasm of mediastinum, part unspecified
1650	Malignant neoplasm of upper respiratory tract, part unspecified
1658	Malignant neoplasm of other sites within the respiratory system and intra-thoracic organs
1659	Malignant neoplasm of ill-defined sites within the respiratory system
1700	Malignant neoplasm of bones of skull and face, except mandible
1701	Malignant neoplasm of mandible
1702	Malignant neoplasm of vertebral column, excluding sacrum and coccyx
1703	Malignant neoplasm of ribs, sternum, and clavicle
1704	Malignant neoplasm of scapula and long bones of upper limb
1705	Malignant neoplasm of short bones of upper limb
1706	Malignant neoplasm of pelvic bones, sacrum, and coccyx
1707	Malignant neoplasm of long bones of lower limb
1708	Malignant neoplasm of short bones of lower limb
1709	Malignant neoplasm of bone and articular cartilage, site unspecified
1710	Malignant neoplasm of connective and other soft tissue of head, face, and neck

Diagnosis Code	Description
1712	Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder
1713	Malignant neoplasm of connective and other soft tissue of lower limb, including hip
1714	Malignant neoplasm of connective and other soft tissue of thorax
1715	Malignant neoplasm of connective and other soft tissue of abdomen
1716	Malignant neoplasm of connective and other soft tissue of pelvis
1717	Malignant neoplasm of connective and other soft tissue of trunk, unspecified
1718	Malignant neoplasm of other specified sites of connective and other soft tissue
1719	Malignant neoplasm of connective and other soft tissue, site unspecified
1720	Malignant melanoma of skin of lip
1721	Malignant melanoma of skin of eyelid, including canthus
1722	Malignant melanoma of skin of ear and external auditory canal
1723	Malignant melanoma of skin of other and unspecified parts of face
1724	Malignant melanoma of skin of scalp and neck
1725	Malignant melanoma of skin of trunk, except scrotum
1726	Malignant melanoma of skin of upper limb, including shoulder
1727	Malignant melanoma of skin of lower limb, including hip
1728	Malignant melanoma of other specified sites of skin
1729	Malignant melanoma of skin, site unspecified
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast
1760	Kaposi's sarcoma, skin
1761	Kaposi's sarcoma, soft tissue
1762	Kaposi's sarcoma, palate
1763	Kaposi's sarcoma, gastrointestinal sites
1764	Kaposi's sarcoma, lung
1765	Kaposi's sarcoma, lymph nodes
1768	Kaposi's sarcoma, other specified sites
1769	Kaposi's sarcoma, unspecified site
179	Malignant neoplasm of uterus, part unspecified

Diagnosis Code	Description
1800	Malignant neoplasm of endocervix
1801	Malignant neoplasm of exocervix
1808	Malignant neoplasm of other specified sites of cervix
1809	Malignant neoplasm of cervix uteri, unspecified site
181	Malignant neoplasm of placenta
1820	Malignant neoplasm of corpus uteri, except isthmus
1821	Malignant neoplasm of isthmus
1828	Malignant neoplasm of other specified sites of body of uterus
1830	Malignant neoplasm of ovary
1832	Malignant neoplasm of fallopian tube
1833	Malignant neoplasm of broad ligament of uterus
1834	Malignant neoplasm of parametrium
1835	Malignant neoplasm of round ligament of uterus
1838	Malignant neoplasm of other specified sites of uterine adnexa
1839	Malignant neoplasm of uterine adnexa, unspecified site
1840	Malignant neoplasm of vagina
1841	Malignant neoplasm of labia majora
1842	Malignant neoplasm of labia minora
1843	Malignant neoplasm of clitoris
1844	Malignant neoplasm of vulva, unspecified site
1848	Malignant neoplasm of other specified sites of female genital organs
1849	Malignant neoplasm of female genital organ, site unspecified
185	Malignant neoplasm of prostate
1860	Malignant neoplasm of undescended testis
1869	Malignant neoplasm of other and unspecified testis
1871	Malignant neoplasm of prepuce
1872	Malignant neoplasm of glans penis
1873	Malignant neoplasm of body of penis
1874	Malignant neoplasm of penis, part unspecified
1875	Malignant neoplasm of epididymis
1876	Malignant neoplasm of spermatic cord
1877	Malignant neoplasm of scrotum
1878	Malignant neoplasm of other specified sites of male genital organs
1879	Malignant neoplasm of male genital organ, site unspecified
1880	Malignant neoplasm of trigone of urinary bladder
1881	Malignant neoplasm of dome of urinary bladder
1882	Malignant neoplasm of lateral wall of urinary bladder
1883	Malignant neoplasm of anterior wall of urinary bladder
1884	Malignant neoplasm of posterior wall of urinary bladder
1885	Malignant neoplasm of bladder neck
1886	Malignant neoplasm of ureteric orifice

Diagnosis Code	Description
1887	Malignant neoplasm of urachus
1888	Malignant neoplasm of other specified sites of bladder
1889	Malignant neoplasm of bladder, part unspecified
1890	Malignant neoplasm of kidney, except pelvis
1891	Malignant neoplasm of renal pelvis
1892	Malignant neoplasm of ureter
1893	Malignant neoplasm of urethra
1894	Malignant neoplasm of paraurethral glands
1898	Malignant neoplasm of other specified sites of urinary organs
1899	Malignant neoplasm of urinary organ, site unspecified
1900	Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
1901	Malignant neoplasm of orbit
1902	Malignant neoplasm of lacrimal gland
1903	Malignant neoplasm of conjunctiva
1904	Malignant neoplasm of cornea
1905	Malignant neoplasm of retina
1906	Malignant neoplasm of choroid
1907	Malignant neoplasm of lacrimal duct
1908	Malignant neoplasm of other specified sites of eye
1909	Malignant neoplasm of eye, part unspecified
1910	Malignant neoplasm of cerebrum, except lobes and ventricles
1911	Malignant neoplasm of frontal lobe
1912	Malignant neoplasm of temporal lobe
1913	Malignant neoplasm of parietal lobe
1914	Malignant neoplasm of occipital lobe
1915	Malignant neoplasm of ventricles
1916	Malignant neoplasm of cerebellum NOS
1917	Malignant neoplasm of brain stem
1918	Malignant neoplasm of other parts of brain
1919	Malignant neoplasm of brain, unspecified site
1920	Malignant neoplasm of cranial nerves
1921	Malignant neoplasm of cerebral meninges
1922	Malignant neoplasm of spinal cord
1923	Malignant neoplasm of spinal meninges
1928	Malignant neoplasm of other specified sites of nervous system
1929	Malignant neoplasm of nervous system, part unspecified
193	Malignant neoplasm of thyroid gland
1940	Malignant neoplasm of adrenal gland
1941	Malignant neoplasm of parathyroid gland
1943	Malignant neoplasm of pituitary gland and craniopharyngeal duct
1944	Malignant neoplasm of pineal gland

Diagnosis Code	Description
1945	Malignant neoplasm of carotid body
1946	Malignant neoplasm of aortic body and other paraganglia
1948	Malignant neoplasm of other endocrine glands and related structures
1949	Malignant neoplasm of endocrine gland, site unspecified
1950	Malignant neoplasm of head, face, and neck
1951	Malignant neoplasm of thorax
1952	Malignant neoplasm of abdomen
1953	Malignant neoplasm of pelvis
1954	Malignant neoplasm of upper limb
1955	Malignant neoplasm of lower limb
1958	Malignant neoplasm of other specified sites
1960	Secondary and unspecified malignant neoplasm of lymph nodes of head, face, and neck
1961	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
1962	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
1963	Secondary and unspecified malignant neoplasm of lymph nodes of axilla and upper limb
1965	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
1966	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
1968	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
1969	Secondary and unspecified malignant neoplasm of lymph nodes, site unspecified
1970	Secondary malignant neoplasm of lung
1971	Secondary malignant neoplasm of mediastinum
1972	Secondary malignant neoplasm of pleura
1973	Secondary malignant neoplasm of other respiratory organs
1974	Secondary malignant neoplasm of small intestine including duodenum
1975	Secondary malignant neoplasm of large intestine and rectum
1976	Secondary malignant neoplasm of retroperitoneum and peritoneum
1977	Secondary malignant neoplasm of liver
1978	Secondary malignant neoplasm of other digestive organs and spleen
1980	Secondary malignant neoplasm of kidney
1981	Secondary malignant neoplasm of other urinary organs
1982	Secondary malignant neoplasm of skin
1983	Secondary malignant neoplasm of brain and spinal cord
1984	Secondary malignant neoplasm of other parts of nervous system
1985	Secondary malignant neoplasm of bone and bone marrow
1986	Secondary malignant neoplasm of ovary
1987	Secondary malignant neoplasm of adrenal gland

Diagnosis Code	Description
19881	Secondary malignant neoplasm of breast
19882	Secondary malignant neoplasm of genital organs
19889	Secondary malignant neoplasm of other specified sites
1990	Disseminated malignant neoplasm without specification of site
1991	Other malignant neoplasm of unspecified site
1992	Malignant neoplasm associated with transplant organ
20000	Reticulosarcoma, unspecified site, extranodal and solid organ sites
20001	Reticulosarcoma of lymph nodes of head, face, and neck
20002	Reticulosarcoma of intrathoracic lymph nodes
20003	Reticulosarcoma of intra-abdominal lymph nodes
20004	Reticulosarcoma of lymph nodes of axilla and upper limb
20005	Reticulosarcoma of lymph nodes of inguinal region and lower limb
20006	Reticulosarcoma of intrapelvic lymph nodes
20007	Reticulosarcoma of spleen
20008	Reticulosarcoma of lymph nodes of multiple sites
20010	Lymphosarcoma, unspecified site, extranodal and solid organ sites
20011	Lymphosarcoma of lymph nodes of head, face, and neck
20012	Lymphosarcoma of intrathoracic lymph nodes
20013	Lymphosarcoma of intra-abdominal lymph nodes
20014	Lymphosarcoma of lymph nodes of axilla and upper limb
20015	Lymphosarcoma of lymph nodes of inguinal region and lower limb
20016	Lymphosarcoma of intrapelvic lymph nodes
20017	Lymphosarcoma of spleen
20018	Lymphosarcoma of lymph nodes of multiple sites
20020	Burkitt's tumor or lymphoma, unspecified site, extranodal and solid organ sites
20021	Burkitt's tumor or lymphoma of lymph nodes of head, face, and neck
20022	Burkitt's tumor or lymphoma of intrathoracic lymph nodes
20023	Burkitt's tumor or lymphoma of intra-abdominal lymph nodes
20024	Burkitt's tumor or lymphoma of lymph nodes of axilla and upper limb
20025	Burkitt's tumor or lymphoma of lymph nodes of inguinal region and lower limb
20026	Burkitt's tumor or lymphoma of intrapelvic lymph nodes
20027	Burkitt's tumor or lymphoma of spleen
20028	Burkitt's tumor or lymphoma of lymph nodes of multiple sites
20030	Marginal zone lymphoma, unspecified site, extranodal and solid organ sites
20031	Marginal zone lymphoma, lymph nodes of head, face, and neck
20032	Marginal zone lymphoma, intrathoracic lymph nodes
20033	Marginal zone lymphoma, intra-abdominal lymph nodes
20034	Marginal zone lymphoma, lymph nodes of axilla and upper limb
20035	Marginal zone lymphoma, lymph nodes of inguinal region and lower limb
20036	Marginal zone lymphoma, intrapelvic lymph nodes

Diagnosis Code	Description
20037	Marginal zone lymphoma, spleen
20038	Marginal zone lymphoma, lymph nodes of multiple sites
20040	Mantle cell lymphoma, unspecified site, extranodal and solid organ sites
20041	Mantle cell lymphoma, lymph nodes of head, face, and neck
20042	Mantle cell lymphoma, intrathoracic lymph nodes
20043	Mantle cell lymphoma, intra-abdominal lymph nodes
20044	Mantle cell lymphoma, lymph nodes of axilla and upper limb
20045	Mantle cell lymphoma, lymph nodes of inguinal region and lower limb
20046	Mantle cell lymphoma, intrapelvic lymph nodes
20047	Mantle cell lymphoma, spleen
20048	Mantle cell lymphoma, lymph nodes of multiple sites
20050	Primary central nervous system lymphoma, unspecified site, extranodal and solid organ sites
20051	Primary central nervous system lymphoma, lymph nodes of head, face, and neck
20052	Primary central nervous system lymphoma, intrathoracic lymph nodes
20053	Primary central nervous system lymphoma, intra-abdominal lymph nodes
20054	Primary central nervous system lymphoma, lymph nodes of axilla and upper limb
20055	Primary central nervous system lymphoma, lymph nodes of inguinal region and lower limb
20056	Primary central nervous system lymphoma, intrapelvic lymph nodes
20057	Primary central nervous system lymphoma, spleen
20058	Primary central nervous system lymphoma, lymph nodes of multiple sites
20060	Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites
20061	Anaplastic large cell lymphoma, lymph nodes of head, face, and neck
20062	Anaplastic large cell lymphoma, intrathoracic lymph nodes
20063	Anaplastic large cell lymphoma, intra-abdominal lymph nodes
20064	Anaplastic large cell lymphoma, lymph nodes of axilla and upper limb
20065	Anaplastic large cell lymphoma, lymph nodes of inguinal region and lower limb
20066	Anaplastic large cell lymphoma, intrapelvic lymph nodes
20067	Anaplastic large cell lymphoma, spleen
20068	Anaplastic large cell lymphoma, lymph nodes of multiple sites
20070	Large cell lymphoma, unspecified site, extranodal and solid organ sites
20071	Large cell lymphoma, lymph nodes of head, face, and neck
20072	Large cell lymphoma, intrathoracic lymph nodes
20073	Large cell lymphoma, intra-abdominal lymph nodes
20074	Large cell lymphoma, lymph nodes of axilla and upper limb
20075	Large cell lymphoma, lymph nodes of inguinal region and lower limb
20076	Large cell lymphoma, intrapelvic lymph nodes
20077	Large cell lymphoma, spleen

Diagnosis Code	Description
20078	Large cell lymphoma, lymph nodes of multiple sites
20080	Other named variants, unspecified site, extranodal and solid organ sites
20081	Other named variants of lymphosarcoma and reticulosarcoma of lymph nodes of head, face, and neck
20082	Other named variants of lymphosarcoma and reticulosarcoma of intrathoracic lymph nodes
20083	Other named variants of lymphosarcoma and reticulosarcoma of intra-abdominal lymph nodes
20084	Other named variants of lymphosarcoma and reticulosarcoma of lymph nodes of axilla and upper limb
20085	Other named variants of lymphosarcoma and reticulosarcoma of lymph nodes of inguinal region and lower limb
20086	Other named variants of lymphosarcoma and reticulosarcoma of intrapelvic lymph nodes
20087	Other named variants of lymphosarcoma and reticulosarcoma of spleen
20088	Other named variants of lymphosarcoma and reticulosarcoma of lymph nodes of multiple sites
20100	Hodgkin's paragranuloma, unspecified site, extranodal and solid organ sites
20101	Hodgkin's paragranuloma of lymph nodes of head, face, and neck
20102	Hodgkin's paragranuloma of intrathoracic lymph nodes
20103	Hodgkin's paragranuloma of intra-abdominal lymph nodes
20104	Hodgkin's paragranuloma of lymph nodes of axilla and upper limb
20105	Hodgkin's paragranuloma of lymph nodes of inguinal region and lower limb
20106	Hodgkin's paragranuloma of intrapelvic lymph nodes
20107	Hodgkin's paragranuloma of spleen
20108	Hodgkin's paragranuloma of lymph nodes of multiple sites
20110	Hodgkin's granuloma, unspecified site, extranodal and solid organ sites
20111	Hodgkin's granuloma of lymph nodes of head, face, and neck
20112	Hodgkin's granuloma of intrathoracic lymph nodes
20113	Hodgkin's granuloma of intra-abdominal lymph nodes
20114	Hodgkin's granuloma of lymph nodes of axilla and upper limb
20115	Hodgkin's granuloma of lymph nodes of inguinal region and lower limb
20116	Hodgkin's granuloma of intrapelvic lymph nodes
20117	Hodgkin's granuloma of spleen
20118	Hodgkin's granuloma of lymph nodes of multiple sites
20120	Hodgkin's sarcoma, unspecified site, extranodal and solid organ sites
20121	Hodgkin's sarcoma of lymph nodes of head, face, and neck
20122	Hodgkin's sarcoma of intrathoracic lymph nodes
20123	Hodgkin's sarcoma of intra-abdominal lymph nodes
20124	Hodgkin's sarcoma of lymph nodes of axilla and upper limb
20125	Hodgkin's sarcoma of lymph nodes of inguinal region and lower limb
20126	Hodgkin's sarcoma of intrapelvic lymph nodes
20127	Hodgkin's sarcoma of spleen

Diagnosis Code	Description
20128	Hodgkin's sarcoma of lymph nodes of multiple sites
20140	Hodgkin's disease, lymphocytic-histiocytic predominance, unspecified site, extranodal and solid organ sites
20141	Hodgkin's disease, lymphocytic-histiocytic predominance of lymph nodes of head, face, and neck
20142	Hodgkin's disease, lymphocytic-histiocytic predominance of intrathoracic lymph nodes
20143	Hodgkin's disease, lymphocytic-histiocytic predominance of intra-abdominal lymph nodes
20144	Hodgkin's disease, lymphocytic-histiocytic predominance of lymph nodes of axilla and upper limb
20145	Hodgkin's disease, lymphocytic-histiocytic predominance of lymph nodes of inguinal region and lower limb
20146	Hodgkin's disease, lymphocytic-histiocytic predominance of intrapelvic lymph nodes
20147	Hodgkin's disease, lymphocytic-histiocytic predominance of spleen
20148	Hodgkin's disease, lymphocytic-histiocytic predominance of lymph nodes of multiple sites
20150	Hodgkin's disease, nodular sclerosis, unspecified site, extranodal and solid organ sites
20151	Hodgkin's disease, nodular sclerosis, of lymph nodes of head, face, and neck
20152	Hodgkin' disease, nodular sclerosis, of intrathoracic lymph nodes
20153	Hodgkin's disease, nodular sclerosis, of intra-abdominal lymph nodes
20154	Hodgkin's disease, nodular sclerosis, of lymph nodes of axilla and upper limb
20155	Hodgkin's disease, nodular sclerosis, of lymph nodes of inguinal region and lower limb
20156	Hodgkin's disease, nodular sclerosis, of intrapelvic lymph nodes
20157	Hodgkin's disease, nodular sclerosis, of spleen
20158	Hodgkin's disease, nodular sclerosis, of lymph nodes of multiple sites
20160	Hodgkin's disease, mixed cellularity, unspecified site, extranodal and solid organ sites
20161	Hodgkin's disease, mixed cellularity, of lymph nodes of head, face, and neck
20162	Hodgkin's disease, mixed cellularity, of intrathoracic lymph nodes
20163	Hodgkin's disease, mixed cellularity, of intra-abdominal lymph nodes
20164	Hodgkin's disease, mixed cellularity, of lymph nodes of axilla and upper limb
20165	Hodgkin's disease, mixed cellularity, of lymph nodes of inguinal region and lower limb
20166	Hodgkin's disease, mixed cellularity, of intrapelvic lymph nodes
20167	Hodgkin's disease, mixed cellularity, of spleen
20168	Hodgkin's disease, mixed cellularity, of lymph nodes of multiple sites
20170	Hodgkin's disease, lymphocytic depletion, unspecified site, extranodal and solid organ sites
20171	Hodgkin's disease, lymphocytic depletion, of lymph nodes of head, face, and neck
20172	Hodgkin's disease, lymphocytic depletion, of intrathoracic lymph nodes

Diagnosis Code	Description
20173	Hodgkin's disease, lymphocytic depletion, of intra-abdominal lymph nodes
20174	Hodgkin's disease, lymphocytic depletion, of lymph nodes of axilla and upper limb
20175	Hodgkin's disease, lymphocytic depletion, of lymph nodes of inguinal region and lower limb
20176	Hodgkin's disease, lymphocytic depletion, of intrapelvic lymph nodes
20177	Hodgkin's disease, lymphocytic depletion, of spleen
20178	Hodgkin's disease, lymphocytic depletion, of lymph nodes of multiple sites
20190	Hodgkin's disease, unspecified type, unspecified site, extranodal and solid organ sites
20191	Hodgkin's disease, unspecified type, of lymph nodes of head, face, and neck
20192	Hodgkin's disease, unspecified type, of intrathoracic lymph nodes
20193	Hodgkin's disease, unspecified type, of intra-abdominal lymph nodes
20194	Hodgkin's disease, unspecified type, of lymph nodes of axilla and upper limb
20195	Hodgkin's disease, unspecified type, of lymph nodes of inguinal region and lower limb
20196	Hodgkin's disease, unspecified type, of intrapelvic lymph nodes
20197	Hodgkin's disease, unspecified type, of spleen
20198	Hodgkin's disease, unspecified type, of lymph nodes of multiple sites
20200	Nodular lymphoma, unspecified site, extranodal and solid organ sites
20201	Nodular lymphoma of lymph nodes of head, face, and neck
20202	Nodular lymphoma of intrathoracic lymph nodes
20203	Nodular lymphoma of intra-abdominal lymph nodes
20204	Nodular lymphoma of lymph nodes of axilla and upper limb
20205	Nodular lymphoma of lymph nodes of inguinal region and lower limb
20206	Nodular lymphoma of intrapelvic lymph nodes
20207	Nodular lymphoma of spleen
20208	Nodular lymphoma of lymph nodes of multiple sites
20210	Mycosis fungoides, unspecified site, extranodal and solid organ sites
20211	Mycosis fungoides of lymph nodes of head, face, and neck
20212	Mycosis fungoides of intrathoracic lymph nodes
20213	Mycosis fungoides of intra-abdominal lymph nodes
20214	Mycosis fungoides of lymph nodes of axilla and upper limb
20215	Mycosis fungoides of lymph nodes of inguinal region and lower limb
20216	Mycosis fungoides of intrapelvic lymph nodes
20217	Mycosis fungoides of spleen
20218	Mycosis fungoides of lymph nodes of multiple sites
20220	Sezary's disease, unspecified site
20221	Sezary's disease of lymph nodes of head, face, and neck
20222	Sezary's disease of intrathoracic lymph nodes
20223	Sezary's disease of intra-abdominal lymph nodes
20224	Sezary's disease of lymph nodes of axilla and upper limb
20225	Sezary's disease of lymph nodes of inguinal region and lower limb

Diagnosis Code	Description
20226	Sezary's disease of intrapelvic lymph nodes
20227	Sezary's disease of spleen
20228	Sezary's disease of lymph nodes of multiple sites
20230	Malignant histiocytosis, unspecified site, extranodal and solid organ sites
20231	Malignant histiocytosis of lymph nodes of head, face, and neck
20232	Malignant histiocytosis of intrathoracic lymph nodes
20233	Malignant histiocytosis of intra-abdominal lymph nodes
20234	Malignant histiocytosis of lymph nodes of axilla and upper limb
20235	Malignant histiocytosis of lymph nodes of inguinal region and lower limb
20236	Malignant histiocytosis of intrapelvic lymph nodes
20237	Malignant histiocytosis of spleen
20238	Malignant histiocytosis of lymph nodes of multiple sites
20240	Leukemic reticuloendotheliosis, unspecified site, extranodal and solid organ sites
20241	Leukemic reticuloendotheliosis of lymph nodes of head, face, and neck
20242	Leukemic reticuloendotheliosis of intrathoracic lymph nodes
20243	Leukemic reticuloendotheliosis of intra-abdominal lymph nodes
20244	Leukemic reticuloendotheliosis of lymph nodes of axilla and upper arm
20245	Leukemic reticuloendotheliosis of lymph nodes of inguinal region and lower limb
20246	Leukemic reticuloendotheliosis of intrapelvic lymph nodes
20247	Leukemic reticuloendotheliosis of spleen
20248	Leukemic reticuloendotheliosis of lymph nodes of multipes sites
20250	Letterer-Siwe disease, unspecified site, extranodal and solid organ sites
20251	Letterer-Siwe disease of lymph nodes of head, face, and neck
20252	Letterer-Siwe disease of intrathoracic lymph nodes
20253	Letterer-Siwe disease of intra-abdominal lymph nodes
20254	Letterer-Siwe disease of lymph nodes of axilla and upper limb
20255	Letterer-Siwe disease of lymph nodes of inguinal region and lower limb
20256	Letterer-Siwe disease of intrapelvic lymph nodes
20257	Letterer-Siwe disease of spleen
20258	Letterer-Siwe disease of lymph nodes of multiple sites
20260	Malignant mast cell tumors, unspecified site, extranodal and solid organ sites
20261	Malignant mast cell tumors of lymph nodes of head, face, and neck
20262	Malignant mast cell tumors of intrathoracic lymph nodes
20263	Malignant mast cell tumors of intra-abdominal lymph nodes
20264	Malignant mast cell tumors of lymph nodes of axilla and upper limb
20265	Malignant mast cell tumors of lymph nodes of inguinal region and lower limb
20266	Malignant mast cell tumors of intrapelvic lymph nodes
20267	Malignant mast cell tumors of spleen

Diagnosis Code	Description
20268	Malignant mast cell tumors of lymph nodes of multiple sites
20280	Other malignant lymphomas, unspecified site, extranodal and solid organ sites
20281	Other malignant lymphomas of lymph nodes of head, face, and neck
20282	Other malignant lymphomas of intrathoracic lymph nodes
20283	Other malignant lymphomas of intra-abdominal lymph nodes
20284	Other malignant lymphomas of lymph nodes of axilla and upper limb
20285	Other malignant lymphomas of lymph nodes of inguinal region and lower limb
20286	Other malignant lymphomas of intrapelvic lymph nodes
20287	Other malignant lymphomas of spleen
20288	Other malignant lymphomas of lymph nodes of multiple sites
20290	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites
20291	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue of lymph nodes of head, face, and neck
20292	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue of intrathoracic lymph nodes
20293	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue of intra-abdominal lymph nodes
20294	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue of lymph nodes of axilla and upper limb
20295	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue of lymph nodes of inguinal region and lower limb
20296	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue of intrapelvic lymph nodes
20297	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue of spleen
20298	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue of lymph nodes of multiple sites
20300	Multiple myeloma, without mention of having achieved remission
20301	Multiple myeloma in remission
20302	Multiple myeloma, in relapse
20310	Plasma cell leukemia, without mention of having achieved remission
20311	Plasma cell leukemia in remission
20312	Plasma cell leukemia, in relapse
20380	Other immunoproliferative neoplasms, without mention of having achieved remission
20381	Other immunoproliferative neoplasms in remission
20382	Other immunoproliferative neoplasms, in relapse
20400	Acute lymphoid leukemia, without mention of having achieved remission
20401	Acute lymphoid leukemia in remission
20402	Acute lymphoid leukemia, in relapse
20410	Chronic lymphoid leukemia, without mention of having achieved remission
20411	Chronic lymphoid leukemia in remission

Diagnosis Code	Description
20412	Chronic lymphoid leukemia, in relapse
20420	Subacute lymphoid leukemia, without mention of having achieved remission
20421	Subacute lymphoid leukemia in remission
20422	Subacute lymphoid leukemia, in relapse
20480	Other lymphoid leukemia, without mention of having achieved remission
20481	Other lymphoid leukemia in remission
20482	Other lymphoid leukemia, in relapse
20490	Unspecified lymphoid leukemia, without mention of having achieved remission
20491	Unspecified lymphoid leukemia in remission
20492	Unspecified lymphoid leukemia, in relapse
20500	Acute myeloid leukemia, without mention of having achieved remission
20501	Acute myeloid leukemia in remission
20502	Acute myeloid leukemia, in relapse
20510	Chronic myeloid leukemia, without mention of having achieved remission
20511	Chronic myeloid leukemia in remission
20512	Chronic myeloid leukemia, in relapse
20520	Subacute myeloid leukemia, without mention of having achieved remission
20521	Subacute myeloid leukemia in remission
20522	Subacute myeloid leukemia, in relapse
20530	Myeloid sarcoma, without mention of having achieved remission
20531	Myeloid sarcoma in remission
20532	Myeloid sarcoma, in relapse
20580	Other myeloid leukemia, without mention of having achieved remission
20581	Other myeloid leukemia in remission
20582	Other myeloid leukemia, in relapse
20590	Unspecified myeloid leukemia, without mention of having achieved remission
20591	Unspecified myeloid leukemia in remission
20592	Unspecified myeloid leukemia, in relapse
20600	Acute monocytic leukemia, without mention of having achieved remission
20601	Acute monocytic leukemia in remission
20602	Acute monocytic leukemia, in relapse
20610	Chronic monocytic leukemia, without mention of having achieved remission
20611	Chronic monocytic leukemia in remission
20612	Chronic monocytic leukemia, in relapse
20620	Subacute monocytic leukemia, without mention of having achieved remission
20621	Subacute monocytic leukemia in remission
20622	Subacute monocytic leukemia, in relapse
20680	Other monocytic leukemia, without mention of having achieved remission

Diagnosis Code	Description
20681	Other monocytic leukemia in remission
20682	Other monocytic leukemia, in relapse
20690	Unspecified monocytic leukemia, without mention of having achieved remission
20691	Unspecified monocytic leukemia in remission
20692	Unspecified monocytic leukemia, in relapse
20700	Acute erythremia and erythroleukemia, without mention of having achieved remission
20701	Acute erythremia and erythroleukemia in remission
20702	Acute erythremia and erythroleukemia, in relapse
20710	Chronic erythremia, without mention of having achieved remission
20711	Chronic erythremia in remission
20712	Chronic erythremia, in relapse
20720	Megakaryocytic leukemia, without mention of having achieved remission
20721	Megakaryocytic leukemia in remission
20722	Megakaryocytic leukemia, in relapse
20780	Other specified leukemia, without mention of having achieved remission
20781	Other specified leukemia in remission
20782	Other specified leukemia, in relapse
20800	Acute leukemia of unspecified cell type, without mention of having achieved remission
20801	Acute leukemia of unspecified cell type in remission
20802	Acute leukemia of unspecified cell type, in relapse
20810	Chronic leukemia of unspecified cell type, without mention of having achieved remission
20811	Chronic leukemia of unspecified cell type in remission
20812	Chronic leukemia of unspecified cell type, in relapse
20820	Subacute leukemia of unspecified cell type, without mention of having achieved remission
20821	Subacute leukemia of unspecified cell type in remission
20822	Subacute leukemia of unspecified cell type, in relapse
20880	Other leukemia of unspecified cell type, without mention of having achieved remission
20881	Other leukemia of unspecified cell type in remission
20882	Other leukemia of unspecified cell type, in relapse
20890	Unspecified leukemia, without mention of having achieved remission
20891	Unspecified leukemia in remission
20892	Unspecified leukemia, in relapse
20900	Malignant carcinoid tumor of the small intestine, unspecified portion
20901	Malignant carcinoid tumor of the duodenum
20902	Malignant carcinoid tumor of the jejunum
20903	Malignant carcinoid tumor of the ileum
20910	Malignant carcinoid tumor of the large intestine, unspecified portion

Diagnosis Code	Description
20911	Malignant carcinoid tumor of the appendix
20912	Malignant carcinoid tumor of the cecum
20913	Malignant carcinoid tumor of the ascending colon
20914	Malignant carcinoid tumor of the transverse colon
20915	Malignant carcinoid tumor of the descending colon
20916	Malignant carcinoid tumor of the sigmoid colon
20917	Malignant carcinoid tumor of the rectum
20920	Malignant carcinoid tumor of the unknown primary site
20921	Malignant carcinoid tumor of the bronchus and lung
20922	Malignant carcinoid tumor of the thymus
20923	Malignant carcinoid tumor of the stomach
20924	Malignant carcinoid tumor of the kidney
20925	Malignant carcinoid tumor of the foregut, not otherwise specified
20926	Malignant carcinoid tumor of the midgut, not otherwise specified
20927	Malignant carcinoid tumor of hindgut, not otherwise specified
20929	Malignant carcinoid tumor of other sites
20930	Malignant poorly differentiated neuroendocrine carcinoma, any site
20931	Merkel cell carcinoma of the face
20932	Merkel cell carcinoma of the scalp and neck
20933	Merkel cell carcinoma of the upper limb
20934	Merkel cell carcinoma of the lower limb
20935	Merkel cell carcinoma of the trunk
20936	Merkel cell carcinoma of other sites
20970	Secondary neuroendocrine tumor, unspecified site
20971	Secondary neuroendocrine tumor of distant lymph nodes
20972	Secondary neuroendocrine tumor of liver
20973	Secondary neuroendocrine tumor of bone
20974	Secondary neuroendocrine tumor of peritoneum
20975	Merkel cell carcinoma, unknown primary site
20979	Secondary neuroendocrine tumor of other sites
261	Nutritional marasmus (including severe malnutrition NOS)
2730	Polyclonal hypergammaglobulinemia
2731	Monoclonal paraproteinemia
2732	Other proteinemias
2733	Macroglobulinemia
2734	Alpha-1-antitrypsin deficiency
2738	Other disorders of plasma protein metabolism
2739	Unspecified disorder of plasma protein metabolism
27541	Hypocalcemia
27542	Hypercalcemia
27549	Other disorders of calcium metabolism

Diagnosis Code	Description
2755	Hungry bone syndrome
2758	Other specified disorders of mineral metabolism
2759	Unspecified disorder of mineral metabolism
2760	Hyperosmolality and/or hypernatremia
2761	Hyposmolality and/or hyponatremia
2762	Acidosis
2763	Alkalosis
2764	Mixed acid-base balance disorder
27651	Dehydration
27652	Hypovolemia
2767	Hyperpotassemia
2768	Hypopotassemia
2769	Electrolyte and fluid disorders not elsewhere classified
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
27730	Amyloidosis, unspecified
27731	Familial Mediterranean fever
27739	Other amyloidosis
2774	Disorders of bilirubin excretion
27783	Iatrogenic carnitine deficiency
27784	Other secondary carnitine deficiency
2782	Hypervitaminosis a
2783	Hypercarotinemia
2784	Hypervitaminosis d
2788	Other hyperalimentation
27900	Hypogammaglobulinemia
27901	Selective IgA immunodeficiency
27902	Selective IgM immunodeficiency
27903	Other selective immunoglobulin deficiencies
27904	Congenital hypogammaglobulinemia
27905	Immunodeficiency with increased IgM
27906	Common variable immunodeficiency
27909	Other deficiency of humoral immunity
27910	Immunodeficiency with predominant t-cell defect, unspecified
27911	Digeorge's syndrome
27912	Wiskott-Aldrich syndrome
27913	Nezelof's syndrome
27919	Other deficiency of cell-mediated immunity

Diagnosis Code	Description
2792	Combined immunity deficiency
2793	Unspecified immunity deficiency
2794	Autoimmune disease, not elsewhere classified
2798	Other specified disorders involving the immune mechanism
2799	Unspecified disorder of the immune system
3430	Infantile cerebral palsy, diplegic
3431	Infantile cerebral palsy, hemiplegic
3432	Infantile cerebral palsy, quadriplegic
3433	Infantile cerebral palsy, monoplegic
3434	Infantile cerebral palsy, infantile hemiplegia
3438	Infantile cerebral palsy, other specified infantile cerebral palsy
3439	Infantile cerebral palsy, infantile cerebral palsy, unspecified
43882	Dysphagia
5550	Regional enteritis, small intestine (includes Crohn's disease)
5551	Regional enterits,large intestine (includes Crohn's disease)
5552	Regional enteritis of small intestine with large intestine
5559	Regional enteritis, unspecified site (includes Crohn's disease, NOS)
5642	Postgastric surgery syndromes
570	Acute and subacute necrosis of liver
5720	Liver abcess and sequelae of chronic liver disease
5770	Acute pancreatitis
5771	Chronic pancreatitis
5793	Other and unspecified postsurgical nonabsorption
78720	Dysphagia, unspecified
78721	Dysphagia, oral phase
78722	Dysphagia, oropharyngeal phase
78723	Dysphagia, pharyngeal phase
78724	Dysphagia, pharyngoesophageal phase
78729	Other dysphagia
9470	Burns of internal organs, mouth and pharynx
9471	Burns of internal organs, larynx, trachea, and lung
9472	Burns of internal organs, esophagus
9473	Burns of internal organs, gastrointestinal tract
9478	Burns of internal organs, other specified sites
9479	Burns of internal organs, unspecified site
95901	Head injury, unspecified
V1367	Personal history of (corrected) congenital malformations of digestive system.
V2130	Low birth weight status, unspecified
V2131	Low birth weight status, less than 500 grams
V2132	Low birth weight status, 500-999 grams
V2133	Low birth weight status, 1000-1499 grams

Diagnosis Code	Description
V2134	Low birth weight status, 1500-1999 grams
V2135	Low birth weight status, 2000-2500 grams
V441	Gastrostomy
V444	Other artificial opening of gastointestinal tract

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

Procedure codes B1457 and B4162 will be considered for prior authorization only for the following diagnosis codes:

Diagnosis Codes							
2705	2708	2709	2710	2711	2712	2713	2714
2718	2719	2720	2721	2722	2723	2724	2725
2726	2727	2728	2729	2740	27410	27411	27419
27481	27482	27489	2749	2751	2752	2753	27540
2771	2772	2775	2776	2777	27781	27782	27785
27786	27787	27788	27789	2779			

The following procedure codes will no longer be considered for prior authorization for the diagnosis codes listed in the previous table:

Diagnosis Codes							
B4100	B4150	B4152	B4153	B4154	B4155	B4158	B4159
B4160	B4161	B9998	T1999				

Prior authorization requests for any diagnosis other than those listed in the tables above or in the table in Section 26.6.2 of this chapter must be reviewed by the CSHCN Services Program Medical Director or designee.

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

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

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

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

26.5.3 Claims Information

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

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

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

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

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

26.5.4 Reimbursement

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

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

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

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

Reimbursement for miscellaneous procedure codes B9998 and T1999 is determined by prior authorization limitations, based on the average wholesale price (AWP) less 10.5 percent.

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

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

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

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

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

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

26.6 Total Parenteral Nutrition (TPN)

26.6.1 Enrollment

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

26.6.2 Benefits, Limitations, and Authorization Requirements

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

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

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

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

Procedure Codes						
B9004	B9006	S9364	S9365	S9366	S9367	S9368

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

Procedure codes B9004 and B9906 are denied as included in another procedure when they are submitted for the same date of service as related procedure codes S9364, S9365, S9366, S9367 or S9368 by any provider.

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

Note: *Procedure codes B9004 and B9006 when purchased new or rented monthly require prior authorization and are benefits for both males and females.*

The procedure codes in the above table and B4185 are a benefit only in the home setting when provided by a home heath DME provider, medical supplier (DME), or a medical supply company.

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

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

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

26.6.2.1 Prior Authorization

Prior authorization is required for all TPN services, including lipids solution. Authorization may be considered for the diagnosis codes listed below. Prior authorization requests for clients with diagnoses other than those listed will be forwarded to the CSHCN Services Program Medical Director or designee for consideration.

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

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

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV)
1400	Malignant neoplasm of upper lip, vermilion border
1401	Malignant neoplasm of lower lip, vermilion border
1403	Malignant neoplasm of upper lip, inner aspect
1404	Malignant neoplasm of lower lip, inner aspect
1405	Malignant neoplasm of lip inner aspect, unspecified as to upper or lower
1406	Malignant neoplasm of commissure of lip
1408	Malignant neoplasm of other sites of lip
1409	Malignant neoplasm of lip vermilion border, unspecified as to upper or lower
1410	Malignant neoplasm of base of tongue
1411	Malignant neoplasm of dorsal surface of tongue
1412	Malignant neoplasm of tip and lateral border of tongue
1413	Malignant neoplasm of ventral surface of tongue
1414	Malignant neoplasm of anterior two-thirds of tongue, part unspecified
1415	Malignant neoplasm of junctional zone of tongue
1416	Malignant neoplasm of lingual tonsil
1418	Malignant neoplasm of other sites of tongue
1419	Malignant neoplasm of tongue, unspecified site
1420	Malignant neoplasm of parotid gland
1421	Malignant neoplasm of submandibular gland
1422	Malignant neoplasm of sublingual gland
1428	Malignant neoplasm of other major salivary glands
1429	Malignant neoplasm of salivary gland, unspecified
1430	Malignant neoplasm of upper gum
1431	Malignant neoplasm of lower gum
1438	Malignant neoplasm of other sites of gum

Diagnosis Code	Description
1439	Malignant neoplasm of gum, unspecified site
1440	Malignant neoplasm of anterior portion of floor of mouth
1441	Malignant neoplasm of lateral portion of floor of mouth
1448	Malignant neoplasm of other sites of floor of mouth
1449	Malignant neoplasm of floor of mouth, part unspecified
1450	Malignant neoplasm of cheek mucosa
1451	Malignant neoplasm of vestibule of mouth
1452	Malignant neoplasm of hard palate
1453	Malignant neoplasm of soft palate
1454	Malignant neoplasm of uvula
1455	Malignant neoplasm of palate, unspecified
1456	Malignant neoplasm of retromolar area
1458	Malignant neoplasm of other specified parts of mouth
1459	Malignant neoplasm of mouth, unspecified site
1460	Malignant neoplasm of tonsil
1461	Malignant neoplasm of tonsillar fossa
1462	Malignant neoplasm of tonsillar pillars (anterior) (posterior)
1463	Malignant neoplasm of vallecula
1464	Malignant neoplasm of anterior aspect of epiglottis
1465	Malignant neoplasm of junctional region of oropharynx
1466	Malignant neoplasm of lateral wall of oropharynx
1467	Malignant neoplasm of posterior wall of oropharynx
1468	Malignant neoplasm of other specified sites of oropharynx
1469	Malignant neoplasm of oropharynx, unspecified site
1470	Malignant neoplasm of superior wall of nasopharynx
1471	Malignant neoplasm of posterior wall of nasopharynx
1472	Malignant neoplasm of lateral wall of nasopharynx
1473	Malignant neoplasm of anterior wall of nasopharynx
1478	Malignant neoplasm of other specified sites of nasopharynx
1479	Malignant neoplasm of nasopharynx, unspecified site
1480	Malignant neoplasm of postcricoid region of hypopharynx
1481	Malignant neoplasm of pyriform sinus
1482	Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
1483	Malignant neoplasm of posterior hypopharyngeal wall
1488	Malignant neoplasm of other specified sites of hypopharynx
1489	Malignant neoplasm of hypopharynx, unspecified site
1490	Malignant neoplasm of pharynx, unspecified
1491	Malignant neoplasm of Waldeyer's ring
1498	Malignant neoplasm of other sites within the lip and oral cavity
1499	Malignant neoplasm of ill-defined sites within the lip and oral cavity

Diagnosis Code	Description
1500	Malignant neoplasm of cervical esophagus
1501	Malignant neoplasm of thoracic esophagus
1502	Malignant neoplasm of abdominal esophagus
1503	Malignant neoplasm of upper third of esophagus
1504	Malignant neoplasm of middle third of esophagus
1505	Malignant neoplasm of lower third of esophagus
1508	Malignant neoplasm of other specified part of esophagus
1509	Malignant neoplasm of esophagus, unspecified site
1510	Malignant neoplasm of cardia
1511	Malignant neoplasm of pylorus
1512	Malignant neoplasm of pyloric antrum
1513	Malignant neoplasm of fundus of stomach
1514	Malignant neoplasm of body of stomach
1515	Malignant neoplasm of lesser curvature of stomach, unspecified
1516	Malignant neoplasm of greater curvature of stomach, unspecified
1518	Malignant neoplasm of other specified sites of stomach
1519	Malignant neoplasm of stomach, unspecified site
1520	Malignant neoplasm of duodenum
1521	Malignant neoplasm of jejunum
1522	Malignant neoplasm of ileum
1523	Malignant neoplasm of Meckel's diverticulum
1528	Malignant neoplasm of other specified sites of small intestine
1529	Malignant neoplasm of small intestine, unspecified site
1530	Malignant neoplasm of hepatic flexure
1531	Malignant neoplasm of transverse colon
1532	Malignant neoplasm of descending colon
1533	Malignant neoplasm of sigmoid colon
1534	Malignant neoplasm of cecum
1535	Malignant neoplasm of appendix
1536	Malignant neoplasm of ascending colon
1537	Malignant neoplasm of splenic flexure
1538	Malignant neoplasm of other specified sites of large intestine
1539	Malignant neoplasm of colon, unspecified site
1540	Malignant neoplasm of rectosigmoid junction
1541	Malignant neoplasm of rectum
1542	Malignant neoplasm of anal canal
1543	Malignant neoplasm of anus, unspecified site
1548	Malignant neoplasm of other sites of rectum, rectosigmoid junction, and anus
1550	Malignant neoplasm of liver, primary

Diagnosis Code	Description
1551	Malignant neoplasm of intrahepatic bile ducts
1552	Malignant neoplasm of liver, not specified as primary or secondary
1560	Malignant neoplasm of gallbladder
1561	Malignant neoplasm of extrahepatic bile ducts
1562	Malignant neoplasm of Ampulla of Vater
1568	Malignant neoplasm of other specified sites of gallbladder and extrahepatic bile ducts
1569	Malignant neoplasm of biliary tract, part unspecified site
1570	Malignant neoplasm of head of pancreas
1571	Malignant neoplasm of body of pancreas
1572	Malignant neoplasm of tail of pancreas
1573	Malignant neoplasm of pancreatic duct
1574	Malignant neoplasm of islets of Langerhans
1578	Malignant neoplasm of other specified sites of pancreas
1579	Malignant neoplasm of pancreas, part unspecified
1580	Malignant neoplasm of retroperitoneum
1588	Malignant neoplasm of specified parts of peritoneum
1589	Malignant neoplasm of peritoneum, unspecified
1590	Malignant neoplasm of intestinal tract, part unspecified
1591	Malignant neoplasm of spleen, not elsewhere classified
1598	Malignant neoplasm of other sites of digestive system and intra-abdominal organs
1599	Malignant neoplasm of ill-defined sites within the digestive organs and peritoneum
1600	Malignant neoplasm of nasal cavities
1601	Malignant neoplasm of auditory tube, middle ear, and mastoid air cells
1602	Malignant neoplasm of maxillary sinus
1603	Malignant neoplasm of ethmoidal sinus
1604	Malignant neoplasm of frontal sinus
1605	Malignant neoplasm of sphenoidal sinus
1608	Malignant neoplasm of other sites of nasal cavities, middle ear, and accessory sinuses
1609	Malignant neoplasm of site of nasal cavities, middle ear, and accessory sinus, unspecified site
1610	Malignant neoplasm of glottis
1611	Malignant neoplasm of supraglottis
1612	Malignant neoplasm of subglottis
1613	Malignant neoplasm of laryngeal cartilages
1618	Malignant neoplasm of other specified sites of larynx
1619	Malignant neoplasm of larynx, unspecified site
1620	Malignant neoplasm of trachea

Diagnosis Code	Description
1622	Malignant neoplasm of main bronchus
1623	Malignant neoplasm of upper lobe, bronchus or lung
1624	Malignant neoplasm of middle lobe, bronchus or lung
1625	Malignant neoplasm of lower lobe, bronchus or lung
1628	Malignant neoplasm of other parts of bronchus or lung
1629	Malignant neoplasm of bronchus and lung, unspecified site
1630	Malignant neoplasm of parietal pleura
1631	Malignant neoplasm of visceral pleura
1638	Malignant neoplasm of other specified sites of pleura
1639	Malignant neoplasm of pleura, unspecified site
1640	Malignant neoplasm of thymus
1641	Malignant neoplasm of heart
1642	Malignant neoplasm of anterior mediastinum
1643	Malignant neoplasm of posterior mediastinum
1648	Malignant neoplasm of other parts of mediastinum
1649	Malignant neoplasm of mediastinum, part unspecified
1650	Malignant neoplasm of upper respiratory tract, part unspecified
1658	Malignant neoplasm of other sites within the respiratory system and intrathoracic organs
1659	Malignant neoplasm of ill-defined sites within the respiratory system
1700	Malignant neoplasm of bones of skull and face, except mandible
1701	Malignant neoplasm of mandible
1702	Malignant neoplasm of vertebral column, excluding sacrum and coccyx
1703	Malignant neoplasm of ribs, sternum, and clavicle
1704	Malignant neoplasm of scapula and long bones of upper limb
1705	Malignant neoplasm of short bones of upper limb
1706	Malignant neoplasm of pelvic bones, sacrum, and coccyx
1707	Malignant neoplasm of long bones of lower limb
1708	Malignant neoplasm of short bones of lower limb
1709	Malignant neoplasm of bone and articular cartilage, site unspecified
1710	Malignant neoplasm of connective and other soft tissue of head, face, and neck
1712	Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder
1713	Malignant neoplasm of connective and other soft tissue of lower limb, including hip
1714	Malignant neoplasm of connective and other soft tissue of thorax
1715	Malignant neoplasm of connective and other soft tissue of abdomen
1716	Malignant neoplasm of connective and other soft tissue of pelvis
1717	Malignant neoplasm of connective and other soft tissue of trunk, unspecified site

Diagnosis Code	Description
1718	Malignant neoplasm of other specified sites of connective and other soft tissue
1719	Malignant neoplasm of connective and other soft tissue, site unspecified
1720	Malignant melanoma of skin of lip
1721	Malignant melanoma of skin of eyelid, including canthus
1722	Malignant melanoma of skin of ear and external auditory canal
1723	Malignant melanoma of skin of other and unspecified parts of face
1724	Malignant melanoma of skin of scalp and neck
1725	Malignant melanoma of skin of trunk, except scrotum
1726	Malignant melanoma of skin of upper limb, including shoulder
1727	Malignant melanoma of skin of lower limb, including hip
1728	Malignant melanoma of other specified sites of skin
1729	Malignant melanoma of skin, site unspecified
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast
1760	Kaposi's sarcoma of skin
1761	Kaposi's sarcoma of soft tissue
1762	Kaposi's sarcoma of palate
1763	Kaposi's sarcoma of gastrointestinal sites
1764	Kaposi's sarcoma of lung
1765	Kaposi's sarcoma of lymph nodes
1768	Kaposi's sarcoma of other specified sites
1769	Kaposi's sarcoma of unspecified site
179	Malignant neoplasm of uterus, part unspecified
1800	Malignant neoplasm of endocervix
1801	Malignant neoplasm of exocervix
1808	Malignant neoplasm of other specified sites of cervix
1809	Malignant neoplasm of cervix uteri, unspecified site
181	Malignant neoplasm of placenta
1820	Malignant neoplasm of corpus uteri, except isthmus

Diagnosis Code	Description
1821	Malignant neoplasm of isthmus
1828	Malignant neoplasm of other specified sites of body of uterus
1830	Malignant neoplasm of ovary
1832	Malignant neoplasm of fallopian tube
1833	Malignant neoplasm of broad ligament of uterus
1834	Malignant neoplasm of parametrium of uterus
1835	Malignant neoplasm of round ligament of uterus
1838	Malignant neoplasm of other specified sites of uterine adnexa
1839	Malignant neoplasm of uterine adnexa, unspecified site
1840	Malignant neoplasm of vagina
1841	Malignant neoplasm of labia majora
1842	Malignant neoplasm of labia minora
1843	Malignant neoplasm of clitoris
1844	Malignant neoplasm of vulva, unspecified site
1848	Malignant neoplasm of other specified sites of female genital organs
1849	Malignant neoplasm of female genital organ, site unspecified
185	Malignant neoplasm of prostate
1860	Malignant neoplasm of undescended testis
1869	Malignant neoplasm of other and unspecified testis
1871	Malignant neoplasm of prepuce
1872	Malignant neoplasm of glans penis
1873	Malignant neoplasm of body of penis
1874	Malignant neoplasm of penis, part unspecified
1875	Malignant neoplasm of epididymis
1876	Malignant neoplasm of spermatic cord
1877	Malignant neoplasm of scrotum
1878	Malignant neoplasm of other specified sites of male genital organs
1879	Malignant neoplasm of male genital organ, site unspecified
1880	Malignant neoplasm of trigone of urinary bladder
1881	Malignant neoplasm of dome of urinary bladder
1882	Malignant neoplasm of lateral wall of urinary bladder
1883	Malignant neoplasm of anterior wall of urinary bladder
1884	Malignant neoplasm of posterior wall of urinary bladder
1885	Malignant neoplasm of bladder neck
1886	Malignant neoplasm of ureteric orifice
1887	Malignant neoplasm of urachus
1888	Malignant neoplasm of other specified sites of bladder
1889	Malignant neoplasm of bladder, part unspecified
1890	Malignant neoplasm of kidney, except pelvis

Diagnosis Code	Description
1891	Malignant neoplasm of renal pelvis
1892	Malignant neoplasm of ureter
1893	Malignant neoplasm of urethra
1894	Malignant neoplasm of paraurethral glands
1898	Malignant neoplasm of other specified sites of urinary organs
1899	Malignant neoplasm of urinary organ, site unspecified
1900	Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
1901	Malignant neoplasm of orbit
1902	Malignant neoplasm of lacrimal gland
1903	Malignant neoplasm of conjunctiva
1904	Malignant neoplasm of cornea
1905	Malignant neoplasm of retina
1906	Malignant neoplasm of choroid
1907	Malignant neoplasm of lacrimal duct
1908	Malignant neoplasm of other specified sites of eye
1909	Malignant neoplasm of eye, part unspecified
1910	Malignant neoplasm of cerebrum, except lobes and ventricles
1911	Malignant neoplasm of frontal lobe of brain
1912	Malignant neoplasm of temporal lobe of brain
1913	Malignant neoplasm of parietal lobe of brain
1914	Malignant neoplasm of occipital lobe of brain
1915	Malignant neoplasm of ventricles of brain
1916	Malignant neoplasm of cerebellum NOS
1917	Malignant neoplasm of brain stem
1918	Malignant neoplasm of other parts of brain
1919	Malignant neoplasm of brain, unspecified site
1920	Malignant neoplasm of cranial nerves
1921	Malignant neoplasm of cerebral meninges
1922	Malignant neoplasm of spinal cord
1923	Malignant neoplasm of spinal meninges
1928	Malignant neoplasm of other specified sites of nervous system
1929	Malignant neoplasm of nervous system, part unspecified
193	Malignant neoplasm of thyroid gland
1940	Malignant neoplasm of adrenal gland
1941	Malignant neoplasm of parathyroid gland
1943	Malignant neoplasm of pituitary gland and craniopharyngeal duct
1944	Malignant neoplasm of pineal gland
1945	Malignant neoplasm of carotid body

Diagnosis Code	Description
1946	Malignant neoplasm of aortic body and other paraganglia
1948	Malignant neoplasm of other endocrine glands and related structures
1949	Malignant neoplasm of endocrine gland, site unspecified
1950	Malignant neoplasm of head, face, and neck
1951	Malignant neoplasm of thorax
1952	Malignant neoplasm of abdomen
1953	Malignant neoplasm of pelvis
1954	Malignant neoplasm of upper limb
1955	Malignant neoplasm of lower limb
1958	Malignant neoplasm of other specified sites
1960	Secondary and unspecified malignant neoplasm of lymph nodes of head, face, and neck
1961	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
1962	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
1963	Secondary and unspecified malignant neoplasm of lymph nodes of axilla and upper limb
1965	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
1966	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
1968	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
1969	Secondary and unspecified malignant neoplasm of lymph nodes, site unspecified
1970	Secondary malignant neoplasm of lung
1971	Secondary malignant neoplasm of mediastinum
1972	Secondary malignant neoplasm of pleura
1973	Secondary malignant neoplasm of other respiratory organs
1974	Secondary malignant neoplasm of small intestine including duodenum
1975	Secondary malignant neoplasm of large intestine and rectum
1976	Secondary malignant neoplasm of retroperitoneum and peritoneum
1977	Secondary malignant neoplasm of liver, specified as secondary
1978	Secondary malignant neoplasm of other digestive organs and spleen
1980	Secondary malignant neoplasm of kidney
1981	Secondary malignant neoplasm of other urinary organs
1982	Secondary malignant neoplasm of skin
1983	Secondary malignant neoplasm of brain and spinal cord
1984	Secondary malignant neoplasm of other parts of nervous system
1985	Secondary malignant neoplasm of bone and bone marrow
1986	Secondary malignant neoplasm of ovary
1987	Secondary malignant neoplasm of adrenal gland

Diagnosis Code	Description
19881	Secondary malignant neoplasm of breast
19882	Secondary malignant neoplasm of genital organs
19889	Secondary malignant neoplasm of other specified sites
1990	Disseminated malignant neoplasm
1991	Other malignant neoplasm of unspecified site
1992	Malignant neoplasm associated with transplant organ
20000	Reticulosarcoma, unspecified site, extranodal and solid organ sites
20001	Reticulosarcoma involving lymph nodes of head, face, and neck
20002	Reticulosarcoma involving intrathoracic lymph nodes
20003	Reticulosarcoma involving intra-abdominal lymph nodes
20004	Reticulosarcoma involving lymph nodes of axilla and upper limb
20005	Reticulosarcoma involving lymph nodes of inguinal region and lower limb
20006	Reticulosarcoma involving intrapelvic lymph nodes
20007	Reticulosarcoma involving spleen
20008	Reticulosarcoma involving lymph nodes of multiple sites
20010	Lymphosarcoma, unspecified site, extranodal and solid organ sites
20011	Lymphosarcoma involving lymph nodes of head, face, and neck
20012	Lymphosarcoma involving intrathoracic lymph nodes
20013	Lymphosarcoma involving intra-abdominal lymph nodes
20014	Lymphosarcoma involving lymph nodes of axilla and upper limb
20015	Lymphosarcoma involving lymph nodes of inguinal region and lower limb
20016	Lymphosarcoma involving intrapelvic lymph nodes
20017	Lymphosarcoma involving spleen
20018	Lymphosarcoma involving lymph nodes of multiple sites
20020	Burkitt's tumor or lymphoma, unspecified site, extranodal and solid organ sites
20021	Burkitt's tumor or lymphoma involving lymph nodes of head, face, and neck
20022	Burkitt's tumor or lymphoma involving intrathoracic lymph nodes
20023	Burkitt's tumor or lymphoma involving intra-abdominal lymph nodes
20024	Burkitt's tumor or lymphoma involving lymph nodes of axilla and upper limb
20025	Burkitt's tumor or lymphoma involving lymph nodes of inguinal region and lower limb
20026	Burkitt's tumor or lymphoma involving intrapelvic lymph nodes
20027	Burkitt's tumor or lymphoma involving spleen
20028	Burkitt's tumor or lymphoma involving lymph nodes of multiple sites
20030	Marginal zone lymphoma, unspecified site, extranodal and solid organ sites
20031	Marginal zone lymphoma, lymph nodes of head, face, and neck
20032	Marginal zone lymphoma, intrathoracic lymph nodes
20033	Marginal zone lymphoma, intra-abdominal lymph nodes
20034	Marginal zone lymphoma, lymph nodes of axilla and upper limb

Diagnosis Code	Description
20035	Marginal zone lymphoma, lymph nodes of inguinal region and lower limb
20036	Marginal zone lymphoma, intrapelvic lymph nodes
20037	Marginal zone lymphoma, spleen
20038	Marginal zone lymphoma, lymph nodes of multiple sites
20040	Mantle cell lymphoma, unspecified site, extranodal and solid organ sites
20041	Mantle cell lymphoma, lymph nodes of head, face, and neck
20042	Mantle cell lymphoma, intrathoracic lymph nodes
20043	Mantle cell lymphoma, intra-abdominal lymph nodes
20044	Mantle cell lymphoma, lymph nodes of axilla and upper limb
20045	Mantle cell lymphoma, lymph nodes of inguinal region and lower limb
20046	Mantle cell lymphoma, intrapelvic lymph nodes
20047	Mantle cell lymphoma, spleen
20048	Mantle cell lymphoma, lymph nodes of multiple sites
20050	Primary central nervous system lymphoma, unspecified site, extranodal and solid organ sites
20051	Primary central nervous system lymphoma, lymph nodes of head, face, and neck
20052	Primary central nervous system lymphoma, intrathoracic lymph nodes
20053	Primary central nervous system lymphoma, intra-abdominal lymph nodes
20054	Primary central nervous system lymphoma, lymph nodes of axilla and upper limb
20055	Primary central nervous system lymphoma, lymph nodes of inguinal region and lower limb
20056	Primary central nervous system lymphoma, intrapelvic lymph nodes
20057	Primary central nervous system lymphoma, spleen
20058	Primary central nervous system lymphoma, lymph nodes of multiple sites
20060	Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites
20061	Anaplastic large cell lymphoma, lymph nodes of head, face, and neck
20062	Anaplastic large cell lymphoma, intrathoracic lymph nodes
20063	Anaplastic large cell lymphoma, intra-abdominal lymph nodes
20064	Anaplastic large cell lymphoma, lymph nodes of axilla and upper limb
20065	Anaplastic large cell lymphoma, lymph nodes of inguinal region and lower limb
20066	Anaplastic large cell lymphoma, intrapelvic lymph nodes
20067	Anaplastic large cell lymphoma, spleen
20068	Anaplastic large cell lymphoma, lymph nodes of multiple sites
20070	Large cell lymphoma, unspecified site, extranodal and solid organ sites
20071	Large cell lymphoma, lymph nodes of head, face, and neck
20072	Large cell lymphoma, intrathoracic lymph nodes
20073	Large cell lymphoma, intra-abdominal lymph nodes
20074	Large cell lymphoma, lymph nodes of axilla and upper limb
20075	Large cell lymphoma, lymph nodes of inguinal region and lower limb

Diagnosis Code	Description
20076	Large cell lymphoma, intrapelvic lymph nodes
20077	Large cell lymphoma, spleen
20078	Large cell lymphoma, lymph nodes of multiple sites
20080	Other named variants of lymphosarcoma and reticulosarcoma, unspecified site
20081	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of head, face, and neck
20082	Other named variants of lymphosarcoma and reticulosarcoma involving intra-thoracic lymph nodes
20083	Other named variants of lymphosarcoma and reticulosarcoma involving intra-abdominal lymph nodes
20084	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of axilla and upper limb
20085	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of inguinal region and lower limb
20086	Other named variants of lymphosarcoma and reticulosarcoma involving intra-pelvic lymph nodes
20087	Other named variants of lymphosarcoma and reticulosarcoma involving spleen
20088	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of multiple sites
20100	Hodgkin's paragranuloma, unspecified site, extranodal and solid organ sites
20101	Hodgkin's paragranuloma involving lymph nodes of head, face, and neck
20102	Hodgkin's paragranuloma involving intrathoracic lymph nodes
20103	Hodgkin's paragranuloma involving intra-abdominal lymph nodes
20104	Hodgkin's paragranuloma involving lymph nodes of axilla and upper limb
20105	Hodgkin's paragranuloma involving lymph nodes of inguinal region and lower limb
20106	Hodgkin's paragranuloma involving intrapelvic lymph nodes
20107	Hodgkin's paragranuloma involving spleen
20108	Hodgkin's paragranuloma involving lymph nodes of multiple sites
20110	Hodgkin's granuloma, unspecified site, extranodal and solid organ sites
20111	Hodgkin's granuloma involving lymph nodes of head, face, and neck
20112	Hodgkin's granuloma involving intrathoracic lymph nodes
20113	Hodgkin's granuloma involving intra-abdominal lymph nodes
20114	Hodgkin's granuloma involving lymph nodes of axilla and upper limb
20115	Hodgkin's granuloma involving lymph nodes of inguinal region and lower limb
20116	Hodgkin's granuloma involving intrapelvic lymph nodes
20117	Hodgkin's granuloma involving spleen
20118	Hodgkin's granuloma involving lymph nodes of multiple sites
20120	Hodgkin's sarcoma, unspecified site, extranodal and solid organ sites
20121	Hodgkin's sarcoma involving lymph nodes of head, face, and neck

Diagnosis Code	Description
20122	Hodgkin's sarcoma involving intrathoracic lymph nodes
20123	Hodgkin's sarcoma involving intra-abdominal lymph nodes
20124	Hodgkin's sarcoma involving lymph nodes of axilla and upper limb
20125	Hodgkin's sarcoma involving lymph nodes of inguinal region and lower limb
20126	Hodgkin's sarcoma involving intrapelvic lymph nodes
20127	Hodgkin's sarcoma involving spleen
20128	Hodgkin's sarcoma involving lymph nodes of multiple sites
20140	Hodgkin's disease, lymphocytic-histiocytic predominance, unspecified site, extranodal and solid organ sites
20141	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of head, face, and neck
20142	Hodgkin's disease, lymphocytic-histiocytic predominance involving intrathoracic lymph nodes
20143	Hodgkin's disease, lymphocytic-histiocytic predominance involving intra-abdominal lymph nodes
20144	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of axilla and upper limb
20145	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of inguinal region and lower limb
20146	Hodgkin's disease, lymphocytic-histiocytic predominance involving intrapelvic lymph nodes
20147	Hodgkin's disease, lymphocytic-histiocytic predominance involving spleen
20148	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of multiple sites
20150	Hodgkin's disease, nodular sclerosis, unspecified site, extranodal and solid organ sites
20151	Hodgkin's disease, nodular sclerosis, involving lymph nodes of head, face, and neck
20152	Hodgkin's disease, nodular sclerosis, involving intrathoracic lymph nodes
20153	Hodgkin's disease, nodular sclerosis, involving intra-abdominal lymph nodes
20154	Hodgkin's disease, nodular sclerosis, involving lymph nodes of axilla and upper limb
20155	Hodgkin's disease, nodular sclerosis, involving lymph nodes of inguinal region and lower limb
20156	Hodgkin's disease, nodular sclerosis, involving intrapelvic lymph nodes
20157	Hodgkin's disease, nodular sclerosis, involving spleen
20158	Hodgkin's disease, nodular sclerosis, involving lymph nodes of multiple sites
20160	Hodgkin's disease, mixed cellularity, unspecified site, extranodal and solid organ sites
20161	Hodgkin's disease, mixed cellularity, involving lymph nodes of head, face, and neck
20162	Hodgkin's disease, mixed cellularity, involving intrathoracic lymph nodes
20163	Hodgkin's disease, mixed cellularity, involving intra-abdominal lymph nodes

Diagnosis Code	Description
20164	Hodgkin's disease, mixed cellularity, involving lymph nodes of axilla and upper limb
20165	Hodgkin's disease, mixed cellularity, involving lymph nodes of inguinal region and lower limb
20166	Hodgkin's disease, mixed cellularity, involving intrapelvic lymph nodes
20167	Hodgkin's disease, mixed cellularity, involving spleen
20168	Hodgkin's disease, mixed cellularity, involving lymph nodes of multiple sites
20170	Hodgkin's disease, lymphocytic depletion, unspecified site, extranodal and solid organ sites
20171	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of head, face, and neck
20172	Hodgkin's disease, lymphocytic depletion, involving intrathoracic lymph nodes
20173	Hodgkin's disease, lymphocytic depletion, involving intra-abdominal lymph nodes
20174	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of axilla and upper limb
20175	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of inguinal region and lower limb
20176	Hodgkin's disease, lymphocytic depletion, involving intrapelvic lymph nodes
20177	Hodgkin's disease, lymphocytic depletion, involving spleen
20178	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of multiple sites
20190	Hodgkin's disease, unspecified type, unspecified site, extranodal and solid organ sites
20191	Hodgkin's disease, unspecified type, involving lymph nodes of head, face, and neck
20192	Hodgkin's disease, unspecified type, involving intrathoracic lymph nodes
20193	Hodgkin's disease, unspecified type, involving intra-abdominal lymph nodes
20194	Hodgkin's disease, unspecified type, involving lymph nodes of axilla and upper limb
20195	Hodgkin's disease, unspecified type, involving lymph nodes of inguinal region and lower limb
20196	Hodgkin's disease, unspecified type, involving intrapelvic lymph nodes
20197	Hodgkin's disease, unspecified type, involving spleen
20198	Hodgkin's disease, unspecified type, involving lymph nodes of multiple sites
20200	Nodular lymphoma, unspecified site, extranodal and solid organ sites
20201	Nodular lymphoma involving lymph nodes of head, face, and neck
20202	Nodular lymphoma involving intrathoracic lymph nodes
20203	Nodular lymphoma involving intra-abdominal lymph nodes
20204	Nodular lymphoma involving lymph nodes of axilla and upper limb
20205	Nodular lymphoma involving lymph nodes of inguinal region and lower limb
20206	Nodular lymphoma involving intrapelvic lymph nodes
20207	Nodular lymphoma involving spleen

Diagnosis Code	Description
20208	Nodular lymphoma involving lymph nodes of multiple sites
20210	Mycosis fungoides, unspecified site, extranodal and solid organ sites
20211	Mycosis fungoides involving lymph nodes of head, face, and neck
20212	Mycosis fungoides involving intrathoracic lymph nodes
20213	Mycosis fungoides involving intra-abdominal lymph nodes
20214	Mycosis fungoides involving lymph nodes of axilla and upper limb
20215	Mycosis fungoides involving lymph nodes of inguinal region and lower limb
20216	Mycosis fungoides involving intrapelvic lymph nodes
20217	Mycosis fungoides involving spleen
20218	Mycosis fungoides involving lymph nodes of multiple sites
20220	Sezary's disease, unspecified site, extranodal and solid organ sites
20221	Sezary's disease involving lymph nodes of head, face, and neck
20222	Sezary's disease involving intrathoracic lymph nodes
20223	Sezary's disease involving intra-abdominal lymph nodes
20224	Sezary's disease involving lymph nodes of axilla and upper limb
20225	Sezary's disease involving lymph nodes of inguinal region and lower limb
20226	Sezary's disease involving intrapelvic lymph nodes
20227	Sezary's disease involving spleen
20228	Sezary's disease involving lymph nodes of multiple sites
20230	Malignant histiocytosis, unspecified site, extranodal and solid organ sites
20231	Malignant histiocytosis involving lymph nodes of head, face, and neck
20232	Malignant histiocytosis involving intrathoracic lymph nodes
20233	Malignant histiocytosis involving intra-abdominal lymph nodes
20234	Malignant histiocytosis involving lymph nodes of axilla and upper limb
20235	Malignant histiocytosis involving lymph nodes of inguinal region and lower limb
20236	Malignant histiocytosis involving intrapelvic lymph nodes
20237	Malignant histiocytosis involving spleen
20238	Malignant histiocytosis involving lymph nodes of multiple sites
20240	Leukemic reticuloendotheliosis, unspecified site, extranodal and solid organ sites
20241	Leukemic reticuloendotheliosis involving lymph nodes of head, face, and neck
20242	Leukemic reticuloendotheliosis involving intrathoracic lymph nodes
20243	Leukemic reticuloendotheliosis involving intra-abdominal lymph nodes
20244	Leukemic reticuloendotheliosis involving lymph nodes of axilla and upper arm
20245	Leukemic reticuloendotheliosis involving lymph nodes of inguinal region and lower limb
20246	Leukemic reticuloendotheliosis involving intrapelvic lymph nodes
20247	Leukemic reticuloendotheliosis involving spleen

Diagnosis Code	Description
20248	Leukemic reticuloendotheliosis involving lymph nodes of multiple sites
20250	Letterer-Siwe disease, unspecified site, extranodal and solid organ sites
20251	Letterer-Siwe disease involving lymph nodes of head, face, and neck
20252	Letterer-Siwe disease involving intrathoracic lymph nodes
20253	Letterer-Siwe disease involving intra-abdominal lymph nodes
20254	Letterer-Siwe disease involving lymph nodes of axilla and upper limb
20255	Letterer-Siwe disease involving lymph nodes of inguinal region and lower limb
20256	Letterer-Siwe disease involving intrapelvic lymph nodes
20257	Letterer-Siwe disease involving spleen
20258	Letterer-Siwe disease involving lymph nodes of multiple sites
20260	Malignant mast cell tumors, unspecified site, extranodal and solid organ sites
20261	Malignant mast cell tumors involving lymph nodes of head, face, and neck
20262	Malignant mast cell tumors involving intrathoracic lymph nodes
20263	Malignant mast cell tumors involving intra-abdominal lymph nodes
20264	Malignant mast cell tumors involving lymph nodes of axilla and upper limb
20265	Malignant mast cell tumors involving lymph nodes of inguinal region and lower limb
20266	Malignant mast cell tumors involving intrapelvic lymph nodes
20267	Malignant mast cell tumors involving spleen
20268	Malignant mast cell tumors involving lymph nodes of multiple sites
20280	Other malignant lymphomas, unspecified site, extranodal and solid organ sites
20281	Other malignant lymphomas involving lymph nodes of head, face, and neck
20282	Other malignant lymphomas involving intrathoracic lymph nodes
20283	Other malignant lymphomas involving intra-abdominal lymph nodes
20284	Other malignant lymphomas involving lymph nodes of axilla and upper limb
20285	Other malignant lymphomas involving lymph nodes of inguinal region and lower limb
20286	Other malignant lymphomas involving intrapelvic lymph nodes
20287	Other malignant lymphomas involving spleen
20288	Other malignant lymphomas involving lymph nodes of multiple sites
20290	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites
20291	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, involving lymph nodes of head, face, and neck
20292	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrathoracic lymph nodes
20293	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intra-abdominal lymph nodes
20294	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of axilla and upper limb

Diagnosis Code	Description
20295	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of inguinal region and lower limb
20296	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrapelvic lymph nodes
20297	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving spleen
20298	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of multiple sites
20300	Multiple myeloma, without mention of having achieved remission
20301	Multiple myeloma, in remission
20302	Multiple myeloma, in relapse
20310	Plasma cell leukemia, without mention of having achieved remission
20311	Plasma cell leukemia, in remission
20312	Plasma cell leukemia, in relapse
20380	Other immunoproliferative neoplasms, without mention of having achieved remission
20381	Other immunoproliferative neoplasms, in remission
20382	Other immunoproliferative neoplasms, in relapse
20400	Acute lymphoid leukemia, without mention of having achieved remission
20401	Lymphoid leukemia, acute, in remission
20402	Acute lymphoid leukemia, in relapse
20410	Chronic lymphoid leukemia, without mention of having achieved remission
20411	Lymphoid leukemia, chronic, in remission
20412	Chronic lymphoid leukemia, in relapse
20420	Subacute lymphoid leukemia, without mention of having achieved remission
20421	Lymphoid leukemia, subacute, in remission
20422	Subacute lymphoid leukemia, in relapse
20480	Other lymphoid leukemia, without mention of having achieved remission
20481	Other lymphoid leukemia, in remission
20482	Other lymphoid leukemia, in relapse
20490	Unspecified lymphoid leukemia, without mention of having achieved remission
20491	Unspecified lymphoid leukemia, in remission
20492	Unspecified lymphoid leukemia, in relapse
20500	Acute myeloid leukemia, without mention of having achieved remission
20501	Myeloid leukemia, acute, in remission
20502	Acute myeloid leukemia, in relapse
20510	Chronic myeloid leukemia, without mention of having achieved remission
20511	Myeloid leukemia, chronic, in remission
20512	Chronic myeloid leukemia, in relapse
20520	Subacute myeloid leukemia, without mention of having achieved remission

Diagnosis Code	Description
20521	Myeloid leukemia, subacute, in remission
20522	Subacute myeloid leukemia, in relapse
20530	Myeloid sarcoma, without mention of having achieved remission
20531	Myeloid sarcoma, in remission
20532	Myeloid sarcoma, in relapse
20580	Other myeloid leukemia, without mention of having achieved remission
20581	Other myeloid leukemia, in remission
20582	Other myeloid leukemia, in relapse
20590	Unspecified myeloid leukemia, without mention of having achieved remission
20591	Unspecified myeloid leukemia, in remission
20592	Unspecified myeloid leukemia, in relapse
20600	Acute monocytic leukemia, without mention of having achieved remission
20601	Monocytic leukemia, acute, in remission
20602	Acute monocytic leukemia, in relapse
20610	Chronic monocytic leukemia, without mention of having achieved remission
20611	Monocytic leukemia, chronic, in remission
20612	Chronic monocytic leukemia, in relapse
20620	Subacute monocytic leukemia, without mention of having achieved remission
20621	Monocytic leukemia, subacute, in remission
20622	Subacute monocytic leukemia, in relapse
20680	Other monocytic leukemia, without mention of having achieved remission
20681	Other monocytic leukemia, in remission
20682	Other monocytic leukemia, in relapse
20690	Unspecified monocytic leukemia, without mention of having achieved remission
20691	Unspecified monocytic leukemia, in remission
20692	Unspecified monocytic leukemia, in relapse
20700	Acute erythremia and erythroleukemia, without mention of having achieved remission
20701	Acute erythremia and erythroleukemia, in remission
20702	Acute erythroleukemia, in relapse
20710	Chronic erythremia, without mention of having achieved remission
20711	Chronic erythremia, in remission
20712	Chronic erythremia, in relapse
20720	Megakaryocytic leukemia, without mention of having achieved remission
20721	Megakaryocytic leukemia, in remission
20722	Megakaryocytic leukemia, in relapse
20780	Other specified leukemia, without mention of having achieved remission

Diagnosis Code	Description
20781	Other specified leukemia, in remission
20782	Other specified leukemia, in relapse
20800	Acute leukemia of unspecified cell type, without mention of having achieved remission
20801	Leukemia of unspecified cell type, acute, in remission
20802	Acute leukemia of unspecified cell type, in relapse
20810	Chronic leukemia of unspecified cell type, without mention of having achieved remission
20811	Leukemia of unspecified cell type, chronic, in remission
20812	Chronic leukemia of unspecified cell type, in relapse
20820	Subacute leukemia of unspecified cell type, without mention of having achieved remission
20821	Leukemia of unspecified cell type, subacute, in remission
20822	Subacute leukemia of unspecified cell type, in relapse
20880	Other leukemia of unspecified cell type, without mention of having achieved remission
20881	Other leukemia of unspecified cell type, in remission
20882	Other leukemia of unspecified cell type, in relapse
20890	Unspecified leukemia, without mention of having achieved remission
20891	Unspecified leukemia, in remission
20892	Unspecified leukemia, in relapse
20900	Malignant carcinoid tumor of the small intestine, unspecified portion
20901	Malignant carcinoid tumor of the duodenum
20902	Malignant carcinoid tumor of the jejunum
20903	Malignant carcinoid tumor of the ileum
20910	Malignant carcinoid tumor of the large intestine, unspecified portion
20911	Malignant carcinoid tumor of the appendix
20912	Malignant carcinoid tumor of the cecum
20913	Malignant carcinoid tumor of the ascending colon
20914	Malignant carcinoid tumor of the transverse colon
20915	Malignant carcinoid tumor of the descending colon
20916	Malignant carcinoid tumor of the sigmoid colon
20917	Malignant carcinoid tumor of the rectum
20920	Malignant carcinoid tumor of the unknown primary site
20921	Malignant carcinoid tumor of the bronchus and lung
20922	Malignant carcinoid tumor of the thymus
20923	Malignant carcinoid tumor of the stomach
20924	Malignant carcinoid tumor of the kidney
20925	Malignant carcinoid tumor of the foregut, not otherwise specified
20926	Malignant carcinoid tumor of the midgut, not otherwise specified

Diagnosis Code	Description
20927	Malignant carcinoid tumor of the hindgut, not otherwise specified
20929	Malignant carcinoid tumor of other sites
20930	Malignant poorly differentiated neuroendocrine carcinoma, any site
20931	Merkel cell carcinoma of the face
20932	Merkel cell carcinoma of the scalp and neck
20933	Merkel cell carcinoma of the upper limb
20934	Merkel cell carcinoma of the lower limb
20935	Merkel cell carcinoma of the trunk
20936	Merkel cell carcinoma of other sites
20970	Secondary neuroendocrine tumor, unspecified site
20971	Secondary neuroendocrine tumor of distant lymph nodes
20972	Secondary neuroendocrine tumor of liver
20973	Secondary neuroendocrine tumor of bone
20974	Secondary neuroendocrine tumor of peritoneum
20975	Merkel cell carcinoma, unknown primary site
20979	Secondary neuroendocrine tumor of other sites
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
27788	Tumor lysis syndrome
5550	Regional enteritis of small intestine
5551	Regional enteritis of large intestine
5552	Regional enteritis of small intestine with large intestine
5559	Regional enteritis of unspecified site

26.6.2.2 Authorization Requirements

Authorization or prior authorization is not required for the diagnosis codes listed in Section 26.6.2, "Benefits, Limitations, and Authorization Requirements," on page 26-36.

Prior authorization and medical review is required for all other diagnoses. Providers must complete the CSHCN Services Program Authorization and Prior Authorization Request Form for TPN authorization requests. Documentation to support medical necessity must accompany the authorization request. Documentation must include the following items:

- Diagnosis
- Start date of TPN
- Estimated time TPN is needed
- Documentation to support medical necessity of TPN

TPN may be approved for up to 12 months duration.

Refer to: Section 4.2, "Authorizations," on page 4-3 for detailed information on authorization requirements.

26.6.3 Claims Information

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

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

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

26.6.4 Reimbursement

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

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

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

26.7 TMHP-CSHCN Services Program Contact Center

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

Chapter

27

Neurostimulators and Neuromuscular Stimulators

27.1 Enrollment

To enroll in the CSHCN Services Program, providers of neurostimulators and neuromuscular stimulator devices and 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 providers of neurostimulator and neuromuscular stimulator devices and supplies must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

27.2 Benefits, Limitations, and Authorization Requirements

As outlined in this chapter, neurostimulator procedures and the rental or purchase of devices and associated supplies, such as leads and form fitting garments, are a benefit of the CSHCN Services Program.

All procedures and related devices for the initial application or surgical implantation of neurostimulators and neuromuscular stimulators require prior authorization with documentation that supports medical necessity with one of the approved diagnoses listed in this section.

Prior authorization requests for neurostimulator and neuromuscular stimulator procedures and related devices may be considered for clients without one of the approved diagnoses and with documentation of medical conditions which will be reviewed by the Department of State Health Services (DSHS)-CSHCN Services Program Medical Director or a designee.

Neurostimulator and neuromuscular stimulator supplies, including leads and electrodes, do not require prior authorization.

Neurostimulator and neuromuscular stimulator supplies may be considered for reimbursement on appeal with documentation of a prior neurostimulator or neuromuscular stimulator procedure for clients with a history greater than five years or for those who did not receive a neurostimulator procedure through the CSHCN Services Program.

The revision or removal of implantable neurostimulators or neuromuscular stimulators does not require prior authorization; however, if the neurostimulator or neuromuscular stimulator device must be replaced, the device itself requires prior authorization with documentation that supports medical necessity with one of the approved diagnoses.

Prior authorization requests, including supporting documentation, must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

27.2.1 Dorsal Column Neurostimulation (DCN)

DCN (procedure codes 61783, 63650, 63655, and 63685) involves the surgical implantation of neurostimulator electrodes within the dura mater or the percutaneous insertion of electrodes in the epidural space. The neurostimulation system stimulates pain-inhibiting nerve fibers, masking the sensation of pain with a tingling sensation (paresthesia).

DCN electrode implantation and the purchase of devices may be a benefit of the CSHCN Services Program when medically necessary for the treatment of chronic intractable pain. Permanent implantation will be considered when criteria are met, including completion of a one-month trial period demonstrating that an implantable device is needed.

Prior authorization for the implantation and purchase of DCN or ICN devices may be considered with one of the medical conditions listed in the table below:

Diagnosis Code	Description
3320	Paralysis agitans
3331	Essential and other specified forms of tremor
3359	Unspecified anterior horn cell disease
33821	Chronic pain due to trauma
33828	Other chronic postoperative pain
33829	Other chronic pain
3383	Neoplasm related pain (acute) (chronic)
3501	Trigeminal neuralgia
3502	Atypical face pain
35571	Causalgia of lower limb
7220	Displacement of cervical intervertebral disc without myelopathy
7230	Spinal stenosis in cervical region
72400	Spinal stenosis, unspecified region other than cervical
72401	Spinal stenosis of thoracic region
72402	Spinal stenosis, lumbar region, without neurogenic claudication
72403	Spinal stenosis, lumbar region, with neurogenic claudication
72409	Spinal stenosis, other region other than cervical
7249	Other unspecified back disorders
7292	Unspecified neuralgia, neuritis, and radiculitis
9059	Late effect of traumatic amputation
99760	Late complications of amputation stump, unspecified

Documentation submitted with the request for permanent implantation and purchase of the DCN device must also demonstrate that:

- Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and were shown to be unsatisfactory, unsuitable,or contraindicated for the client.
- The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation.

- The facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and follow-up of the client are available.
- There has been demonstrated evidence of pain relief during a trial period of DCN with a temporarily implanted electrode or electrodes preceding the permanent implantation. The trial period must be a minimum of 30 days in duration.

Note: *The trial period including device and supplies is considered part of DCN procedure and will not be separately reimbursed.*

Providers may request prior authorization for clients without one of the medical conditions listed for DCN or ICN in the table above. The provider must submit documentation of medical necessity with the request which will be reviewed by the DSHS-CSHCN Services Program Medical Director or a designee.

Only one similar device code may be reimbursed per date of service for any provider. The following procedure codes may be reimbursed for the purchase of a DCN device:

Procedure Codes				
E0740	L8681	L8682	L8683	L8684
L8685	L8686	L8687	L8688	L8689

27.2.2 Intracranial Neurostimulation (ICN)

ICN involves the stereotactic implantation of electrodes in the brain.

The surgical implantation, revision, and removal of intracranial deep-brain stimulators (DBS) are a benefit for the relief of chronic intractable pain when more conservative methods, such as TENS, PENS, or pharmacological management, have failed or were contraindicated.

ICN is also covered for the treatment of intractable tremors due to idiopathic Parkinson's disease or essential tremors.

Prior authorization is required for the implantation and purchase of an ICN device with one of the medical conditions below:

Diagnosis Code	Description
3320	Paralysis agitans
3331	Essential and other specified forms of tremor
3359	Unspecified anterior horn cell disease
33821	Chronic pain due to trauma
33828	Other chronic postoperative pain
33829	Other chronic pain
3383	Neoplasm related pain (acute) (chronic)
3501	Trigeminal neuralgia
3502	Atypical face pain
35571	Causalgia of lower limb
7220	Displacement of cervical intervertebral disc without myelopathy
7230	Spinal stenosis in cervical region
72400	Spinal stenosis, unspecified region other than cervical
72401	Spinal stenosis of thoracic region
72402	Spinal stenosis, lumbar region, without neurogenic claudication
72403	Spinal stenosis, lumbar region, with neurogenic claudication
72409	Spinal stenosis, other region other than cervical
7249	Other unspecified back disorders
7292	Unspecified neuralgia, neuritis, and radiculitis

Diagnosis Code	Description
9059	Late effect of traumatic amputation
99760	Late complications of amputation stump, unspecified

ICN procedures may be reimbursed using the following procedure codes:

Procedure Codes				
61781	61782	61783	61850	61860
61863	61864	61867	61868	61870
61885	61886			

Only one similar device code may be reimbursed per date of service for any provider. The following procedure codes may be reimbursed for the purchase of an ICN device:

Procedure Codes				
E0740	L8681	L8682	L8683	L8684
L8685	L8686	L8687	L8688	L8689

27.2.3 Neuromuscular Electrical Stimulation (NMES)

NMES (procedure codes 64550 and 64580) is used for the treatment of muscle atrophy or to enhance the functional activity of neurologically impaired clients as described in Section 27.2.3.1 and Section 27.2.3.2.

NMES requires prior authorization. The prior authorization request form must include documentation of a spinal cord injury or disuse atrophy that is refractory to conventional therapy.

The following procedure codes may be reimbursed for the rental or purchase of an NMES device:

Procedure Codes				
E0720	E0730	E0731	E0745	E0762
E0764				

The purchase of an NMES device is limited to once every 5 years.

27.2.3.1 NMES for Muscle Atrophy

NMES may be reimbursed when used to treat muscle disuse atrophy when brain, spinal cord, and peripheral nerve supply to the muscle is intact, as well as other non-neurological reasons. Examples of NMES treatment for non-neurological reasons include, but are not limited to, casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery until orthotic training begins.

27.2.3.2 NMES for Walking in Clients with Spinal Cord Injury

The type of NMES used to enhance an SCI client's ability to walk is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. Reimbursement for NMES and FES is limited to SCI clients who have completed a training program consisting of at least 32 physical therapy sessions with the device over a period of 3 months.

The trial period of physical therapy will enable the physician treating the client for SCI to properly evaluate the client's ability to use NMES and FES devices frequently and for the long term.

Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program.

Note: *The goal of physical therapy must be to train SCI clients on the use of NMES and FES devices to achieve walking, not to reverse or retard muscle atrophy.*

NMES and FES used for walking is a benefit for clients with SCI who have all of the following characteristics:

- Intact lower motor unit (L1 and below; both muscle and peripheral nerve)
- Muscle and joint stability for weight bearing at upper and lower extremities, and the balance and control necessary to maintain an upright support posture independently
- Demonstrated brisk muscle contraction with NMES and have sensory perception electrical stimulation sufficient for muscle contraction
- High motivation, commitment, and cognitive ability necessary to use such devices for walking
- Ability to transfer independently and demonstrated independent standing tolerance for at least 3 minutes
- Demonstrated hand and finger function to manipulate controls
- At least 6-month recovery post spinal cord injury and restorative surgery
- Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis
- Demonstrated a willingness to use the device in the long term

NMES and FES used for walking is not a benefit for clients with any of the following conditions:

- Cardiac pacemakers
- Severe scoliosis or severe osteoporosis
- Skin disease or cancer at area of stimulation
- Irreversible contracture
- Autonomic dysflexia

27.2.4 Percutaneous Electrical Nerve Stimulation (PENS)

Implantation of PENS and electrodes is a benefit of the CSHCN Services Program. PENS (procedure codes 64553, 64555, and 64590) is a diagnostic service and may be covered for a 1-month trial to determine if an implantable device is needed. The medical necessity for such diagnostic services which are furnished beyond the first month must be documented, including the rationale for not considering an implantable device.

Because PENS is an office or outpatient therapy, the rental or purchase of the PENS devices, accessories, and supplies is not a benefit of the CSHCN Services Program.

Providers may request prior authorization for clients without one of the medical conditions listed for PENS in the table below. The provider must submit documentation of medical necessity with the request which will be reviewed by the DSHS-CSHCN Services Program Medical Director of a designee.

- The client must have a diagnosis indicating chronic pain that is refractory to conventional therapy. The covered diagnosis codes include the following:

Diagnosis Code	Description
3320	Paralysis agitans
3331	Essential and other specified forms of tremor
3359	Unspecified anterior horn cell disease
33821	Chronic pain due to trauma
33828	Other chronic postoperative pain
33829	Other chronic pain
3383	Neoplasm related pain (acute) (chronic)
3501	Trigeminal neuralgia
3502	Atypical face pain
35571	Causalgia of lower limb

Diagnosis Code	Description
7220	Displacement of cervical intervertebral disc without myelopathy
7230	Spinal stenosis in cervical region
72400	Spinal stenosis, unspecified region other than cervical
72401	Spinal stenosis of thoracic region
72402	Spinal stenosis, lumbar region, without neurogenic claudication
72403	Spinal stenosis, lumbar region, with neurogenic claudication
72409	Spinal stenosis, other region other than cervical
7249	Other unspecified back disorders
7292	Unspecified neuralgia, neuritis, and radiculitis
9059	Late effect of traumatic amputation
99760	Late complications of amputation stump, unspecified

- Treatment with TENS must have failed or have been contraindicated for the client.

All equipment and supplies for PENS are considered part of the service and are not reimbursed separately.

27.2.5 Sacral Nerve Stimulation (SNS)

SNS (procedure codes 64561, 64581, and 64590) is a benefit of the CSHCN Services Program when medically necessary for the treatment of urinary retention, urinary frequency, and urinary/fecal incontinence using medical conditions 59655, 78760, 78820, 78831, or 78841. Prior authorization is required for the implantation and purchase of SNS devices.

The client's medical record must include documentation of the following:

- The urinary retention, urinary frequency, and urinary/fecal incontinence are refractory to conventional therapy (documented behavioral, pharmacological, or surgical corrective therapy).
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

Providers may request prior authorization for clients without one of the medical conditions listed above. The provider must submit documentation of medical necessity with the request that will be reviewed by the DSHS-CSHCN Services Program Medical Director or designee.

Only one similar device code may be reimbursed per date of service for any provider. The following procedure codes may be reimbursed for the purchase of an SNS device:

Procedure Codes				
L8681	L8682	L8683	L8684	L8685
L8686	L8687	L8688	L8689	

27.2.6 Transcutaneous Electrical Nerve Stimulation (TENS)

TENS (procedure codes 64550 and 64580) is a benefit of the CSHCN Services Program. Rental of the TENS device, accessories, and supplies is a benefit for the treatment of acute postoperative pain or to determine if TENS will benefit a client with chronic pain.

The following procedure codes may be reimbursed for the rental or purchase of a TENS device:

Procedure Codes				
E0720	E0730	E0731	E0745	E0762
E0764				

Once it has been determined that TENS should be continued for chronic pain and the client has been trained to use the stimulator, the CSHCN Services Program will no longer reimburse TENS therapy as an outpatient or office service.

27.2.6.1 TENS Rental

The rental of a TENS device may be considered for prior authorization with documentation of a condition that indicates acute postoperative pain or chronic pain that is refractory to conventional therapy.

The rental of a TENS may be considered before purchase and is limited to a trial period of 1 month. One additional month's rental of the TENS device may be considered with documentation of medical necessity. Supplies, such as lead wires and electrodes, are considered to be part of the rental and will not be reimbursed separately. Garments may be reimbursed during the rental period when medically necessary.

Rental reimbursement may not exceed the purchase price. Purchase is justified when the estimated duration of need multiplied by the rental rate exceeds the purchase price of the equipment.

27.2.6.2 TENS Purchase

The purchase of a TENS device, accessories, and supplies may be considered only after a 1-month trial period. In addition, the purchase of a TENS device will be considered for prior authorization with documentation of all of the following:

- Acute postoperative pain or chronic pain that is refractory to conventional therapy
- Successful test stimulation (during the rental or other therapeutic period) that shows improvement as measured by a demonstrated increase in range of motion
- Improved ability to complete activities of daily living or perform activities outside the home

The purchase of a TENS device is limited to once every 5 years.

27.2.7 Pelvic Floor Stimulation

Prior authorization is not required for the purchase of a pelvic floor stimulator (procedure code E0740) when the criteria listed below are met:

- Has a diagnosis of stress or urge incontinence (diagnosis codes 6256, 78831, or 78833).
- Has completed a six-month trial of conservative treatment with no significant clinical improvement, such as Kegel exercises, behavior management, bladder training or medication.

Providers may request prior authorization for clients who do not meet the criteria listed above. The provider must submit documentation of medical necessity with the request, which will be reviewed by the DSHS-CSHCN Services Program Medical Director or a designee.

27.2.8 Vagal Nerve Stimulation (VNS)

The implantation, revision, programming, and removal of the VNS device are a benefit of the CSHCN Services Program for clients with medically intractable seizures who are not candidates for surgical intervention. VNS (procedure codes 61885, 61886, 64553, 64568, 64569, and 64570) may be reimbursed only when the diagnosis reflects medically refractory partial-onset seizures.

Prior authorization is required for the implantation and purchase of VNS devices.

VNS is not a benefit in the following cases:

- Treatment of clients with an absent left vagus nerve
- Treatment of clients with depression
- Treatment of clients with a progressively terminal illness or a medical disease that imparts a poor diagnosis

Prior Authorization is not required for procedure codes 64569 and 64570.

Incapacities that are due to intellectual disabilities (ID) or cerebral palsy may confound the assessment of benefits resulting from VNS. When a diagnosis of ID or cerebral palsy exists, the treating physician must document in the medical record how VNS will measurably benefit the client in spite of ID or cerebral palsy.

Providers may request prior authorization for clients without one of the medical conditions listed above. The provider must submit documentation of medical necessity with the request that will be reviewed by the DSHS-CSHCN Services Program Medical Director or designee.

Only one similar device code may be reimbursed per date of service for any provider. The following procedure codes may be reimbursed for the purchase of a VNS device:

Procedure Codes				
E0740	L8681	L8682	L8683	L8684
L8685	L8686	L8687	L8688	L8689

27.2.9 Electronic Analysis for Implantable Neurostimulators

The following procedure codes may be reimbursed for the electronic analysis of the implanted neurostimulator:

Procedure Codes				
95970	95971	95972	95973	95974
95975	95978	95979		

27.2.10 Revision or Removal of Implantable Neurostimulators

The revision or removal of implantable neurostimulators (DCN, ICN, SNS, or VNS) may be reimbursed as a surgery or assistant surgery using the following procedure codes:

Device	Procedure Codes
DCN	61783, 63661, 63662, 63663, 63664, or 63688
ICN	61781, 61782, 61880 or 61888*
SNS	64585 or 64595
VNS	61888*, 64569 or 64570
*Not a benefit for assistant surgery.	

Ambulatory surgical centers may be reimbursed using the procedure codes listed in the table above, except for procedure codes 61781, 61782, and 61783. These procedure codes are not a benefit for ambulatory surgical centers.

Supplies for the implantable devices listed in this policy may be reimbursed for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator implantation within the last 5 years.

Note: *Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number, and purchasing entity of the initial device may be required.*

Supplies for implantable devices as listed in this policy may be considered for reimbursement on appeal with documentation of a prior neurostimulator or neuromuscular stimulator implantation procedure for clients with a history greater than 5 years or for those who did not receive a neurostimulator procedure through CSHCN Services Program.

The revision or removal of a peripheral neurostimulator used in PENS therapy may be reimbursed using procedure code 64595.

27.2.11 Implantable Neurstimulators and Neuromuscular Stimulators

Implantable neurostimulator services may be reimbursed using procedure code 64575. Implantable supply (procedure codes A4290, L8680, and L8696) will be denied if they are not submitted for clients with a purchased device and a claims history within 5 years of related procedure code 64575 by any provider.

One of the following implantable neurostimulator device procedure codes must be billed on the same date of service as related procedure code 64575 by any provider.

Procedure Codes					
L8681	L8682	L8633	L8684	L8685	L8686
L8687	L8688	L8689			

Neurostimulator supplies, including leads and electrodes, may be benefits for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator procedure within the last five years.

Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number, and purchasing entity of the initial device may be required.

27.2.11.1 NMES and TENS Garments

The prior authorization request form for the purchase of the NMES and TENS conductive garments must include supporting documentation that shows:

- The garment has been prescribed by a physician for use in delivering covered NMES and TENS treatment.
- The client has successfully completed a 1-month trial period.
- The conductive garment is necessary for one of the medical indications outlined below:
  - The client cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
  - The client cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
  - The client has a documented medical condition, such as a skin problem, that precludes the application of conventional electrodes, adhesive tapes, and lead wires.

The rental of the NMES and TENS garment is not a benefit during the trial rental period unless the client has a documented skin problem prior to the start of the trial period; and DSHS or its designee is satisfied that the use of such an item is medically necessary for the client.

27.2.11.2 NMES and TENS Supplies

NMES and TENS supplies may be reimbursed with procedure code A4556, A4557, or A4595.

Supplies for purchased devices are limited as follows:

- If additional electrodes are required, procedure code A4556 may be reimbursed at a maximum of 15 per month.
- If additional lead wires are required, procedure code A4557 may be reimbursed at a maximum of two per month.
- Procedure code A4595 is limited to one per month.

The physician or physical therapist providing the services may furnish the equipment necessary for assessment. When the physician or physical therapist advises the client to rent the TENS from a supplier during the trial period rather than supplying it, program payment may be made for the rental of the TENS as well as for the services of the physician or physical therapist who is evaluating its use. However, the combined program payment made for the physician's or physical therapist's

services and rental of the stimulator from a supplier should not exceed the amount which would be a benefit for the total service, including the stimulator, furnished by the physician or physical therapist alone.

27.3 Claims Information

To avoid claim denials, providers billing as a group must use the performing provider identifier number on their claims.

Neurostimulator devices and 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.

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.

All claims and authorization requests submitted by CSHCN Services Program home health durable medical equipment (DME) providers must be submitted with benefit code DM3.

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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

27.4 Reimbursement

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

Inpatient hospitals may be reimbursed at 80 percent of the All Patient Refined Diagnosis Related Groups (APR-DRG) payment for all CSHCN serivces.

Outpatient hospital services are reimbursed at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

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

Advanced practice registered nurses (APRNs) and physician assistants (PAs) may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service performed by a physician.

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.*

27.5 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.

Chapter

28

Orthotic and Prosthetic Devices

28.1 Enrollment

To enroll in the CSHCN Services Program, an orthotics and prosthetics provider must be actively enrolled in Texas Medicaid as a durable medical equipment (DME) provider or as a licensed prosthetist and/or orthotist, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process by enrolling as an individual or as a group of performing providers, and comply with all applicable state laws and requirements. The CSHCN Services Program does not enroll orthotists and prosthetists as facilities. Out-of-state orthotics and prosthetics providers must meet all of these conditions, and be located in the United States, within 50 miles of the Texas state border, and approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

28.2 Benefits, Limitations, and Authorization Requirements

Orthoses, prostheses, and prescription shoes may be a benefit of the CSHCN Services Program. These benefits are solely for external orthoses and prostheses. Items must be prescribed by a licensed physician or podiatrist (for conditions below the ankle) and fitted by an orthotist or prosthetist enrolled in the CSHCN Services Program, even if the device is supplied by another enrolled provider type. Noncustom commercial products may be supplied through a physician's office. Licensed occupational therapists may provide upper extremity splints and inhibitive casting, and licensed physical therapists may provide lower extremity inhibitive casts.

Training in the use of an orthotic or prosthetic device for a client who has not worn one previously, has not worn one for a prolonged time period, or is receiving a different type may be reimbursed when provided by a licensed PT or OT. Therapy for the purpose of training a client in the use of an orthotic or prosthetic device will be approved for up to five times a week for 1 month; then three times a week for 2 months. Additional request forms require documentation of medical necessity.

28.2.1 General Authorization Requirements

All orthoses and prostheses procedures addressed in this chapter require prior authorization. Requests for prior authorization must be in writing on a completed CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form with all procedure codes included. Documentation that supports the medical necessity of the requested item must be included with the prior authorization request.

Modifications of orthotic and prosthetic systems, due to growth or a change in medical status, may be prior authorized. Repairs required due to normal wear may be prior authorized. Additional information may be requested to determine if repairs and modifications are cost-effective.

28.2.2 Orthoses and Prostheses (Not All-Inclusive)

The following listed conditions are a guide. Additional documentation of medical necessity must be provided if orthoses, prostheses (artificial limbs), or other orthopedic devices are requested for an unlisted condition:

Orthoses	Applicable Condition
Helmet	Neoplasms of the brain, subarachnoid hemorrhage, subdural hemorrhage, hemophilia, epilepsy, cerebral palsy
Spinal orthosis, collar, corset, body jacket (thoracic-lumbar-sacral orthoses [TLSO], lumbar-sacral orthoses [LSO], cervical thoracic-lumbar-sacral orthoses [CTLSO])	Scoliosis, spinal injuries, paraplegia, kyphosis, neurofibromatosis, cerebral palsy, spina bifida, spinal tumor
Hip orthosis (HO), Pavlik harness, Ilfled, Craig	Dislocated hip, cerebral palsy, spina bifida, congenital deformities of hip
Thoracic-hip-knee-ankle orthosis (THKAO), parapodium (standing frame), swivel walker	Spina bifida, spinal injuries, spinal tumor, cerebral palsy, paraplegia
Hip-knee-ankle-foot orthosis (HKAFO), knee-ankle-foot orthosis (KAFO) (also known as a long leg brace), knee orthosis (KO), knee immobilizer	Spina bifida, cerebral palsy, paraplegia, late effects of CVA, spinal cord lesions, arthrogryposis, club foot, varus deformities of feet, genu varus and genu valgus if due to growth deformity, arthropathy associated with hematological disorders related to lower extremity conditions
Ankle foot orthosis (AFO)	Foot anomalies, cerebral palsy, hemiplegia, spina bifida, club foot, arthrogryposis, arthropathy associated with extremity conditions
Inhibitive casting	Cerebral palsy, increased muscle tone related to central nervous system lesions/disorders
Foot orthosis, Dennis Brown splint, counter-rotation system	Foot anomalies, tibial torsion, club foot, varus deformities of feet, cerebral palsy, spina bifida arthrogryposis, arthritic conditions (medical justification needed for valgus deformities of the feet)
Upper extremity orthosis, shoulder orthosis (SO), elbow orthosis (EO), wrist-hand-finger orthosis (WHFO), mobile arm support (MAS: shoulder-elbow-wrist-hand orthoses [SEWHO])	Cerebral palsy, spinal cord injury, brachial plexus lesions, nerve lesions, paralysis, juvenile rheumatoid arthritis, reduction of deformities
Static or Dynamic Mechanical Stretching Device	Cerebral palsy, increased muscle tone related to central nervous system lesions/disorders
University of California–Berkeley (UCB) shoe	Valgus deformity and significant congenital pes planus with pain, a structural problem that results in significant pes planus, acute plantar fasciitis, or a diagnosis of hemophilia
Reciprocating gait orthosis (RGO)	Spina bifida or similar functional disabilities
Partial foot, ankle, below knee, above knee, hip disarticulation, hemipelvectomy, immediate postsurgical	Congenital absence, surgical revision, or traumatic amputation of lower extremity or hip

Orthoses	Applicable Condition
Partial hand, wrist disarticulation, below elbow, above elbow, elbow disarticulation	Congenital absence, surgical revision, or traumatic amputation of upper extremity or shoulder
Myoelectric prostheses (powered limbs)	Congenital absence of limb, traumatic amputation limb, bilateral shoulder disarticulation

28.2.2.1 Repairs, Replacements, and Modifications to Orthoses and Prostheses

Repairs, replacements, and modifications to orthoses and prostheses are a benefit of the CSHCN Services Program when medically necessary criteria are met.

Repairs due to normal wear and modifications due to growth or change in medical status will be considered for prior authorization when the repair or modification is more cost-effective than the replacement of the device.

- Additional information from the provider may be requested to determine cost-effectiveness.
- Documentation supporting medical necessity must be provided when requesting prior authorization.

Replacement of orthotic or prosthetic devices will be considered for prior authorization with medical justification.

- Orthotic devices are anticipated to last a minimum of 6 months from the receipt of the initial system.
- Prosthetic devices are anticipated to last a minimum of one year from the receipt of the initial definitive/permanent system.
- Preparatory or temporary prostheses may be replaced in less than 12 months of their receipt, but they will undergo medical review if the permanent prosthesis is requested less than 6 months after provision of the preparatory or temporary prosthesis.
- Replacement of an orthosis or prosthesis will be considered when loss or irreparable damage has occurred due to a traumatic event such as a vehicle accident, a residential fire, or theft. A copy of the police or fire report is required when appropriate, along with the measures to be taken to prevent a repeat of similar loss.

Socket replacements will be considered for prior authorization with documentation of functional or physiological need, including, but not limited to, changes in the residual limb, functional need changes, or irreparable damage or wear due to excessive weight or prosthetic demands of very active amputees.

28.2.2.2 Mechanical Stretching Devices

Mechanical stretching devices are a benefit of the CSHCN Services Program. Mechanical stretching devices are not motorized and may be prefabricated or custom fabricated. The following are Classifications of Stretching Devices:

- Dynamic low-load prolonged-duration stretch (LLPS) devices
- Static progressive stretch (SPS) device
- Patient-actuated serial stretch (PASS) device

28.2.2.3 Orthoses and Prostheses Training

Training in the use of an orthosis or prosthesis for a client who has not worn one previously, has not worn one for a prolonged time period, or is receiving a different type is a benefit when the training is provided by a licensed physical or occupational therapist.

Therapy for the purpose of training a client in the use of an orthosis or prosthesis may be approved for up to 5 times per week for 1 month; then 3 times per week for 2 months. Additional requests will require medical review.

RGO and dynamic splints require medical review at the onset of training therapy.

28.3 Orthoses and Related Services

All requests for prior authorization must include documentation of medical necessity including documentation that the client meets one of the following general indications for the requested device:

- Reducing pain by restricting mobility of the affected body part
- Facilitating healing following injury or surgery to the affected body part
- Supporting weak muscles or a deformity of the affected body part

The provider must maintain written documentation in the client's medical record including the prescription for the device and accurate diagnostic information supporting the medical necessity for the requested device.

28.3.1 Prior Authorization and Documentation Requirements

Prior authorization is required for all orthoses and related services. All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the client meets all of the following general indications for the requested device.

Orthoses will be considered for prior authorization with documentation that the device is needed for one of the following indications:

- To reduce pain by restricting mobility of the affected body part.
- To facilitate healing following an injury to the affected body part or related soft tissue.
- To facilitate healing following a surgical procedure on the affected body part or related soft tissue.
- To support weak muscles and/or a deformity of the affected body part.

The provider must maintain the following written documentation in the client's medical record:

- The prescription for the device.
- Orthotic and devices must be prescribed by a physician (M.D., D.O.) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot.
- Accurate diagnostic information supporting the medical necessity for the requested device.
- The prior authorization is valid for a maximum period of six months from the prescription signature date. At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.
- Other orthopedic devices will be considered for prior authorization with documentation of medical necessity as outlined for the specific orthotic device.

28.3.2 Orthotic and Orthopedic Devices Procedure Codes

The following orthoses procedure codes may be reimbursed in the home setting to an orthotist, prosthetist, medical supplier (DME), and custom DME provider:

Orthoses Procedure Codes				
Protective Helmets				
A8000	A8001	A8002	A8003	A8004
Static and Dynamic Devices (Purchased and Rental)				
E1800	E1801	E1802	E1805	E1806
E1810	E1811	E1812	E1815	E1816
E1818	E1820 (purchase only)	E1821 (purchase only)	E1825	E1830

Orthoses Procedure Codes				
E1840	E1841			
Cervical Orthoses				
L0112	L0120	L0130	L0140	L0150
L0160	L0170	L0172	L0174	L0180
L0190	L0200			
Thoracic Rib Belts				
L0220				
Thoracic–Lumbar–Sacral Orthoses				
L0450	L0452	L0454	L0455	L0456
L0457	L0458	L0460	L0462	L0464
L0466	L0467	L0468	L0469	L0470
L0472	L0480	L0482	L0484	L0486
L0488	L0490	L0491	L0492	
Sacroiliac Orthoses				
L0621	L0622	L0623	L0624	
Lumbar Orthoses				
L0625	L0626	L0627		
Lumbar–Sacral Orthoses				
L0628	L0629	L0630	L0631	L0632
L0633	L0634	L0635	L0636	L0637
L0638	L0639	L0640	L0641	L0642
L0643	L0648	L0649	L0650	L0651
Cervical–Thoracic–Lumbar–Sacral Orthoses				
L0700	L0710			
Halo Procedures				
L0810	L0820	L0830	L0859	L0861
Spinal Corset Orthoses				
L0970	L0972	L0974	L0976	
Miscellaneous Devices				
L0978	L0980	L0982	L0984	L0999
Spinal Orthosis–Milwaukee Brace				
L1000				
CTLSO- Infant Size Immobilizer				
L1001				
Spinal Orthoses for Scoliosis				
L1005	L1010	L1020	L1025	L1030
L1040	L1050	L1060	L1070	L1080
L1085	L1090	L1100	L1110	L1120
Thoracic–Lumbar–Sacral Orthoses–Initial and Additions				
L1200	L1210	L1220	L1230	L1240
L1250	L1260	L1270	L1280	L1290

Orthoses Procedure Codes				
Other Spinal Orthoses				
L1300	L1310	L1499		
Hip Orthoses				
L1600	L1610	L1620	L1630	L1640
L1650	L1652	L1660	L1680	L1685
L1686	L1690	L1700		
Legg Perthes Orthoses				
L1710	L1720	L1730	L1755	
Knee Orthoses				
K0901	K0902	L1810	L1812	L1820
L1830	L1831	L1832	L1833	L1834
L1836	L1840	L1843	L1844	L1845
L1846	L1847	L1848	L1850	L1860
Ankle-Foot Orthoses/Ankle Orthoses				
L1900	L1902	L1904	L1906	L1907
L1910	L1920	L1930	L1932	L1940
L1945	L1950	L1951	L1960	L1970
L1971	L1980	L1990		
Knee-Ankle-Foot Orthoses				
L2000	L2005	L2010	L2020	L2030
L2034	L2035	L2036	L2037	L2038
Hip-Knee-Ankle-Foot Orthoses				
L2040	L2050	L2060	L2070	L2080
L2090				
Fracture Orthoses–Lower Limb				
L2106	L2108	L2112	L2114	L2116
L2126	L2128	L2132	L2134	L2136
Additions to Lower–Limb Orthoses				
L2180	L2182	L2184	L2186	L2188
L2190	L2192	L2200	L2210	L2220
L2230	L2232	L2240	L2250	L2260
L2265	L2270	L2275	L2280	L2300
L2310	L2320	L2330	L2335	L2340
L2350	L2360	L2370	L2375	L2380
L2385	L2387	L2390	L2395	L2397
L2405	L2415	L2425	L2430	L2492
L2500	L2510	L2520	L2525	L2526
L2530	L2540	L2550	L2570	L2580
L2600	L2610	L2620	L2622	L2624
L2627	L2628	L2630	L2640	L2650
L2660	L2670	L2680	L2750	L2755

Orthoses Procedure Codes				
L2760	L2768	L2770	L2780	L2785
L2795	L2800	L2810	L2820	L2830
L2840	L2850	L2861		
Miscellaneous Lower–Limb Orthosis				
L2999				
Foot Orthoses/Inserts and Arch Supports				
L3000	L3001	L3002	L3003	L3010
L3020	L3030	L3031	L3040	L3050
L3060	L3070	L3080	L3090	L3100
L3140	L3150	L3160	L3170	
Orthopedic Shoes and Surgical Boots				
L3201	L3202	L3203	L3204	L3206
L3207	L3208	L3209	L3211	L3212
L3213	L3214	L3215	L3216	L3217
L3219	L3221	L3222	L3224	L3225
L3230	L3250	L3251	L3252	L3253
L3254	L3255	L3257	L3260	L3265
Heel Lifts and Wedges				
L3300	L3310	L3320	L3330	L3332
L3334	L3340	L3350	L3360	L3370
L3380	L3390	L3400	L3410	L3420
L3430	L3440	L3450	L3455	L3460
L3465	L3470	L3480	L3485	
Additions to Orthopedic Shoes				
L3500	L3510	L3520	L3530	L3540
L3550	L3560	L3570	L3580	L3590
L3595				
Transfer of Orthosis				
L3600	L3610	L3620	L3630	L3640
L3649				
Shoulder Orthoses				
L3650	L3660	L3670	L3671	L3674
L3675	L3677	L3678		
Elbow/Elbow–Wrist–Hand/Elbow–Wrist–Hand–Finger Orthoses				
L3702	L3710	L3720	L3730	L3740
L3760	L3762	L3763	L3764	L3765
L3766				
Wrist–Hand/Wrist–Hand–Finger/Hand–Finger Orthoses				
L3806	L3807	L3808	L3809	L3891
L3900	L3901	L3904	L3905	L3906
L3908	L3912	L3913	L3915	L3916

Orthoses Procedure Codes				
L3917	L3918	L3919	L3921	L3923
L3924	L3925	L3927	L3929	L3930
L3931	L3933	L3935		
Additions to Upper–Limb Joint				
L3956				
Shoulder–Elbow/Shoulder–Elbow–Wrist–Hand Orthoses				
L3960	L3961	L3962	L3967	L3971
L3973	L3975	L3976	L3977	L3978
Fracture Orthoses–Upper Limb				
L3980	L3981	L3982	L3984	L3995
Miscellaneous Upper–Limb Orthosis				
L3999				
Orthoses Replacement Procedures				
L4000	L4002	L4010	L4020	L4030
L4040	L4045	L4050	L4055	L4060
L4070	L4080	L4090	L4100	L4110
L4130				
Repair of Orthoses				
L4205	L4210			
Walking Boots, Foot Drop Splints, and Static Ankle–Foot Orthoses				
L4350	L4360	L4361	L4370	L4386
L4387	L4392	L4394	L4396	L4397
L4398	L4631			

28.3.3 Noncovered Orthotic and Prosthetic Services

The following services are not a benefit of the CSHCN Services Program:

- Replacement or repair of an orthotic or prosthetic device due to confirmed misuse or abuse by the client, the client's family, or the vendor
- Orthoses primarily used for athletic or recreational purposes

28.3.4 Spinal Orthoses

Spinal orthoses include, but are not limited to, cervical orthoses, thoracic rib belts, thoracic-lumbar-sacral orthoses (TLSO), sacroiliac orthoses, lumbar orthoses, lumbar-sacral orthoses (LSO), cervical- thoracic-lumbar-sacral orthoses (CTLSO), halo procedures, spinal corset orthoses, and spinal orthoses for scoliosis.

Spinal orthoses will be considered for prior authorization with documentation of one of the general indications in Section 28.3.1, "Prior Authorization and Documentation Requirements," on page 28-5.

28.3.5 Thoracic-Hip-Knee-Ankle (THKA) Orthoses

THKA orthoses will be considered for prior authorization with documentation of one of the general indications outlined in Section 28.3.1, "Prior Authorization and Documentation Requirements," on page 28-5.

28.3.6 Lower-Limb Orthoses

Lower-limb orthoses include, but are not limited to, hip orthoses (HO), Legg Perthes orthoses, knee orthoses (KO), ankle-foot orthoses (AFO), knee-ankle-foot orthoses (KAFO), hip-knee-ankle-foot orthoses (HKAFO), fracture orthoses, and reciprocating gait orthoses (RGO).

In addition to the general indication requirements, lower-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices.

28.3.6.1 Ankle-Foot Orthoses (AFO)

AFOs used during ambulation will be considered for prior authorization for clients with documentation of all of the following:

- Weakness or deformity of the foot and ankle
- A need for stabilization for medical reasons
- Anticipated improvement in functioning during activities of daily living (ADLs) with use of the device

AFOs not used during ambulation (static AFO) will be considered for prior authorization for clients with documentation of one of the following conditions:

- Plantar fasciitis
- Plantar flexion contracture of the ankle, with additional documentation that includes all of the following:
  - Dorsiflexion on pretreatment passive range of motion testing is at least ten degrees.
  - The contracture is interfering or is expected to interfere significantly with the client's functioning during ADLs.
  - The AFO will be used as a component of a physician-prescribed therapy plan care, which includes active stretching of the involved muscles or tendons.
  - There is reasonable expectation that the AFO will correct the contracture.

28.3.6.2 Reciprocating Gait Orthoses (RGO)

Reciprocating gait orthoses will be considered for prior authorization for clients with spina bifida or similar functional disabilities.

The prior authorization request must include a statement from the prescribing physician that indicates medical necessity for the RGO, the physical therapy treatment plan, and documentation that the client or family is willing to comply with the treatment plan.

28.3.7 Foot Orthoses

Foot orthoses include, but are not limited to, foot inserts, orthopedic shoes, wedges, and lifts.

Foot orthoses will be considered for prior authorization for clients with documentation of all the following:

- The client has symptoms associated with the particular foot condition.
- The client has failed to respond to a course of appropriate, conservative treatment, including physical therapy, injections, strapping, or anti-inflammatory medications.
- The client has at least one of the following:
  - Torsional conditions, such as metatarsus adductus, tibial torsion, or femoral torsion
  - Structural deformities
  - Hallux valgus deformities
  - In-toe or out-toe gait
  - Musculoskeletal weakness

In addition to the general indication requirements, foot orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices.

28.3.7.1 Foot Inserts

Removable foot inserts will be considered for prior authorization for clients with documentation of at least one of the following medical conditions:

- Diabetes mellitus
- History of amputation of the opposite foot or part of either foot
- History of foot ulceration or pre-ulcerative calluses of either foot
- Peripheral neuropathy with evidence of callus formation of either foot
- Deformity of either foot
- Poor circulation of either foot

The CSHCN Services Program may authorize removable foot inserts independently of orthopedic shoes with documentation that the client has appropriate footwear into which the insert can be placed.

A University of California–Berkeley (UCB) removable foot insert will be considered for prior authorization with documentation that the device is required to correct or treat at least one of the following conditions:

- A valgus deformity and significant congenital pes planus (diagnosis code 75461), which is symptomatic for pain
- A structural problem which results in significant pes planus
- Acute plantar fasciitis
- A diagnosis of hemophilia

Authorization requests for removable shoe insert must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

Refer to: Section 4.2, "Authorizations," on page 4-3 for detailed information about authorization requirements.

28.3.7.2 Prescription Shoes

Prescription shoes (corrective or orthopedic shoes) must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist. An orthopedic shoe is used by clients whose feet, although impaired, are essentially intact. An orthopedic shoe differs from a prosthetic shoe, which is used by clients who are missing all or most of the forefoot.

Orthopedic shoes will be considered for prior authorization when at least one of the following criteria is met:

- The shoe is permanently attached to a brace.
- The shoe is custom modified by an orthotist or prosthetist/orthotist at the direction of the prescribing physician.
- The shoe is necessary to hold a surgical correction, postoperative casting, or serial or clubfoot.
- Casting (does not have to be attached to a brace). A prescription shoe may be prior authorized up to one year from the date of the surgical procedure.
- Documented by a physician as to specific medical rationale. Lifts for unequal leg length greater than one-half inch will be covered with documentation of medical need; the prescription shoe itself and the lift may be reimbursable.

Only one pair of prescription shoes will be prior authorized every three months. Two pairs of shoes may be purchased at the same time; in such situations, however, additional requests for shoes will not be considered for coverage for another six months.

If the primary diagnosis is valgus deformities of the feet, medical justification is required.

28.3.7.3 Noncovered Shoes or Shoe Inserts

The following are not considered a prescription shoe:

- A tennis shoe, even if prescribed by a physician and worn with a removable brace.
- A shoe insert when it is not a part of a modified shoe or when the shoe in which it is inserted is not attached to a brace (other than University of California–Berkeley-type, Healthcare Common Procedure Coding System [HCPCS] procedure code L3000).

28.3.7.4 Wedges and Lifts

Wedges and lifts must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist and must be for treatment of unequal leg length greater than one-half inch.

Prior authorization is required with justification of medical necessity for wedges and lifts.

28.3.8 Upper-Limb Orthoses

Upper-limb orthoses include, but are not limited to, shoulder orthoses (SO), elbow orthoses (EO), elbow-wrist-hand orthoses (EWHO), elbow-wrist-hand-finger orthoses (EWHFO), wrist-hand-finger orthoses (WHFO), wrist-hand orthoses (WHO), hand-finger orthoses (HFO), finger orthoses (FO), shoulder-elbow-wrist-hand orthoses (SEWHO), shoulder-elbow orthoses (SEO), and fracture orthoses.

In addition to the general indication requirements, upper-limb orthoses will be considered for prior authorization with documentation of one of the general indications outlined in Section 28.3.1, "Prior Authorization and Documentation Requirements," on page 28-5.

28.3.9 Other Orthopedic Devices

28.3.9.1 Protective Helmets

Protective helmets used for conditions such as neoplasm of the brain, subarachnoid subdural hemorrhage, epilepsy, or cerebral palsy may be reimbursed by the CSHCN Services Program with prior authorization using the following procedure codes:

Procedure Codes				
A8000	A8001	A8002	A8003	A8004

Protective helmets will be considered for prior authorization for clients with a documented medical condition that makes the client susceptible to injury during ADLs. Covered medical conditions include the following:

- Neoplasm of the brain
- Subarachnoid hemorrhage
- Epilepsy
- Cerebral palsy

Requests for all conditions other than those listed above require submission of additional documentation that supports the medical necessity of the requested device.

28.3.9.2 Cranial Molding Orthosis

The CSHCN Services Program may cover cranial molding orthosis (procedure code S1040) for positional plagiocephaly with documentation supporting the use of the cranial molding orthosis to modify or prevent an associated functional impairment. Cranial molding orthosis may only be approved for children who are 3 through 18 months of age.

The CSHCN Services Program may cover cranial molding orthosis for use after surgery for cranial deformities, including craniosynostosis.

Studies indicate repositioning and physical therapy can be effective treatment for positional plagiocephaly. If detected early, repositioning combined with prone positioning while awake can correct the condition in the majority of children. For infants with a diagnosis of positional plagiocephaly who do not meet the criteria described in this chapter, the use of a cranial molding orthosis is considered cosmetic and, therefore, not medically necessary.

The effective use of cranial molding orthosis for the treatment of brachycephaly or a high cephalic index without cranial asymmetry has not been clearly documented, is not medically necessary, and, therefore, is not a benefit of the CSHCN Services Program.

Definitions of Plagiocephaly

Plagiocephaly is defined as an asymmetric skull deformity that is generally characterized by occipital flattening giving the head an oblique configuration.

Synostotic plagiocephaly occurs when there is a premature union of cranial sutures (coronal or lamboid). This pathological condition generally requires surgical intervention, with or without postoperative use of a cranial orthosis.

Positional plagiocephaly results from external pressure (molding) that causes the cranium, in which the premature union of the cranial sutures (coronal or lamboid) has not occurred, to become asymmetrical.

Authorization Requirements

Prior authorization is required for cranial molding orthosis which will be reviewed by the CSHCN medical director or designee.

Cranial molding orthosis may be considered for prior authorization when they are part of a treatment plan for shaping the skull in cases of post-operative synostotic plagiocephaly or positional plagiocephaly with an associated functional impairment. Documentation that the use of the cranial molding orthosis will modify or prevent the development of such impairment is required.

Documentation supporting medical necessity must include all of the following:

- Plan of treatment and/or follow up schedule
- The assessment and recommendations of the appropriate primary care physician, pediatric subspecialist, craniofacial team, or pediatric neurosurgeon
- A full description of the physical findings, precise diagnosis, age of onset and the etiology of the deformity
- Reports of any radiological procedures used in making the diagnosis
- Client is at least 3 months of age, but not greater than 18 months of age
- Anthropometric measurements documenting greater than 10 mm of cranial asymmetry

The written documentation of medical necessity must also include that aggressive repositioning interventions was attempted, with or without physical therapy, of at least three months' duration without improvement in cranial asymmetry. The attempted aggressive repositioning interventions may include, but is not limited to:

- Repositioning the client's head to the opposite side of the preferred position when the infant is either lying down, reclined, or sitting.
- Gently turning and stretching the client's neck at each diaper change.
- Repositioning the client's bed, thus encouraging the infant to look away from the flattened side to view other objects of interest.
- The trial of repositioning intervention has failed to improve the deformity and is judged to be unlikely to do so.

Repositioning may not be indicated for children who are over 6 months of age. Repositioning therapy for this age group may be waived with documentation of medical necessity.

Requests for clients with a comorbid diagnosis that prohibits repositioning will be evaluated on an individual basis.

Prior authorization requests for subsequent cranial molding orthosis must include documentation of medical necessity including new measurements.

Muscular torticollis (wry neck) characterized by tight or shortened neck muscles that result in a head tilt or turn, is often associated with the secondary development of positional plagiocephaly. Therefore, clients with muscular torticollis and positional plagiocephaly must have documentation of early, aggressive treatment (stretching, positioning and/or physiotherapy) prior to consideration of prior authorization for cranial orthosis.

28.3.9.3 Static and Dynamic Mechanical Stretching Devices

Static and dynamic mechanical stretching devices will be considered for prior authorization for a 3-month trial period when the request is submitted with the following documentation supporting medical necessity:

- Client's condition
- Client's current course of therapy
- Rationale for the use of the static or dynamic mechanical stretching device
- Agreement by the client or family that the client will comply with the prescribed use of the static or dynamic mechanical stretching device

Requests for purchase of the device must include documentation of successful completion of the 3-month trial period, with improvement in the client's condition as measured by one of the following:

- Demonstrated increase in range of motion
- Demonstrated improvement in the ability to complete ADLs or perform activities outside the home

Note: *If the cost of the rental is expected to exceed the purchase price, purchase of the device should be considered.*

Authorization requests for static or dynamic mechanical stretching devices must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

Refer to: Section 4.2, "Authorizations," on page 4-3 for detailed information about authorization requirements.

28.4 Prostheses and Related Services

28.4.1 Prior Authorization and Documentation Requirements

Prior authorization is required for all prostheses and related services. All requests for prior authorization must include a valid prescription for the prosthetic device that is prescribed by a physician (M.D., D.O.).

Note: *The prescription must be maintained in the client's medical record, and is valid for a maximum period of 6 months. At the end of the 6-month prescription period, additional prior authorization is required for any repairs, replacements, or related services.*

Documentation of medical necessity must include, but is not limited to, documentation that the client meets the following general indications for the device:

- The prosthesis replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the limb.
- The prosthesis is required for activities of daily living and/or for rehabilitation purposes.

The provider must maintain the following documentation in the client's medical record:

- The prescription for the requested prosthetic device
- Written documentation of a rehabilitation program prescribed by the treating physician, including expected goals with the use of the prosthesis
- Written documentation that the client or client's family/caregiver is willing to comply with the rehabilitation program

28.4.2 Prostheses Procedure Codes

The following prostheses procedure codes may be reimbursed in the home setting to an orthotist, prosthetist, medical supplier (DME), and custom DME provider:

Prostheses Procedure Codes				
Partial Foot, Ankle, and Knee Disarticulation Sockets				
L5000	L5010	L5020	L5050	L5060
L5100	L5105	L5150	L5160	
Above-Knee Short Prostheses				
L5200	L5210	L5220	L5230	
Hip and Knee Disarticulation Prostheses				
L5250	L5270	L5280	L5301	L5312
L5321	L5331	L5341		
Postsurgical Prostheses				
L5400	L5410	L5420	L5430	L5450
L5460	L5500	L5505		
Preparatory Prostheses				
L5510	L5520	L5530	L5535	L5540
L5560	L5570	L5580	L5585	L5590
L5595	L5600			
Additions to Lower-Limb Prostheses				
L5610*	L5611*	L5613*	L5614*	L5616*
L5617	L5618	L5620	L5622	L5624
L5626	L5628	L5629	L5630	L5631
L5632	L5634	L5636	L5637	L5638
L5639	L5640	L5642	L5643	L5644
L5645	L5646	L5647	L5648	L5649
L5650	L5651	L5652	L5653	L5654
L5655	L5656	L5658	L5661	L5665
L5666	L5668	L5670	L5671	L5672
L5673	L5676	L5677	L5678	L5679
L5680	L5681	L5682	L5683	L5684
L5685	L5686	L5688	L5690	L5692
L5694	L5695	L5696	L5697	L5698
L5699				
Replacement Sockets				
L5700	L5701	L5702	L5703	
Protective Covers				
L5704	L5705	L5706	L5707	
Additions to Lower-Limb Prosthesis-Exoskeletal and Endoskeletal				
L5710*	L5711*	L5712*	L5714*	L5716*
L5718*	L5722*	L5724*	L5726*	L5728*
L5780*	L5781	L5785	L5790	L5795
* Must be billed with the functional modifiers in Section 28.4.5, "Lower-Limb Prostheses," on page 28-18.				

Prostheses Procedure Codes				
L5810*	L5811*	L5812*	L5814*	L5816
L5818*	L5822*	L5824*	L5826*	L5828*
L5830*	L5840*	L5845	L5848*	L5850
L5855	L5856*	L5857*	L5858	L5859*
L5910	L5920	L5925	L5930*	L5940
L5950	L5960	L5961*	L5962	L5964
L5966	L5968			
All Lower-Limb Prostheses				
L5970*	L5971*	L5972*	L5973*	L5974*
L5975*	L5976*	L5978*	L5979*	L5980*
L5981*	L5982*	L5984	L5985	L5986
L5987*				
Additions to Lower-Limb Prostheses				
L5988	L5990	L5999		
Partial Hand, Wrist, and Elbow Disarticulation Prostheses				
L6000	L6010	L6020	L6026	L6050
L6055	L6100	L6110	L6120	L6130
L6200	L6205	L6250		
Shoulder Disarticulation and Interscapular Thoracic Prostheses				
L6300	L6310	L6320	L6350	L6360
L6370				
Immediate Postsurgical Wrist, Elbow, or Shoulder Disarticulation Prostheses				
L6380	L6382	L6384	L6386	L6388
Endoskeletal Elbow, Shoulder, and Interscapular Thoracic Prostheses				
L6400	L6450	L6500	L6550	L6570
Preparatory Wrist, Elbow, and Shoulder Disarticulation Prostheses				
L6580	L6582	L6584	L6586	L6588
L6590				
Additions to Upper-Limb Prostheses				
L6600	L6605	L6610	L6611	L6615
L6616	L6620	L6621	L6623	L6624
L6625	L6628	L6629	L6630	L6632
L6635	L6637	L6638	L6640	L6641
L6642	L6645	L6646	L6647	L6648
L6650	L6655	L6660	L6665	L6670
L6672	L6675	L6676	L6677	L6680
L6682	L6684	L6686	L6687	L6688
L6689	L6690	L6691	L6692	L6693
L6694	L6695	L6696	L6697	L6698

* Must be billed with the functional modifiers in Section 28.4.5, "Lower-Limb Prostheses," on page 28-18.

Prostheses Procedure Codes				
Terminal Devices				
L6703	L6704	L6706	L6707	L6708
L6709	L6711	L6712	L6713	L6714
L6715	L6721	L6722	L6805	L6810
L6880	L6881	L6882		
Replacement Sockets				
L6883	L6884	L6885		
Additions – Glove for Terminal Devices				
L6890	L6895			
Hand Restoration				
L6900	L6905	L6910	L6915	
Wrist, Elbow, and Shoulder Inner Sockets – Externally Powered				
L6920	L6925	L6930	L6935	L6940
L6945	L6950	L6955	L6960	L6965
L6970	L6975			
Electronic Hand, Elbow and Wrist Prosthetic Device				
L7007	L7008	L7009	L7040	L7045
L7170	L7180	L7181	L7185	L7186
L7190	L7191	L7259		
Additions to Upper-Limb Prostheses				
L7400	L7401	L7402	L7403	L7404
L7405				
Miscellaneous Upper-Limb Prosthesis				
L7499				
Repair of Prosthetic Device				
L7510	L7520			
Prosthetic Donning Sleeve				
L7600				
Prosthetic Sheath, Shrinker, or Sock				
L8400	L8410	L8415	L8417	L8420
L8430	L8435	L8440	L8460	L8465
L8470	L8480	L8485	L8499	

* Must be billed with the functional modifiers in Section 28.4.5, "Lower-Limb Prostheses," on page 28-18.

28.4.3 Preparatory or Temporary Prostheses

Preparatory or temporary prostheses are a benefit of the CSHCN Services Program.

A preparatory or temporary prosthesis allows for extensive gait training for lower-limb amputees and extensive functional training for upper-limb amputees. A preparatory prosthesis is intended as the final step before the permanent or definitive application. A client with a preparatory prosthesis does not need to be in the hospital, may be involved in chemotherapy or other medical or rehabilitative treatment that affects the size or healing of the residual limb, and may be under-

going changes to the residual limb that would preclude the fitting of the permanent or definitive prosthesis. A preparatory prosthesis is used by the client for varying time periods (4 to 12 months) before the permanent or definitive prosthesis needs to be ordered.

28.4.4 Upper-Limb Prostheses

Upper-limb prostheses will be considered for prior authorization with documentation of all of the indications defined in the Prostheses and Related Services section above. In addition, the following criteria apply for specific prosthetic devices.

28.4.4.1 Myoelectric Prostheses

Myoelectric upper extremity prostheses will be considered for prior authorization for clients with bilateral shoulder disarticulation.

Myoelectric hand prostheses will be considered for prior authorization for clients with traumatic or congenital absence of forearm(s) and hand(s).

28.4.5 Lower-Limb Prostheses

Lower-limb prostheses will be considered for prior authorization with documentation of all of the indications defined in the Section 28.4.1, "Prior Authorization and Documentation Requirements," on page 28-14. In addition, the following documentation is required for all lower-limb prostheses:

- Written documentation of the client's current and potential functional levels. A functional level is defined as a measurement of the capacity and potential of individuals to accomplish their expected post-rehabilitation daily function. The potential functional ability is based on reasonable expectations of the treating physician and the prosthetist, and may include the following:
  - The client's history, including prior use of a prosthesis, if applicable
  - The client's current condition, including the status of the residual limb, and any co-existing medical conditions
  - The client's desire to ambulate

The following functional modifiers and levels have been defined by the Centers for Medicare & Medicaid Services (CMS):

Functional Modifier	Functional Level	Description
K0	Level 0	Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance quality of life or mobility.
K1	Level 1	Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
K2	Level 2	Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.
K3	Level 3	Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
K4	Level 4	Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high-impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

A client whose functional level is zero is not a candidate for a prosthetic device; the device is not considered medically necessary. Advanced knee, ankle, or foot prostheses procedure codes must be submitted with the appropriate functional modifier in the table above.

28.4.5.1 Microprocessor-Controlled Lower-Limb Prostheses

Microprocessor-controlled lower-limb prostheses (e.g., Otto Bock C-Leg, Intelligent Prosthesis, or Ossur Rheo Knee) will be considered for prior authorization for clients who have a transfemoral amputation from a nonvascular cause, such as trauma or tumor, and a functional level of 3 or above.

The licensed prosthetist or orthotist who provides the device must be trained in the fitting and programming of the microprocessor-controlled prosthetic device.

28.4.5.2 Foot Prostheses

The following foot prostheses will be considered for prior authorization for clients whose documented functional level is 1 or above:

- A solid ankle-cushion heel (SACH) foot
- An external keel SACH foot or single axis ankle/foot

A flexible-keel foot or multi-axial ankle/foot will be considered for prior authorization for clients whose documented functional level is 2 or above.

A flex foot system, energy storing foot, multi-axial ankle/foot, dynamic response, or flex-walk system or equivalent will be considered for prior authorization for clients whose documented functional level is 3 or above.

A prosthetic shoe will be considered for prior authorization if it is an integral part of a prosthesis for clients with a partial foot amputation.

28.4.5.3 Knee Prosthesis

A single-axis, constant-friction knee or other basic knee systems will be considered for prior authorization for clients whose documented functional level is 1 or above.

A fluid, pneumatic, or electronic knee prosthesis will be considered for prior authorization for clients whose documented functional level is 3 or above.

A high-activity knee control frame will be considered for prior authorization for clients whose documented functional level is 4.

28.4.5.4 Ankle Prosthesis

An axial rotation unit will be considered for prior authorization for clients whose documented functional level is 2 or above.

28.4.5.5 Sockets

Prior authorization for test (diagnostic) sockets for an individual prosthesis is limited to a quantity of two test sockets.

Prior authorization for same-socket inserts for an individual prosthesis is also limited to a quantity of two.

Requests for test sockets or same-socket inserts beyond these limitations must include documentation of medical necessity that supports the need for the additional sockets.

28.4.5.6 Accessories

Accessories to prostheses, such as stump stockings and harnesses, will be considered for prior authorization when they are essential to the effective use of the artificial limb.

28.5 Repairs, Replacements, and Modifications to Orthoses and Prostheses

Repairs, replacements, and modifications to orthoses and prostheses are a benefit of the CSHCN Services Program when medically necessary criteria are met.

Repairs due to normal wear and modifications due to growth or change in medical status will be considered for prior authorization when the repair or modification is more cost-effective than the replacement of the device.

- Additional information from the provider may be requested to determine cost-effectiveness.
- Documentation supporting medical necessity must be provided when requesting prior authorization.
- Replacement of orthotic or prosthetic devices will be considered for prior authorization with medical justification.
- Orthotic devices are anticipated to last a minimum of 6 months from the receipt of the initial system.
- Prosthetic devices are anticipated to last a minimum of one year from the receipt of the initial definitive/permanent system.
- Preparatory or temporary prostheses may be replaced in less than 12 months of their receipt, but they will undergo medical review if the permanent prosthesis is requested less than 6 months after provision of the preparatory or temporary prosthesis.
- Replacement of an orthosis or prosthesis will be considered when loss or irreparable damage has occurred due to a traumatic event such as a vehicle accident, a residential fire, or theft. A copy of the police or fire report is required when appropriate, along with the measures to be taken to prevent a repeat of similar loss.

Socket replacements will be considered for prior authorization with documentation of functional or physiological need, including, but not limited to, changes in the residual limb, functional need changes, or irreparable damage or wear due to excessive weight or prosthetic demands of very active amputees.

28.5.1 Other Artificial Devices

A **prosthesis** is defined as "a custom-fabricated or fitted medical device that is not surgically implanted and is used to replace a missing limb, appendage, or other external human body part, including an artificial limb, hand, or foot."

The term "prosthesis" does not include an artificial eye, ear, finger, or toe, a dental appliance, a cosmetic device, including an artificial breast, eyelash, or wig, or other device that does not have a significant impact on the musculoskeletal functions of the body.

Refer to: Section 39.2.1.8, "Eye Prostheses," on page 39-9 for information about eye prostheses.

Section 31.2.37.12, "Mastectomy and Related Services," on page 31-117 and Chapter 17, "Durable Medical Equipment (DME)," on page 17-1 for information about breast prostheses.

Chapter 14, "Dental," on page 14-1 for information about dental services.

28.6 CSHCN Services Program Documentation of Receipt

The CSHCN Services Program Documentation of Receipt form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. Providers must retain individual delivery slips or invoices for each DOS that document the date of delivery for all supplies provided to a client and must disclose them to the CSHCN Services Program or its designee upon request.

The documentation of receipt form is available in both English and Spanish.

Documentation of delivery must include one of the following:

- Delivery slip or invoice signed and dated by client/caregiver. The delivery slip or invoice must contain the client's full name and address to which the supplies were delivered, the item description and the numerical quantities that were delivered to the client.
- A dated carrier tracking document with shipping date and delivery date. The dated carrier tracking document must be attached to the delivery slip or invoice. The dated delivery slip or invoice must include an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client. This document could also include prices, shipping weights, shipping charges, and any other description.

28.7 Claims Information

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

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

The HCPCS/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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

28.8 Reimbursement

Orthotics and prosthetics services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

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.*

28.9 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.

Chapter

29

Outpatient Behavioral Health

29.1 Enrollment

To enroll in the CSHCN Services Program, outpatient behavioral health providers are required to 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 outpatient behavioral health providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

The CSHCN Services Program enrolls the following types of providers of outpatient behavioral health services:

- Licensed marriage and family therapist (LMFT)
- Licensed clinical social worker (LCSW, formerly LMSW-ACP)
- Licensed professional counselor (LPC)
- Licensed psychologist or neuropsychologist (PhD)
- Psychiatrist (doctor of medicine [MD] or doctor of osteopathy [DO])

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

29.1.1 Provisionally Licensed Psychologist (PLP)

The Texas State Board of Examiners of Psychologist (TSBEP) requires the provisionally licensed psychologist (PLP) to work under the supervision of a licensed psychologist and does not allow a PLP to engage in independent practice. Therefore, a PLP will not be independently enrolled in the CSHCN Services Program and must provide services under the delegating psychologist's provider identifier.

29.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program does not provide outpatient behavioral health services to clients who are also enrolled in Texas Medicaid, Comprehensive Care Program (CCP), or Children's Health Insurance Program (CHIP).

Outpatient behavioral health services are limited to no more than 30 encounters by all practitioners per client, per calendar year. Benefits include, but are not limited to, psychological and neuropsychological testing, psychotherapy, psychoanalysis, counseling, and narcosynthesis.

Laboratory and radiology services do not count toward the 30 outpatient encounters per client, per calendar year limitation. Pharmacological regimen oversight does not count toward the 30 encounters per client, per calendar year limitation.

Pharmacological regimen oversight refers to a brief, face-to-face office encounter for the sole purpose of evaluating, monitoring, or changing drug prescriptions or making simple drug dosage adjustments. Pharmacological regimen oversight is a lesser level of drug monitoring than pharmacological management which is considered part of an evaluation and management (E/M) visit.

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with potentially significant side effects. Pharmacological management represents a skilled aspect of client care and is intended for use by clients who are being managed primarily by psychotropics, antidepressants, electroconvulsive therapy (ECT), or other types of psychopharmacologic medications that are part of the billable E/M visit.

The focus of a pharmacological management encounter is the use of medication for relief of a client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness, which necessitates a discussion beyond minimal psychotherapy or counseling in a given day, the focus of the service is broader and is considered outpatient psychotherapy or counseling rather than pharmacological management.

Visits for the sole purpose of pharmacological management should be billed as a regular physician visit, not as a behavioral health visit using the appropriate E/M procedure code. Pharmacological management visits should be conducted on the basis of medical necessity.

29.2.1 Authorization Requirements

Authorization is not required for outpatient behavioral health services. The CSHCN Services Program may reimburse a maximum of 30 outpatient behavioral health services encounters by any practitioner per client, per calendar year.

29.2.2 Documentation Requirements

Services not supported by documentation in the client's medical record are subject to recoupment. All entries must be clear and concise, legible to individuals other than the author, and dated (month/date/year) and signed by the performing provider.

Documentation must include all of the following:

- Beginning and ending times for each counseling session or test administered
- Diagnosis
- Support for the medical necessity of the chosen treatment
- All pertinent information about the client's condition that substantiates the need for services, including, but not limited to, the following:
  - Reason for referral or the presenting problem
  - Prior history, including prior treatment
  - Other pertinent medical, social, and family history
  - Clinical observations and mental status examinations
  - The name of each test (e.g., WAIS-R, Rorschach, MMPI) administered
  - The scoring of the test
  - Narrative descriptions of the test findings
  - An explanation to substantiate the necessity of retesting, if testing is repeated
  - Background, symptoms, impression
  - Narrative description of the assessment
  - Behavioral observations during the counseling session
  - Narrative description of the counseling session
  - Treatment plan and recommendations, including expected long-term and short-term benefits

The original testing material must be maintained by the provider and readily available for retrospective review by the Department of State Health Services (DSHS) or its designee.

29.2.3 Pharmacological Management Services Documentation

Documentation for pharmacological management services must include the following:

- Complete diagnosis
- Medication history
- Current symptoms and problems (including the presenting mental status or physical symptoms) that indicate the client requires a medication adjustment
- Problems, reactions, and side effects (if any) to medications or ECT
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any
- Reasons for medication adjustments, changes, or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcomes

29.2.4 Pharmacological Regimen Oversight Documentation

Documentation for pharmacological regimen oversight must address all of the following information in the client's medical record:

- A description of the client's condition, described as one of the following:
  - The client has been evaluated and determined to be stable but continues to have a psychiatric diagnosis that needs close monitoring of therapeutic drug levels.
  - The client requires evaluation for prescription renewal, a new psychiatric medication, or a minor medication dosage adjustment.
- Documentation of the medication history with current signs and symptoms and new medication modifications with anticipated outcomes.

29.2.5 Reimbursement—The 12-Hour System Limitation

The following provider types are limited to a maximum combined total of 12 hours per provider, per day for inpatient or outpatient behavioral health services:

- Physician Assistants (PAs)
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed professional counselor (LPC)

Each hour of testing counts towards the 12 hour limit. Doctors of medicine (MDs) and doctors of osteopathy (DOs) are not subject to the 12-hour system limitation because they can delegate services and, as a result, may submit claims in excess of 12 hours per day.

Doctors of medicine (MDs) and doctors of osteopathy (DOs) are not subject to the 12-hour system limitation because they can delegate services, and, as a result, may submit claims in excess of 12 hours per day. Additionally, because a psychologist can delegate to multiple PLPs and may submit claims for PLP services in excess of 12 hours per day, PLPs are not subject to the 12-hour system limitation. PLPs who perform delegated psychology services under the delegating psychologist's CSHCN provider identifier are subject to retrospective review.

No single behavioral health services provider may be reimbursed for more than 12 hours of behavioral health services per day. As a result, all providers who are not subject to the 12-hour system limitation, and each provider to whom they delegate, are subject to retrospective review and recoupment.

29.2.6 Procedure Codes Included in the 12-Hour System Limitation

The following table lists the outpatient behavioral health procedure codes included in the system limitation. The table also includes the time increments that the system applies based on the billed procedure code. The system uses the "time applied" time increments to determine whether the 12-hour-per-day system limitation has been exceeded.

Procedure Code	Time Assigned by Procedure Code Description	Time Applied
90791	N/A	60 minutes
90792	N/A	60 minutes
90832	30 minutes	30 minutes
90833	30 minutes with an E/M service. (List separately in addition to the code for primary procedure.)	30 minutes
90834	45 minutes	45 minutes
90836	45 minutes with an E/M service. (List separately in addition to the code for primary procedure.)	45 minutes
90837	60 minutes	60 minutes
90838	60 minutes with an E/M service. (List separately in addition to the code for primary procedure.)	60 minutes
90847	N/A	50 minutes
96101	60 minutes	60 minutes
96116	60 minutes	60 minutes
96118	60 minutes	60 minutes
N/A = Not Applicable		

Note: *Procedure code 90853 is not included in the 12-hour system limitation, so it is not shown in the table.*

LCSWs or LPCs may use only the following procedure codes when filing claims: 90832, 90834, 90837, 90847, and 90853.

LMFTs may use only the following procedure codes and modifier U8 when filing claims: 90832, 90834, 90837, 90847, and 90853.

Only psychiatrists, APRNs, and PAs may use the following procedure codes when filing claims:

Procedure Codes				
90792	90833	90836	90838	90865

Psychiatrists and psychologists may use the following procedure codes when filing claims:

Procedure Codes				
90791	90832	90834	90837	90845
90847	90853	96101	96116	96118

PLP services may be reimbursed using procedure code 90791 with modifier U9.

29.2.7 Psychological and Neuropsychological Testing

Neurobehavioral status exams (procedure code 96116), psychological (procedure code 96101) and neuropsychological (procedure code 96118) testing is limited to a total of 4 hours per day and 8 hours per calendar year, per client, for any provider. Claims submitted for an amount greater than 4 hours per day or 8 hours per year must be submitted with documentation of medical necessity. All supporting documentation must be maintained by the provider in the client's medical record.

Interpretation and documentation time, including time to document test results in the client's medical record is not reimbursed separately. Interpretation and documentation time is included in psychological testing (procedure code 96101), neuropsychological testing (procedure code 96118), and neurobehavioral status exams (procedure code 96116).

The number of units on the claim must reflect the time spent face-to-face testing with the client plus the time spent scoring and interpreting the results in one hour increments.

If the performance, interpretation, and reporting of the testing span more than one day, the date of service on the claim must reflect the date and the time spent for each service performed.

- Providers must submit only one claim for each psychological or neuropsychological testing performed, even if the scoring and interpretation cannot be completed on the same date as the testing.
- A claim must not be submitted until testing is complete. Providers can submit one claim with multiple details on separate claims for each date of service.

Providers must bill the units of each half hour of testing and indicate that number of units on the claim form.

Psychological testing (procedure code 96101), neuropsychological testing (procedure code 96118), and neurobehavioral status exams (procedure code 96116) are not reimbursed to an APRN or physician assistant. Behavioral health testing and neurobehavioral status exams may be performed during an assessment by an APRN or physician assistant, but is not reimbursed separately. The most appropriate office encounter code must be used.

Psychological testing (procedure code 96101), neuropsychological testing (procedure code 96118), and neurobehavioral status exams (procedure code 96116) may be reimbursed on the same date of service as a psychiatric diagnostic evaluation (without medical services) (procedure code 90791) or psychiatric diagnostic evaluation (with medical services) (procedure code 90792).

Psychological testing (procedure code 96101) done on the same date of service as neuropsychological testing (procedure code 96118) is denied as part of another service.

Procedure codes 90833, 90836, and 90838 are add on codes and must be billed with a primary E/M code in order to be reimbursed.

29.2.8 Psychotherapy and Counseling

Reimbursement for outpatient psychotherapy or counseling is limited to no more than 4 hours per client, per day.

When more than one type of session (individual, group, or family outpatient psychotherapy or counseling) is provided by any provider on the same date of service, each session type will be reimbursed individually. Services are reimbursed only for clients who are eligible for the CSHCN Services Program.

Family psychotherapy is defined as therapy that focuses on the dynamics of the family unit where the goal is to strengthen the family's problem solving and communication skills. Individual psychotherapy is defined as therapy that focuses on the treatment of an individual which may include more than the client in a session in the effort of the client developing healthy coping skills.

Only the psychologist, LMFT, LCSW, or LPC provider actually performing the behavioral health service may bill the CSHCN Services Program. These providers must not bill for services performed by individuals under their supervision. A psychiatrist may bill for services performed by individuals under their supervision.

Professional services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Hospitals are reimbursed 80 percent of the rate allowed by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which is equivalent to the hospital's Medicaid interim rate.

29.2.8.1 Treatment for Alzheimer's and Dimentia

Treatment for CSHCN Services Program clients with Stage 1, 2, or 3 Alzheimer's disease or dementia may be reimbursed with prior authorization as follows:

Stage 1- No impairment (normal function)

The person does not experience any memory problems. An interview with a medical professional does not show any evidence of symptoms of dementia

Stage 2- Very mild cognitive decline (may be normal age-related changes or earliest signs of Alzheimer's disease)

The person may feel as if he or she is having memory lapses - forgetting familiarwords or the location of everyday objects. But no symptoms of dementia can bedetected during a medical examination or by friends, family or co-workers

Stage 3- Mild cognitive decline (early-stage Alzheimer's can be diagnosed in some, but not all, individuals with these symptoms)

Friends, family or co-workers begin to notice difficulties. During a detailed medical interview, doctors may be able to detect problems in memory or concentration. Common stage 3 difficulties include:

- Noticeable problems coming up with the right word or name
- Trouble remembering names when introduced to new people
- Having noticeably greater difficulty performing tasks in social or work settings.
- Forgetting material that one has just read
- Losing or misplacing a valuable object
- Increasing trouble with planning or organizing

Psychotherapy services must not be continued if no longer beneficial to the client.

The following psychotherapy procedure codes for clients with Alzheimer's disease or dementia may be reimbursed for clients who meet one of the stages listed above and are diagnosed with one of the diagnosis codes listed below:

Procedure Codes					
90832	90833	90834	90836	90837	90838
90847	90853				

Diagnosis Code	Description
29010	Presenile, dementia, uncomplicated
29012	Presenile, dementia with delusional features
29013	Presenile, dementia with depressive features
33183	Mild cognative impairment, so stated
79952	Cognitive communication deficit

Documentation to support the treatment for Alzheimer's disease or dementia must be maintained in the client's medical record and may be subject to retrospective review. Psychotherapy services must not be continued if no longer beneficial to the client.

29.2.9 Pharmacological Regimen Oversight and Pharmacological Management

The pharmacological regimen oversight services describes a physician service and may not be delegated to a non-physician or incident to a physician's service. APRNs or physician assistants, whose scope of license permits them to prescribe medication, may perform the service. The service must only be billed if the physician, APRN, or physician assistant actually performs the service.

29.2.10 Noncovered Services

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

- Services provided by a psychiatric nurse (registered nurse [RN] or licensed vocational nurse [LVN]), mental health worker, or licensed psychological associate (LPA)
- Thermogenic therapy
- Recreational therapy
- Psychiatric day care
- Psychiatric day treatment
- Psychiatric day hospital
- Partial hospitalization
- Neurofeedback including, but not limited to, electroencephalography (EEG) feedback
- Music therapy
- Dance therapy
- Hypnosis
- "Adult activity" or "individual activity" (These services are payable only if guidelines for group therapy are met and termed "group therapy.")
- Services provided to clients residing in residential treatment centers
- Services provided to clients in an acute-care hospital
- Educationally related services provided in a school setting

The CSHCN Services Program does not reimburse procedure codes 90846 and 90849.

29.2.11 National Correct Coding Initiative (NCCI) Guidelines

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.

29.3 Claims Information

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

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

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

29.4 Reimbursement

Outpatient behavioral health services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

APRNs and PAs will be reimbursed the lesser of the billed amount or the amount allowed by Texas Medicaid. Reimbursement for services performed by APRNs is 92 percent of the physician's Texas Medicaid reimbursement for the same service. The reimbursement methodology for these services is contained in the specific policy for each service.

The PLP, LPC, and LMSW providers will be reimbursed the lesser of the billed amount or the amount allowed by Texas Medicaid. Reimbursement for PLP, LPC, and LMSW services is 70 percent of the physician's Texas Medicaid reimbursement for the same service.

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.*

29.5 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.

Chapter

30

Physical Medicine and Rehabilitation

30.1 Enrollment

To enroll in the CSHCN Services Program, physical medicine and rehabilitation 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 laws and requirements. Out-of-state physical medicine and rehabilitation providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and be approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

30.2 Benefits, Limitations, and Authorization Requirements

Physical therapy (PT) and occupational therapy (OT) services are benefits of the CSHCN Services Program for clients with an acute or chronic medical condition when documentation from the prescribing physician and the treating therapist shows there is or will be progress made toward goals.

Note: *An advanced practice registered nurse (APRN) or physician assistant (PA) may sign and date all documentation related to the provision of PT or OT services on behalf of the client's physician when the client's physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number are required.*

The CSHCN Services Program reimburses therapists and outpatient facilities based on the procedure codes listed in this chapter. Therapy sessions include the time span the therapist is with the client, time spent preparing the client for the session, and the time spent completing documentation.

30.2.1 Osteopathic Manipulative Treatment (OMT)

OMT services provided by a licensed physician are benefits when they are performed with the expectation of restoring the client's level of function that has been lost or reduced due to injury or illness.

Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

OMT may be considered for reimbursement by the CSHCN Services Program in the following situations:

- Acute musculoskeletal condition
- Acute exacerbation of a chronic condition
- Acute treatment pre- or postsurgery that is directly related to the surgery

Procedure codes 98925, 98926, 98927, 98928, and 98929 must be used when billing for OMT.

30.2.2 Physical Therapy (PT), and Occupational Therapy (OT)

Therapy goals for an acute or chronic medical condition include, but are not limited to, improving, maintaining, and slowing the deterioration of function.

PT and OT evaluations and treatment must be ordered or prescribed by the client's physician, APRN, or PA and be based on medical necessity.

A client may receive any combination of physical, occupational, or speech therapy in the office, home, or outpatient setting, up to one hour per day for each type of therapy.

Therapy evaluations are a benefit once per 180 rolling days, any provider. Therapy re-evaluations are a benefit when documentation supports one of the following:

- A change in the client's status
- A request for extension of services
- A change of provider

Additional therapy evaluations or re-evaluations that exceed these limits may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter that is signed and dated by the client, parent, or guardian that documents all of the following:
  - The date that the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation of why providers were changed

An evaluation or re-evaluation will be denied when billed by any provider on the same date of service as therapy treatment from the same discipline.

OT and PT procedure codes 97039, 97139, 97755, 97799, and S8990 will be denied if billed on the same date of service as procedure code G0152 by any provider.

All documentation that is related to the therapy services that were prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

Group Therapy

Group therapy consists of simultaneous treatment to two or more clients who may or may not be doing the same activities. If the therapist is dividing attention among the clients, providing only brief, intermittent personal contact, or giving the same instructions to two or more clients at the same time, the treatment is recognized as group therapy. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one client contact is not required.

Group Therapy Guidelines

In order to meet CSHCN Services Program criteria for group therapy, all of the following applies:

- Physician prescription for group therapy.
- Performance by or under the general supervision of a qualified licensed therapist as defined by licensure requirements.
- The licensed therapist involved in group therapy services must be in constant attendance (meaning in the same room) and active in the therapy.
- Each client participating in the group must have an individualized treatment plan for group treatment, including interventions, short- and long-term goals, and measurable outcomes.

Note: *The CSHCN Services Program does not limit the number of clients who can participate in a group therapy session. Providers are subject to certification and licensure board standardsregarding group therapy.*

Group Therapy Documentation Requirements

The following documentation must be maintained in the client's medical record:

- Physician prescription for group therapy
- Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals

Documentation for each group therapy session must include the following:

- Name and signature of the licensed therapist providing supervision over the group therapy session
- Treatment goal addressed in the group
- Specific treatment technique(s) utilized during the group therapy session
- How the treatment technique will restore function
- Start and stop times for each session
- Group therapy setting or location
- Number of clients in the group

The client's medical record must be made available upon request.

Group therapy procedure code 97150 must be reported for each member of the group.

Providers must use the following procedure codes for authorization and for claim submission when billing for physical and occupational therapy services:

Procedure Codes				
S8990	97001	97002	97003	97004
97012	97016	97018	97022	97024
97026	97028	97032	97033	97034
97035	97036	97039	97110	97112
97113	97116	97124	97139	97140
97150	97530	97535	97537	97542
97750	97755	97760	97761	97762
97799				

Physical therapists must use procedure code 97001 for evaluation and procedure code 97002 for reevaluation. Occupational therapists must use procedure code 97003 for evaluation and procedure code 97004 for reevaluation. These codes do not require modifiers.

Reimbursement of an evaluation (procedure codes 97001 and 97003) is limited to once every 180 rolling days to any provider. Reimbursement for reevaluation (procedure codes 97002 and 97004) will be considered when documentation supports a change in the client's status or with a request for extension of services, or with a change of provider.

The following procedure codes are billed in 15-minute increments. Providers should not bill for services performed less than 8 minutes. Treatment procedure codes are limited to 1 hour of physical therapy and 1 hour of occupational therapy on the same day, any provider, with GP or GO modifiers.

Procedure Codes				
S8990	97032	97033	97034	97035
97036	97039	97110	97112	97113
97116	97124	97139	97140	97530
97535	97537	97542	97750	97755
97760	97761	97762		

The following procedure codes are not payable in 15-minute increments and are limited to a quantity of once per day, per distinct therapy type (physical or occupational):

Procedure Codes				
97012	97016	97018	97022	97024
97026	97028	97150	97799	

Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units

All claims for reimbursement of these procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit=15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service.

If the total billable minutes are not divisible by 15 and are greater than seven, the minutes are converted to one (1) unit of service. If the total billable minutes are not divisible by 15 and are seven minutes or fewer, the minutes are converted to zero (0) units.

Example: *68 total billable minutes/15 = four units + eight minutes. Since eight minutes are more than seven minutes, those eight minutes are converted to one unit. Therefore, 68 total billable minutes equals five units of service.*

Time intervals for one through eight units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

Noncovered Services

The following services are not a benefit of the CSHCN Services Program:

- Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment
- Treatment solely for the instruction of other agency or professional personnel in the client's physical or occupational therapy program
- Procedure code 98960
- Procedure code 97010 (This does not require special medical training)

- Procedure code 97014 (Unattended services are not covered)
- Training in nonessential tasks, such as homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling, or teaching a second language
- VitalStim therapy for dysphagia
- Services and procedures that are investigational or experimental

30.2.2.1 Authorization Requirements

PT and OT evaluations and reevaluations do not require prior authorization. All other PT and OT services require prior authorization.

Prior authorization for therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition that results in a significant decrease in functional ability and will benefit from therapy services in an office or outpatient setting.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider's scope of practice as defined by state law.

An initial prior authorization may be granted for a period not to exceed 180 days. Subsequent prior authorization requests may be requested for up to 180 days when submitted with documentation of a chronic condition.

PT and OT services that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. Additional services may be considered with documentation that supports the medical necessity for exceeding the 1-hour-per-day limitation.

To complete the prior authorization process by paper, the provider must submit the prior authorization requirements documentation through fax or mail and must retain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To complete the prior authorization process electronically, the provider must submit the prior authorization requirements documentation through any approved method and must retain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To avoid unnecessary denials, the physician, APRN, or PA must submit correct and complete information including documentation of medical necessity for the service requested. The ordering practitioner must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request for therapy.

Initial Prior Authorization Requests

The initial request for prior authorization must be received before therapy treatments are initiated. Requests that are received after therapy initiation will be denied for dates of service that occurred before the date that the request was received.

Note: *If medically necessary services are provided after hours or on a recognized holiday or weekend, services may be authorized when the request is submitted on the next business day.*

A completed CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1) form and supporting documentation must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines will not be given by the CSHCN Services Program for providers to correct incomplete prior authorization requests.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1) form. The request form must be signed and dated by the ordering physician, APRN, or PA.

Note: *A request received without the ordering practitioner's signature will not be processed and will be returned to the provider.*

- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.

Note: *A therapy evaluation is current when it is performed within 60 rolling days before the initiation of therapy services.*

- A client-specific comprehensive treatment plan that was established by the ordering physician, APRN, PA, or therapist to be followed during treatment in the therapy setting and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Treatment goals that are related to the client's individual needs for the requested therapy discipline and associated disciplines
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation that require the therapy services
  - Requested dates of service

Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Requests for subsequent services that are received after the current prior authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

Prior authorization requests for subsequent services may be considered for increments up to 180 days for each request with documentation that supports medical necessity and includes all of the following:

- A completed CSHCN Services Program Authorization Request for Extension of Outpatient Therapy (TP2) form that has been signed and dated by the ordering physician, APRN, or PA

Note: *A request received without the provider's signature will not be processed and will be returned to the provider.*

- A current therapy evaluation or re-evaluation for each therapy discipline that documents the client's age at the time of the evaluation or re-evaluation.
  - A therapy evaluation or re-evaluation is current when it is performed within 30 rolling days before the request for subsequent services

An updated, client-specific comprehensive treatment plan that was established by the ordering physician, APRN, PA, or therapist to be followed during treatment must include all of the following:

- Date and signature of the licensed therapist
- Diagnosis(es)
- Updated treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
- A description of the specific therapy disciplines that are being prescribed
- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation that requires the therapy services
- A brief summary of the outcomes of the previous treatment as it relates to the client's debilitating condition
- Requested dates of service

Revisions to Existing Prior Authorization Requests

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing prior authorization must be received no later than the next business day after the date that the revised therapy treatments are initiated. Requests that are received more than one day after the initiation of the revised services will be denied for dates of service that occurred before the date that the request was received.

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form that has been signed by the ordering practitioner
- A new evaluation with required documentation of medical necessity
- A change-of-provider letter, which has been signed and dated by the client, parent, or guardian and documents the date that the client ended therapy (effective date of change) with the previous provider, the names of the previous and new providers, and an explanation of why providers were changed.

A change of provider during an existing authorization period will not extend the original authorization period approved to the previous provider. Regardless of the number of provider changes, clients may not receive therapy services beyond the limitations outlined above.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1)

CSHCN Services Program Authorization Request for Extension of Outpatient Therapy (TP2)

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

Note: *A physician's prescription is considered current when it is signed and dated within 60 rolling days before the start of therapy. A prescription is valid for 6 months.*

30.3 Coordination with the Public School System

Clients may receive therapy services from both the CSHCN Services Program and school districts only when the therapy provided by the CSHCN Services Program addresses different client needs. If the client is of school age, therapy provided through the CSHCN Services Program is not intended to duplicate, replace, or supplement services that are the legal responsibility of other entities or institutions.

The CSHCN Services Program encourages the private therapist to coordinate with other therapy providers to avoid treatment plans that might compromise the client's ability to progress.

30.4 Claims Information

To be considered for reimbursement, claims must identify the specific therapy type. Claims for PT services must include modifier GP, and claims for OT services must include modifier GO. Evaluation and reevaluation procedure codes do not require the modifiers.

Outpatient therapy services provided by a physical or occupational therapist or by an outpatient facility must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid

Services (CMS) NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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.

Note: *NCCI guidelines do not apply to therapy procedure codes if a valid prior authorization number is submitted on the claim.*

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

30.5 Reimbursement

Physicians, podiatrists, APRNs, PAs, and occupational or physical therapists may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

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

Outpatient hospital services are reimbursed at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

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.*

30.6 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.

Chapter

31

Physician

31.1 Enrollment

Physicians, podiatrists, physician groups, and podiatry groups may enroll as Children with Special Healthcare Needs (CSHCN) Services Program providers by completing the provider enrollment application available through the TMHP-CSHCN Services Program website at www.tmhp.com. Providers may also enroll or reenroll in the CSHCN Services Program online. For assistance with the application process, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Option 2.

In this section the term "physician" means a doctor of medicine (MD), doctor of osteopathy (DO), or doctor of podiatric medicine (DPM).

Physicians must be actively enrolled as a Medicaid provider before enrolling in the CSHCN Services Program. "Actively enrolled" physicians 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. Physicians must be licensed by the Texas licensing board. Out-of-state physicians must meet all these conditions and be located in the United States, within 50 miles of the Texas state border.

Requests for medical services provided by an out-of-state provider more than 50 miles from the Texas state border must be submitted for consideration to TMHP at the address in Section 2.1, "Provider Enrollment," on page 2-2.

Refer to: Section 2.1.8, "Out-of-State Providers," on page 2-9 for more information about out-of-state services.

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

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 25 Texas Administrative Code (TAC) 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.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 2.1.5.1, "Types of Providers," on page 2-6 for additional information.

Section 3.1.4, "Services Provided Outside of Texas," on page 3-3 for more detailed information about services provided outside of Texas.

31.1.1 Group Practices

Provider groups that are enrolled in Texas Medicaid can enroll in the CSHCN Services Program by completing an enrollment application. The CSHCN Services Program application must include the Medicaid group provider identifier and performing provider identifiers for all physicians in the group.

31.1.2 Changes in Provider Enrollment

If additions or changes occur in the provider's enrollment information after the enrollment process is completed, the provider must notify TMHP of the changes.

Refer to: Section 2.1.2, "Changes in Enrollment," on page 2-4 for additional information.

31.1.3 Substitute Physician

Physicians may bill for the services of a substitute physician who sees clients in the billing physician's practice under either a reciprocal or locum tenens arrangement.

A reciprocal arrangement is one in which a substitute physician covers for the billing physician on an occasional basis when the billing physician is unavailable to provide services. Reciprocal arrangements are limited to a continuous period no longer than 14 days and do not have to be in writing.

A *locum tenens* arrangement is one in which a substitute physician assumes the practice of a billing physician for a temporary period no longer than 90 days when the billing physician is absent for reasons such as illness, pregnancy, vacation, continuing medical education, or active duty in the Armed Forces. The locum tenens 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. *Locum tenens* arrangements must be in writing.

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.

The billing provider's name, address, and national provider identifier must appear in Block 33 of the claim form. The name and mailing address of the substitute physician must be documented on the claim in Block 19, not Block 33. When a physician bills for a substitute physician, the modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q5 modifier is used to indicate a reciprocal arrangement and the Q6 modifier is used to indicate a *locum tenens* arrangement.

31.2 Benefits, Limitations, and Authorization Requirements

Physician and podiatrist services include reasonable and medically necessary services that are ordered and performed by a physician or under the personal supervision of a physician and that are within the scope of practice of his or her profession, as defined by state law. The physician must examine the client, make a diagnosis, establish a plan of care, and document these tasks on the appropriate client medical records before submitting claims. Payment may be recouped if the documentation is not in the client's medical record.

To be payable by the CSHCN Services Program, services must be personally performed by the physician or by a qualified person working under the personal supervision of the physician. Personal supervision means that the physician must be in the building of the office or facility when and where the service is provided. Direct supervision means the physician must be physically present in the room at the time the service is provided.

If an attending physician provides personal and identifiable direction to interns or residents who are participating in the care of a CSHCN Services Program client in a teaching setting through an approved and accredited training program by the appropriate accreditation agencies, the attending physician's services are a benefit. For major surgical procedures and other complex and dangerous procedures or situations, the attending physician must be physically present during the procedure or situation to provide personal and identifiable direction. Payment for services may be recouped if personal and identifiable direction is not provided or is not appropriately documented.

To demonstrate that personal and identifiable direction was provided, the attending physician must have:

- Reviewed the client's history and physical examination and personally examined the client within a reasonable period after the client's admission and before the client's discharge.

- Confirmed or revised the client's diagnosis.
- Determined the course of treatment to be followed.
- Provided appropriate supervision of the interns or residents.
- Entered the appropriate daily documentation of the tasks identified above in the client's medical record before the claim is submitted.

31.2.1 Authorization and Prior Authorization Requirements

Some services, as specified throughout this chapter, require authorization or prior authorization as a condition for reimbursement. Authorization and prior authorization is not a guarantee of payment.

- Authorization must occur no later than 95 days after the date of service.
- Prior authorization must be obtained before the service is provided.

Authorization requests received after the authorization deadline are denied.

The 95-day filing deadline is for all services that require authorization (not *prior* authorization), including extensions and emergency situations.

Before submitting an authorization or prior authorization request, the provider must verify the client's eligibility. Any service provided while the client is not eligible cannot be reimbursed. Providers are responsible for knowing which services require authorization or prior authorization.

All requests for prior authorizations or authorizations must be submitted in writing on the CSHCN Services Program-approved authorization and prior authorization forms. Forms are located on the Forms page of the TMHP website. Providers may fax their authorization or prior authorization requests to the TMHP-CSHCN Services Program Authorization Department at 1-512-514-4222. This fax number is only for authorization or prior authorization requests.

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

Requests to extend the authorization deadline are not considered except in cases involving retroactive eligibility.

Exception: *For clients that receive retroactive eligibility, the authorization and prior authorization requirement may be waived if the client's eligibility had not been determined by the time TMHP received the request. Claims for these services must be received within 95 days of the eligibility add date and must include a completed request for authorization/prior authorization, along with all other applicable documentation.*

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for additional information.

Section 4.2.1, "Services that Require Authorization," on page 4-3 for a list of some of the services requiring authorization.

Section 4.3.1, "Services that Require Prior Authorization," on page 4-5 for a list of some of the services requiring prior authorization.

31.2.2 Aerosol Treatments/Inhalation Therapy

Aerosol therapy is a benefit of the CSHCN Services Program for any covered diagnosis or related condition listed in the table below. Continuous inhalation treatment with aerosol medication for acute airway obstruction (procedure codes 94644 and 94645) is a benefit of the CSHCN Services Program. On physician claims, nebulizers and metered-dose inhaler treatments must be billed with procedure code 94640.

Pentamidine aerosol treatment (procedure codes 94642 and J2545) is a benefit of the CSHCN Services Program for diagnosis code 042, human immunodeficiency virus (HIV) disease, for the treatment of pneumocystis carinii.

Diagnosis Codes	Description
042	Human immunodeficiency virus (HIV) disease
0796	Respiratory syncytial virus (RSV)
1363	Pneumocystosis
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
46400	Acute laryngitis, without mention of obstruction
46401	Acute laryngitis, with obstruction
46410	Acute tracheitis, without mention of obstruction
46411	Acute tracheitis, with obstruction
46420	Acute laryngotracheitis, without mention of obstruction
46421	Acute laryngotracheitis, with obstruction
46430	Acute epiglottitis, without mention of obstruction
46431	Acute epiglottitis, with obstruction
4644	Croup
46450	Unspecified supraglottitis, without mention of obstruction
46451	Unspecified supraglottitis, with obstruction
4650	Acute laryngopharyngitis
4658	Acute upper respiratory infections of other multiple sites
4659	Acute upper respiratory infections of unspecified site
4660	Acute bronchitis
46611	Acute bronchiolitis due to RSV
46619	Acute bronchiolitis due to other infectious organisms
4786	Edema of larynx
47875	Laryngeal spasm
4788	Upper respiratory tract hypersensitivity reaction, site unspecified
4800	Pneumonia due to adenorivus
4801	Pneumonia due to respiratory syncytial virus
4802	Pneumonia due to parainfluenza virus
4803	Pneumonia due to SARS-associated coronavirus
4808	Pneumonia due to other virus not elsewhere classified
4809	Unspecified viral pneumonia
481	Pneumococcal pneumonia (streptococcis pneumoniae pneumonia)
4820	Pneumonia due to Klebsiella pneumoniae
4821	Pneumonia due to Pseudomonas
4822	Pneumonia due to Hemoplilus influenzae (H.influenzae)
48230	Pneumonia due to unspecified Streptococcus

Diagnosis Codes	Description
48231	Pneumonia due to Streptococcus, group A
48232	Pneumonia due to Streptococcus, group B
48239	Pneumonia due to other Streptococcus
48240	Pneumonia due to Staphylococcus, unspecified
48241	Methicillin susceptible Staphylococcus aureus
48242	Methicillin resistant pneumonia due to Staphylococcus aureus
48249	Other Staphylococcus pneumonia
48281	Pneumonia due to anaerobes
48282	Pneumonia due to Escherichia coli (E. coli)
48283	Pneumonia due to other gram-negative bacteria
48284	Legionnaires' disease
48289	Pneumonia due to other specified bacteria
4829	Unspecified bacterial pneumonia
4830	Pneumonia due to Mycoplasma pneumoniae
4831	Pneumonia due to Chlamydia
4838	Pneumonia due to other specified organism
4841	Pneumonia in cytomegalic inclusion disease
4843	Pneumonia in whooping cough
4845	Pneumonia in anthrax
4846	Pneumonia in aspergillosis
4847	Pneumonia in other systemic mycoses
4848	Pneumonia in other infectious diseases classified elsewhere
485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
490	Bronchitis NOS
4910	Simple chronic bronchitis
4911	Mucopurulent chronic bronchitis
49120	Obstructive chronic bronchitis, without exacerbation
49121	Obstructive chronic bronchitis, with acute exacerbation
49122	Obstructive chronic bronchitis with acute bronchitis
4918	Other chronic bronchitis
4919	Unspecified chronic bronchitis
4920	Emphysematous bleb
4928	Other emphysema
49300	Extrinsic asthma without mention of status asthmaticus or acute exacerbation or unspecified
49301	Extrinsic asthma with status asthmaticus
49302	Extrinsic asthma with acute exacerbation
49310	Intrinsic asthma without mention of status asthmaticus or acute exacerbation or unspecified
49311	Intrinsic asthma with status asthmaticus
49312	Intrinsic asthma with acute exacerbation

Diagnosis Codes	Description
49320	Chronic obstructive asthma without mention of status asthmaticus or acute exacerbation or unspecified
49321	Chronic obstructive asthma with status asthmaticus
49322	Chronic obstructive asthma with acute exacerbation
49390	Asthma, unspecified without mention of status asthmaticus or acute exacerbation or unspecified
49391	Asthma, unspecified with status asthmaticus
49392	Asthma, unspecified with acute exacerbation
4940	Bronchiectasis without acute exacerbation
4941	Bronchiectasis with acute exacerbation
4950	Farmers' lung
4951	Bagassosis
4952	Bird-fanciers' lung
4953	Suberosis
4954	Malt workers' lung
4955	Mushroom workers' lung
4956	Maple bark-strippers' lung
4957	Ventilation pneumonitis
4958	Other specified allergic alveolitis and pneumonitis
4959	Unspecified allergic alveolitis and pneumonitis
496	Chronic airway obstruction, not elsewhere classified
5173	Acute chest syndrome
5184	Unspecified acute edema of lung
5186	Allergic bronchopulmonary aspergillosis

Procedure codes J7605, J7608, J7622, J7626, J7631, J7633, J7639, J7644, and J7682 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes	Description
01550	Tuberculous bronchiectasis
27702	Cystic fibrosis with pulmonary manifestations
46611	Acute bronchiolitis due to respiratory syncytial virus (RSV)
46619	Acute bronchiolitis due to other infectious organisms
4801	Pneumonia due to respiratory syncytial virus (RSV)
48242	Methicillin resistant pneumonia due to Staphylococcus aureus
486	Pneumonia, organism unspecified
48801	Influenza due to identified Avian influenza virus with pneumonia
48802	Influenza due to identified Avian influenza virus with other respiratory manifestations
48811	Influenza due to identified novel H1N1 influenza virus with pneumonia
48812	Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations
4910	Simple chronic bronchitis
4911	Mucopurulent chronic bronchitis

Diagnosis Codes	Description
49120	Obstructive chronic bronchitis, without exacerbation
49121	Obstructive chronic bronchitis, with (acute) exacerbation
49122	Obstructive chronic bronchitis with acute bronchitis
4918	Other chronic bronchitis
4919	Unspecified chronic bronchitis
4920	Emphysematous bleb
4928	Other emphysema
49300	Extrinsic asthma, unspecified
49301	Extrinsic asthma with status asthmaticus
49302	Extrinsic asthma with (acute) exacerbation
49310	Intrinsic asthma, unspecified
49311	Intrinsic asthma with status asthmaticus
49312	Intrinsic asthma with (acute) exacerbation
49320	Chronic obstructive asthma, unspecified
49321	Chronic obstructive asthma with status asthmaticus
49322	Chronic obstructive asthma with (acute) exacerbation
49381	Exercise induced bronchospasm
49382	Cough variant asthma
49390	Asthma, unspecified
49391	Asthma, unspecified with status asthmaticus
49392	Asthma, unspecified with (acute) exacerbation
4940	Bronchiectasis without acute exacerbation
4941	Bronchiectasis with acute exacerbation
4950	Farmers' lung
4951	Bagassosis
4952	Bird-fanciers' lung
4953	Suberosis
4954	Malt workers' lung
4955	Mushroom workers' lung
4956	Maple bark-strippers' lung
4957	"Ventilation" pneumonitis
4958	Other specified allergic alveolitis and pneumonitis
4959	Unspecified allergic alveolitis and pneumonitis
496	Chronic airway obstruction, not elsewhere classified
500	Coal workers' pneumoconiosis
501	Asbestosis
502	Pneumoconiosis due to other silica or silicates
503	Pneumoconiosis due to other inorganic dust
504	Pneumonopathy due to inhalation of other dust
505	Pneumoconiosis, unspecified
5060	Bronchitis and pneumonitis due to fumes and vapors

Diagnosis Codes	Description
5061	Acute pulmonary edema due to fumes and vapors
5062	Upper respiratory inflammation due to fumes and vapors
5063	Other acute and subacute respiratory conditions due to fumes and vapors
5064	Chronic respiratory conditions due to fumes and vapors
5069	Unspecified respiratory conditions due to fumes and vapors
5070	Pneumonitis due to inhalation of food or vomitus
5071	Pneumonitis due to inhalation of oils and essences
5078	Pneumonitis due to other solids and liquids
5080	Acute pulmonary manifestations due to radiation
5081	Chronic and other pulmonary manifestations due to radiation
5088	Respiratory conditions due to other specified external agents
5089	Respiratory conditions due to unspecified external agent
51911	Acute bronchospasm
51919	Other diseases of trachea and bronchus
7864	Abnormal sputum
74861	Congenital bronchiectasis

31.2.3 Allergy Services

Allergy testing and desensitization are benefits of the CSHCN Services Program.

Providers must use the following procedure codes to bill for allergy testing:

Procedure Codes				
86001	86003	86005	86486	95004
95017	95018	95024	95027	95028
95076	95180	95199		

Allergy blood testing (procedure codes 86001, 86003, and 86005) are a benefit of the CSHCN Services Program under the following circumstances:

- The client is unable to discontinue medications
- An allergy skin test is inappropriate for the client because of the following reasons:
  - The client is pediatric
  - The client is disabled
  - The client suffers from a skin condition such as dermatitis

Procedure code 86001 is limited to 20 allergens per rolling year, any provider. Procedure code 86003 is limited to 30 allergens per rolling year, any provider. Procedure code 86005 is limited to 4 screenings per rolling year, same provider.

Providers must indicate the number of allergens tested in the Units field in Block 24G of the CMS-1500 paper claim form. If the number of tests is not indicated in this field, payment is made for only one test.

31.2.3.1 Collagen Skin Tests

Collagen skin tests are a benefit of the CSHCN Services Program and may be reimbursed using procedure code Q3031.

Collagen skin tests are administered to detect a hypersensitivity to bovine collagen. This skin test is given four weeks prior to any type of surgical procedure which utilizes collagen.

31.2.3.2 Prior Authorization Requirements

Allergy services generally do not require prior authorization; however, prior authorization is required for unlisted procedure code 95199 and when benefit limitations are exceeded for procedure codes 86001, 86003, and 86005.

Every effort should be made to use the appropriate Healthcare Common Procedure Coding System (HCPCS) or Current Procedural terminology (CPT) procedure code which describes the procedure being performed. If a procedure code does not exist to describe the service performed, procedure code 95199 should be submitted with appropriate documentation to assist in determining coverage. The documentation submitted must include all of the following:

- The client's diagnosis
- Medical records indicating prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the procedure to be performed
- Reason for recommending the procedure
- A CPT or HCPCS procedure code that is comparable to the procedure being requested
- Documentation that the procedure is not investigational or experimental
- Place of service the procedure is to be performed
- The physician's intended fee for this procedure

Requests for prior authorization of procedure codes 86001, 86003, and 86005 must be submitted with documentation of medical necessity and include all of the following:

- Results of any previous treatment
- Documentation indicating that the client's treatment could not be completed within the policy limits for the requested procedures
- Client diagnosis and conditions that support the medical necessity for the additional procedures requested
- Explanation of client outcomes that the requested procedures will achieve

Prior authorization requests must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request Form.

31.2.4 Ambulatory Blood Pressure Monitoring

Ambulatory blood pressure monitoring is a benefit of the CSHCN Services Program when used as a diagnostic tool to assist a physician in diagnosing hypertension in individuals whose blood pressure is either elevated, or inconclusive when evaluated in the office alone.

Procedure codes 93784, 93786, 93788, and 93790 are a benefit for diagnostic purposes only and should not be used for maintenance monitoring. Ambulatory blood pressure monitoring is indicated for the evaluation of one of the following conditions:

- White coat hypertension, which includes all of the following:
  - A clinic or office blood pressure measurement greater than 140/90 mm Hg on at least three separate clinic or office visits with two separate measurements made at each visit
  - At least two documented separate blood pressure measurements taken outside the clinic or office, which are less than 140/90 mm Hg
  - No evidence of end-organ damage
- Resistant hypertension
- Evaluation of hypotensive symptoms as a response to hypertension medications
- Nocturnal angina
- Episodic hypertension
- Evaluation of syncope

Providers must document that the ambulatory blood pressure monitoring was performed for at least 24 hours.

Ambulatory blood pressure monitoring is limited to two services per lifetime, any provider. Claims that exceed the limitation of two services per lifetime may be considered for reimbursement when documentation of medical necessity is submitted with the claim.

31.2.5 Anesthesia Services

Anesthesia services are a benefit of the CSHCN Services Program and may be reimbursed to anesthesiologists, certified registered nurse anesthetists (CRNAs), anesthesiologist assistants (AA), and other qualified professionals.

Anesthesia must be administered by an anesthesia practitioner. An anesthesia practitioner is defined as the following:

- An anesthesiologist performing the anesthesia service alone
- A CRNA who is either medically directed or not medically directed
- An AA performing delegated services
- A qualified professional as identified by the Texas Medical Board performing delegated services

Authorization is not required for anesthesia services. Specific surgical procedures, however, may require prior authorization. Anesthesia may be reimbursed if prior authorization for the surgical procedure was not obtained, but services provided by the facility, surgeon, and assistant surgeon are denied.

For time-based anesthesiology procedure codes, anesthesia practitioners must document interruptions in anesthesia time in the client's medical record. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance (e.g., when the client may be safely placed under postoperative supervision).

The anesthesiologist who medically directs the CRNA, AA, or other qualified professional must document the same time that the CRNA, AA, or other qualified professional documents.

Time units are determined on the basis of one time unit for each 15 minutes of anesthesia. Providers must submit the total anesthesia time in minutes on the claim. The claims administrator will convert total minutes to time units.

Anesthesia services for obstetrical or family planning procedures are not a benefit of the CSHCN Services Program.

Local, regional, or general anesthesia provided by a surgeon is not a separately payable benefit of the CSHCN Services Program when performed by the operating surgeon. If anesthesia services are provided and modifier 47 is used, the services are included in the global fee for the surgical procedure.

31.2.5.1 Medical Direction

Personal medical direction of an anesthesia practitioner (CRNA, AA, or other qualified professional) by an anesthesiologist is a benefit of the CSHCN Services Program if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.

Exception: *Anesthesiologists may simultaneously supervise more than a combination of four CRNAs, AAs, or other qualified professionals, as defined by the Texas Medical Board under emergency circumstances.*

- The anesthesiologist is physically present in the operating suite.

Medical direction is a covered service only if all of the following criteria are met:

- The anesthesiologist performs a preanesthetic examination and evaluation.
- The anesthesiologist prescribes the anesthesia plan.
- The anesthesiologist personally participates in the critical and key portions of the anesthesia plan, including induction and emergence, if applicable.

- The anesthesiologist must ensure that a qualified professional, including anesthesiologist assistants, can perform any procedures in the anesthesia plan that the anesthesiologist does not perform personally.
- The anesthesiologist monitors the course of anesthesia administration at frequent intervals.
- The anesthesiologist must provide direct supervision when medically directing an anesthesia procedure. Direct supervision means the anesthesiologist must be immediately available to furnish assistance and direction.
- The anesthesiologist provides indicated postanesthesia care.
- The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist directing the administration of no more than four anesthesia procedures may provide the following without affecting the eligibility of the medical direction services:
  - Address an emergency of short duration in the immediate area.
  - Administer an epidural or caudal anesthetic to ease labor pain for a client who is not enrolled in the CSHCN Services Program.
  - Provide periodic, rather than continuous, monitoring of an obstetrical client who is not enrolled in the CSHCN Services Program.
  - Receive clients entering the operating suite for the next surgery.
  - Check or discharge clients in the recovery room.
  - Handle scheduling matters.

An anesthesiologist may medically direct up to four concurrent anesthesia procedures. Concurrent medical direction refers to involvement of the anesthesiologist in directing two, three, or four current anesthesia procedures.

Concurrency is defined as the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a CSHCN Services Program client. For example, if three procedures are medically directed but only two involve CSHCN Services Program clients, the CSHCN Services Program claims should be billed as concurrent medical direction of three procedures.

The following information must be available to the state upon request and is subject to retrospective review:

- The name of each CRNA, AA, and other qualified professional concurrently being medically directed or supervised and a description of the procedure that was performed must be documented and maintained on file.
- Signatures of the anesthesiologist, CRNAs, AAs, or other qualified professionals involved in administering anesthesia services must be documented in the client's medical record.
- For medical direction, the anesthesiologist must document in the client's medical record that he or she:
  - Performed the pre-anesthetic exam and evaluation.
  - Provided the indicated post-anesthesia care.
  - Was present during the critical and key portions of the anesthesia procedure including, if applicable, induction and emergence.
  - Was present during the anesthesia procedure to monitor the client's status.

31.2.5.2 Monitored Anesthesia Care

Monitored anesthesia care may include any of the following:

- Intraoperative monitoring by an anesthesiologist or qualified professional under the medical direction of an anesthesiologist.
- Monitoring the client's vital physiological signs in anticipation of the need for general anesthesia.

- Monitoring the client to detect development of an adverse physiological reaction to a surgical procedure.

31.2.5.3 Anesthesia Modifiers

Each anesthesia procedure code must be submitted with the appropriate anesthesia modifier(s) whether billing as the sole provider or for the medical direction of CRNAs, AAs, or other qualified professionals.

When an anesthesia service is billed without the appropriate reimbursement modifiers, or is billed with modifier combinations other than those listed in this section, the claim is denied.

A claim billed with a modifier indicating that the anesthesia was not medically directed or medically supervised (modifier AD, QK, QX, or QY) is denied if a previous claim has been billed with a modifier indicating the service was personally performed (modifier AA or QZ) and is reimbursed for the same client, date of service, and procedure code.

A claim billed with a modifier indicating that the anesthesia was personally performed by an anesthesiologist (modifier AA) is denied if another claim has been paid indicating the service was personally performed by, and reimbursed to, a CRNA (modifier QZ) for the same client, date of service, and procedure code. The opposite is also true—a CRNA-administered procedure is denied if a previous claim was paid to an anesthesiologist for the same client, date of service, and procedure code. Denied claims may be appealed with supporting documentation of any unusual circumstances.

State-Defined Modifiers

Modifiers U1 (indicating one anesthesia claim is expected) and U2 (indicating two anesthesia claims are expected) are state-defined modifiers that may be billed by an anesthesiologist, CRNA, or AA.

Modifier U3 indicates that the anesthesia was performed with dental services.

Modifier U1 indicating that only one claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

Anesthesia providers must submit the U1 or U2 modifier in combination with an appropriate pricing modifier when billing for anesthesia procedure codes.

Anesthesiologist Services and Modifier Combinations

Modifiers AA and U1 must both be submitted when an anesthesiologist has personally performed the anesthesia service.

Anesthesiologists may be reimbursed for medical direction of anesthesia practitioners by using one of the following modifier combinations:

Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
Anesthesiologist Providing Medical Direction or Medical Supervision to Other Qualified Professionals		
QY and U1	When medically directing one procedure performed by another qualified professional.	Only the anesthesiologist
QK and U1	When medically directing two, three, or four concurrent procedures provided by other qualified professionals.	Only the anesthesiologist

Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
AD and U1 (emergency circumstances only)	When medically supervising five or more concurrent procedures provided by other qualified professionals. The AD modifier must be used in emergency circumstances only and limited to 6 units (90 minutes maximum) per case for each occurrence requiring supervision of five or more concurrent procedures.	Only the anesthesiologist
Anesthesiologist Providing Medical Direction or Medical Supervision of CRNAs or AAs		
QY and U2	When medically directing one procedure provided by a CRNA or AA.	Both the anesthesiologist and CRNA or AA
QK and U2	When medically directing two, three, or four concurrent procedures involving CRNA(s) or AA(s).	Both the anesthesiologist and CRNA(s) or AA(s)
AD and U2 (emergency circumstances only)	When medically supervising five or more concurrent procedures involving CRNA(s) or AA(s). The AD modifier must be used in emergency circumstances only and limited to 6 units (90 minutes maximum) per case for each occurrence requiring supervision of five or more concurrent procedures.	Both the anesthesiologist and CRNA(s) or AA(s)

CRNA or AA Services and Modifier Combinations

Modifiers QZ and U1 must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the surgeon.

Modifiers QX and U2 must be submitted by a CRNA or AA who provided services under the medical direction of an anesthesiologist.

Monitored Anesthesia Care

Anesthesiologists, CRNAs, or AAs may use modifier QS to report monitored anesthesia care.

The QS modifier is an informational modifier, and must be billed with any combination of pricing modifiers for reimbursement.

31.2.5.4 Dental General Anesthesia

Procedure code 00170 with modifier U3 should be used when billing for the appropriate reimbursement of dental general anesthesia.

Refer to: Chapter 14, "Dental," on page 14-1 for more information about dental services.

31.2.5.5 Reimbursement

To be reimbursed, providers of anesthesia services must include the following on submitted claims:

- Appropriate national anesthesia procedure codes
- Correct modifier(s)

- Name of the anesthesiologist, CRNA, or medically directed AA administering the anesthesia
- Exact amount of face-to-face time with the client

If procedure code 01996 is used, it must be reported as a medical service rather than an anesthesia service.

The anesthesiologist's reimbursement for medical direction of CRNAs, AAs, and other qualified professionals is 100 percent of the maximum allowable fee.

The CRNA's or AA's reimbursement for performing an anesthesia service when directed by a surgeon or anesthesiologist is 92 percent of the maximum allowable fee.

Refer to: Chapter 12, "Certified Registered Nurse Anesthetist (CRNA)," on page 12-1 for more information on CRNA services.

If multiple CRNAs, anesthesiologists, or anesthesiologist assistants under anesthesiologist supervision are providing anesthesia services for a client, only one CRNA or AA and one anesthesiologist may be reimbursed.

Procedure codes 99100, 99116, 99135, and 99140 are qualifying circumstances that impact the character of the anesthesia services provided. These procedures are not payable alone, but are payable in addition to the anesthesia service. Documentation supporting the medical necessity for use of these procedure codes may be subject to retrospective review.

31.2.5.6 Conversion Factor

A conversion factor is the multiplier that transforms relative value into payment amounts. There is a standard conversion factor for anesthesia services that can be obtained from the online fee lookup on the TMHP website at www.tmhp.com.

31.2.5.7 Time-Based Fees

Reimbursement of time-based anesthesia services is defined as [(Minutes/15) + Relative Value Units (RVUs)] x Conversion Factor x Modifier Combination Adjustment = Anesthesia Reimbursement. It is derived from the following steps:

1) Divide the total anesthesia time in minutes (the time of all procedures performed, directed or supervised) by 15.
2) Add the RVUs for the procedure performed (use the procedure with the highest RVUs when multiple procedures are performed at the same time).
3) Multiply this sum by the appropriate conversion factor.
4) Multiply this sum by the modifier combination adjustment percentage.

Reimbursement of time-based fees requires documentation of exact time in minutes of face-to-face time with the client.

If anesthesia services are performed for two surgical procedures at separate times during the same date of service, both may be reimbursed based on the documentation submitted with the claim.

31.2.6 Audiometry/Hearing Services

The CSHCN Services Program may reimburse appropriately-enrolled providers for audiometry and other hearing services.

Authorization is not required for hearing services provided by physicians.

Refer to: Chapter 20, "Hearing Services," on page 20-1 for more information about hearing services.

CSHCN Services Program clients who are 17 years of age or older, legal residents of the state of Texas, and are employable, may be eligible for assistance from the Department of Assistive and Rehabilitative Services (DARS). The CSHCN Services Program is the payer of last resort and may request that clients meeting these requirements apply to DARS.

31.2.7 Augmentative Communication Devices (ACDs)

The purchase, rental, replacement, modification, and repair of ACDs that function independently of any other technology (i.e., may not rely on a computer in any way) are benefits of the CSHCN Services Program when medically necessary.

Refer to: Chapter 10, "Augmentative Communication Devices (ACDs)," on page 10-1.

31.2.8 Biofeedback Services

Biofeedback is a form of therapy in which a physiologic activity is monitored, amplified, and conveyed by visual or acoustic signals. Procedure codes 90901 and 90911 may be benefits of the CSHCN Services Program for biofeedback services:

The CSHCN Services Program will cover biofeedback services with prior authorization for clients who are 4 years of age and older with the following conditions:

- Urinary incontinence (i.e., stress, urge, overflow, mixed)
- Fecal incontinence

Procedure codes 90901 and 90911 are limited to one procedure code for each date of service by any provider to include all modalities of the services performed during a specific session regardless of the number of modalities performed.

Any device used during a biofeedback session is considered part of the procedure and will not be reimbursed separately.

31.2.8.1 Medical Record Documentation

The physician must provide correct and complete information including documentation establishing medical necessity of the service requested, which must remain in the client's medical record and maintain the record of the performing staff member(s') certification. Claims may be subject to retrospective review.

31.2.8.2 Provider Certification

Biofeedback services must be performed by a staff member who is certified by Biofeedback Certification International Alliance (BCIA). The accepted certification types are:

Certification Type	Description
General biofeedback certification (BCB)	Professionals certified in general biofeedback covering all modalities such as SEMG, Thermal, GSR, HRV, and an overview of neurofeedback.
Pelvic muscle dysfunction biofeedback certification (BCB-PMD)	Professionals certified to use SEMG biofeedback to treat elimination disorders including incontinence and pelvic pain.

31.2.8.3 Authorization Requirements

Prior authorization is required for biofeedback services.

The number of sessions prior authorized will not exceed a total of 12 sessions and will not exceed a total duration of 12 weeks. The following documentation must be submitted for consideration of prior authorization:

- Failure of pharmacotherapy and behavioral training
- Evidence of dyssynergic or non-relaxing detrusor/voluntary sphincter activity based on urodynamic evaluation to include urinary flow testing and complex cystometry
- The client has agreed to actively participate in the biofeedback sessions
- Diagnosis of fecal, stress, urge, overflow, or a mix of stress and urge incontinence
- Medical records indicate that the physician has excluded any underlying medical conditions that could be causing the problem

- For clients who are 21 years of age or older with a diagnosis of stress, urge, overflow, or a mix of stress and urge incontinence, the medical records must indicate failed pelvic muscle exercise (PME) service

Note: *A failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing 4 weeks of PME exercises.*

After completion of the initial biofeedback treatment course, prior authorization may be considered for a total of 6 follow-up sessions not to exceed 3 sessions per week and total duration not to exceed 8 weeks. Prior authorization documentation submitted must be for the same condition as the original request, must include each original symptom, and how the symptom has objectively improved. The documentation may include, but is not limited to:

- For urinary incontinence, the biofeedback therapy should result in improvement of continence scores. There should be a decrease in high-grade stress incontinence, nocturnal enuresis, and loss of urine during activity. For clients who are 21 years of age and older, the pelvic floor muscle contraction strength should improve with the ability to hold the contractions longer and to increase repetitions.
- For fecal incontinence, the biofeedback therapy should result in improvement of continence scores. Squeeze and anal pressures, squeeze duration, and for clients who are 21 years of age and older, pelvic floor muscle contraction strength should show improvement.

Total authorized sessions for any combination of procedure codes 90901 and 90911, including the 12 initial sessions and 6 follow-up sessions, will not exceed 18 sessions for urinary or fecal incontinence conditions.

31.2.8.4 Noncovered Services

Neurofeedback (i.e., EEG biofeedback) is not a benefit of the CSHCN Services Program.

31.2.9 Blood Factor Products

Blood factor products are benefits of the CSHCN Services Program.

When submitting claims, products must be identified by the National Drug Code (NDC), and the following procedure codes must be used:

Procedure Codes				
Q9975	J7180	J7181	J7183	J7185
J7186	J7187	J7189	J7190	J7192
J7193	J7194	J7195	J7198	J7200
J7201				

Procedure codes Q9975 and J7201 are a benefit with diagnosis codes 2860 and 2863.

Procedure codes J7180, J7181, and J7200 are a benefit with diagnosis code 2863.

Procedure code J7183 is a benefit with diagnosis code 2864.

Procedure codes J7186 and J7187 are a benefit with diagnosis codes 2860 and 2864.

Procedure code J7189 is a benefit with diagnosis codes 2860, 2861, 2863, 28652, 2867, 2869, and V8302.

Procedure codes J7185, J7190, J7192, and J7198 are benefits with diagnosis codes 2860, 2861, 2862, 2863, and 28652.

Procedure codes J7193, J7194, and J7195 are benefits with diagnosis code 2861.

The following table lists the descriptions for the above mentioned diagnosis codes:

Diagnosis Code	Description
2860	Congenital factor VIII disorder
2861	Congenital factor IX disorder
2862	Congenital factor XI deficiency

Diagnosis Code	Description
2863	Congenital deficiency of other clotting factors
2864	Von Willebrand's disease
28652	Acquired hemophilia
2867	Acquired coagulation factor deficiency
2869	Other and unspecified coagulation defects
V8302	Symptomatic hemophilia A carrier

Medical review is required for approval of blood factor products for any diagnosis other than those listed above. Requests must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request for Hemophilia Blood Factor Products form.

Claims must be submitted with the quantity and number of units of blood factor products that were provided.

- On electronic claims, enter the following information:
  - Quantity Billed field --Enter a quantity of 1 for the blood factor product procedure code.
  - NDC QTY field --Indicate the number of units provided.
- On paper claim forms, enter the number of blood factor units provided in Block 24G.

Reimbursement of professional services for blood factor products is the lower of the billed amount or 70 percent of the rate allowed by Texas Medicaid.

31.2.10 Bone Growth Stimulators

Internal (implanted) or external (not implanted) bone growth (osteogenic) stimulators are a benefit of the CSHCN Services Program.

Electromagnetic bone growth stimulators promote healthy bone growth and repair by low intensity electrical stimulation. Electrical stimulation is provided by implanting low-voltage electrodes within the tissue surrounding the bone (internal) or by external placement of a device which transmits low-voltage currents through the soft tissue to the bone (external).

Ultrasonic bone growth stimulators promote healthy bone growth and repair through low-intensity pulsed ultrasound waves.

Bone growth stimulators are a benefit for skeletally mature individuals only.

Bone growth stimulation (procedure codes 20974, 20975, and 20979) is limited to one service every six months. Bone growth stimulation for a second fracture that occurs during the six-month limitation period may be considered on appeal with documentation of medical necessity that supports that the criteria have been met for the second fracture.

Refer to: Section 31.2.10.1, "Prior Authorization Requirements for Bone Growth Stimulators" for information about prior authorization requirements for procedure codes 20974, 20975, and 20979.

Due to the short life of the equipment, osteogenic stimulators are purchased.

An ultrasonic bone growth stimulator may not be reimbursed concurrently with other noninvasive bone growth stimulation devices.

Monitoring the effectiveness of bone growth stimulation treatment should be billed as the appropriate evaluation and management (E/M) code.

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

Durable medical equipment (DME) may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.10.1 Prior Authorization Requirements for Bone Growth Stimulators

Prior authorization is required for bone growth stimulator devices. Inpatient admissions require prior authorization. Ambulatory or day surgery requires authorization.

Prior authorization requests for bone stimulator devices must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

A completed CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.

To avoid unnecessary authorization denials, the physician must provide correct and complete information, including documentation for medical necessity of the DME or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the bone growth stimulator.

Documentation that supports medical necessity for a bone growth stimulator device must be maintained by the ordering physician and requesting provider in the client's medical record and is subject to retrospective review.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

The manufacturer will replace the bone growth stimulator device during the course of treatment should the device become nonfunctional. Repairs to purchased equipment will not be prior authorized. All repairs are considered part of the purchase price.

A new bone growth stimulator may be considered for prior authorization with documentation that supports treatment of a different fracture site when the criteria listed in the following sections are met.

Low-Intensity Ultrasound Bone Growth Stimulators

Documentation of the following is required for prior authorization of the external, low-intensity ultrasound bone growth stimulator device (procedure code E0760):

- Nonunion of a fracture other than the skull or vertebrae in a skeletally mature person, documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days each, including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs
- The fracture is not tumor-related
- The fracture is not fresh (less than 7 days), closed or grade I open, tibial diaphyseal fractures, or closed fractures of the distal radius (Colles fracture)

Non-Invasive Bone Growth Stimulators

Documentation of the following is required for prior authorization of the external, electromagnetic bone stimulator device (procedure code E0747):

- At least one of the following conditions:
  - Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for 3 months or longer despite appropriate fracture care.
  - Delayed unions of fractures of failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures).
- Serial radiographs have confirmed that no progressive signs of healing have occurred.
- The fractured gap is 1 cm or less.

- The individual can be adequately immobilized and is likely to comply with nonweight bearing restrictions.

Documentation of one of the following is required for prior authorization of the external, electromagnetic bone stimulator device for spinal application (procedure code E0748):

- One or more failed fusions
- Grade II or worse spondylolisthesis
- A multiple level fusion with extensive bone grafting is required
- Other risk factors for fusion failure are present, including gross obesity, degenerative osteoarthritis, severe spondylolisthesis, current smoking, previous fusion surgery, previous disc surgery, or gross instability

Invasive Bone Growth Stimulators

Documentation of one of the following is required for prior authorization of the surgically implanted osteogenesis stimulator device (procedure code E0749):

- Nonunion of long bone fractures (i.e., clavicle, humerus, radius, ulna, femur, tibia, fibula, and metacarpal, metatarsal, carpal, and tarsal bones). Nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for three or more months prior to starting treatment with the bone growth stimulator. Serial radiographs must include a minimum of 2 sets of radiographs separated by a minimum of 90 days. Each set of radiographs must include multiple views of the fracture site.
- Failed fusion of a joint other than the spine when a minimum of three months has elapsed since the joint fusion was performed.
- Congenital pseudoarthrosis.
- An adjunct to spinal fusion surgery for patients at high risk for pseudoarthrosis due to previously failed spinal fusion at the same site.
- An adjunct to multiple-level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

31.2.10.2 Authorization Requirements for Bone Growth Stimulation

Authorization is required for bone growth stimulation professional services (procedure codes 20974, 20975, and 20979). Providers must submit documentation of medical necessity, which includes the appropriate clinical indications for a low-intensity ultrasound, non-invasive, or invasive device, as defined in section Section 31.2.10.1, "Prior Authorization Requirements for Bone Growth Stimulators".

Authorization requests for bone growth stimulation must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

Refer to: Section 4.2, "Authorizations," on page 4-3 for detailed information about authorization requirements.

31.2.11 Casting

The CSHCN Services Program may reimburse the application of casts, splinting, and strapping in addition to an E/M procedure code when no surgery is performed. If casting, splinting, strapping, or traction is billed the same day as surgery, it is considered part of the surgical procedure.

Supplies used for casting, splinting, and strapping are not reimbursed separately.

Procedure codes 29450 and 29750 are benefits for the following diagnosis codes:

Diagnosis Code	Description
73671	Acquired equinovarus deformity
75450	Congenital talipes varus
75451	Congenital talipes equinovarus
75452	Congenital metatarsus primus varus

Diagnosis Code	Description
75453	Congenital metatarsus varus
75459	Other congenital varus deformity of feet
75460	Congenital talipes valgus
75461	Congenital pes planus
75462	Talipes calcaneovalgus
75469	Other congenital valgus deformity of feet
75470	Unspecified talipes
75471	Talipes cavus
75479	Other congenital deformity of feet

The following procedure codes may be reimbursed for surgery when billing for casting, splinting, or strapping services:

Procedure Codes				
Body and upper extremity casts				
29000	29010	29015	29035	29040
29044	29046	29049	29055	29058
29065	29075	29085	29086	
Body and upper extremity splints				
29105	29125	29126	29130	29131
Body and upper extremity strapping				
29200	29220	29240	29260	29280
Lower extremity casts				
29305	29325	29345	29355	29358
29365	29405	29425	29435	29440
29445				
Lower extremity splints				
29505	29515			
Lower extremity strapping				
29520	29530	29540	29550	
Cast removal or repair				
29700	29705	29710	29720	29730
29740				

31.2.12 Chemotherapy

Chemotherapy services are a benefit of the CSHCN Services Program when they are provided by a physician or under the supervision of a physician.

Note: *Authorization is not required for administration of chemotherapy.*

Providers billing for chemotherapy administration may be reimbursed by using the appropriate procedure codes shown in the following table:

Procedure Codes				
95991	96401	96402	96405	96406
96409	96411	96413	96415	96416
96417	96420	96422	96423	96425

Procedure Codes				
96440	96446	96450	96521	96522
96523	96542	96549		

For the first 15 minutes through the first hour of chemotherapy infusion, procedure code 96409 or 96413 must be used for a single or initial chemotherapeutic medication. Procedure code 96411 must be used for each additional chemotherapeutic medication given and must be billed with procedure code 96409 or 96413.

Procedure code 96415 must be used for each additional hour beyond the initial hour and must be used in conjunction with procedure code 96413.

Procedure code 96417 must be used for each subsequent infusion up to 1 hour and must be used in conjunction with procedure code 96413. Procedure code 96415 must be used for each additional hour.

Procedure codes 96416 and 96425 must be used when initiating an infusion that will take more than 8 hours and requires using an implanted pump or a portable pump.

Procedure code 96422 must be used for the first hour of intra-arterial push administration. Procedure code 96423 must be used for each additional hour in conjunction with procedure code 96422.

The chemotherapy administration procedure codes listed above include charges for intravenous (IV) solutions (such as saline, dextrose and water, Ringer's solution, etc.) and IV equipment (administration sets, needles, extension tubing, etc.).

The chemotherapy administration procedure codes 96440 and 96450 include payment for the surgical procedure. Separate reimbursement for the surgical codes will not be allowed.

The appropriate E/M procedure code may be billed by a physician for a face-to-face visit with the client to review chemotherapy options.

Chemotherapeutic drugs and other injections given in the course of chemotherapy may be reimbursed using the appropriate procedure code. The chemotherapeutic agents should be billed separately, including the name of the drug and actual amount administered for correct reimbursement.

Physicians providing a chemotherapy administration service as an inpatient service on the same day as an E/M service must bill using modifier 25 except for procedure code 99211. A different diagnosis is not required.

When a significant, separately identifiable E/M service is performed, the appropriate E/M code must be submitted with modifier 25 and the chemotherapy procedure code. A different diagnosis is not required for an E/M service provided on the same day. Documentation that supports a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Modifier 25 must be used to describe circumstances in which an office visit was provided at the same time as other separately identifiable services. This modifier may be appended to the E/M code when the services are rendered. Both services must be documented as distinct and documentation must be maintained in the client's medical record and made available upon request by the CSHCN Services Program.

Chemotherapy planning program (procedure code 99213, 99214, or 99215) may be reimbursed.

Inpatient and outpatient hospitals must use revenue code 636 for reimbursement of the technical component. The appropriate chemotherapy procedure code must be listed on the claim.

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

31.2.13 Clinician-Directed Care Coordination Services

Clinician (physician or APRN)-directed care coordination services are a benefit of the CSHCN Services Program.

Clinician-directed care coordination services are a benefit only when provided by a primary care clinician, specialist, or subspecialist who attests that he or she is providing the medical home for the client.

The medical home is defined as:

- A partnership between the child, the child's family, and the primary care provider (or place where the child receives care).
- A care delivery model that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

In providing a medical home for the client, the primary care clinician directs care coordination together with the child or youth and family. Care coordination is a family-centered process that links children or youths with special health needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

Clinician-directed care coordination services (face-to-face and non-face-to-face) must include the following activities, with permission of the client or family:

- Supervising the development and revision of a client's written care plan (a formal document or contained in the client's progress notes) in partnership with the client, family, and other agreed-upon contributors and sharing of this care plan with other providers, agencies, and organizations involved in the care of the client
- Coordinating care among multiple providers
- Maintaining a central record or database that contains all pertinent client medical information, including hospitalizations and specialty care
- Assisting the client and family in communicating clinical issues when a client is referred for a consultation or additional care
- Evaluating, interpreting, and managing consultant recommendations for the client and family in partnership and collaboration with consultants, other providers, the client, and the family

Clinician-directed care coordination services should also include supervision of development and revision of the client's emergency medical plan in partnership with the client, the family, and other providers to be used by emergency medical services (EMS) personnel, utility service companies, schools, other community agencies, and caregivers.

31.2.13.1 Face-to-Face Clinician-Directed Care Coordination Services

Face-to-face care coordination services are encompassed within the various levels of E/M services and prolonged services.

Providers should use the most appropriate face-to-face E/M procedure codes to bill for care coordination services.

When counseling or care coordination requires more than 50 percent of the client or family encounter (face-to-face time in the office or other outpatient setting, or floor or unit time in the hospital), then time may be considered the key or controlling factor to qualify for a particular level of E/M service.

Counseling is discussion with the client or family, concerning diagnostic studies or results, prognosis, risks and benefits, management options, importance of adhering to the treatment regimen, and client and family education.

An E/M procedure code for a face-to-face problem-focused care coordination visit may be billed on the same day as a preventive medicine visit. Modifiers must be used as appropriate for billing.

Any face-to-face inpatient or outpatient E/M procedure code that is a benefit of the CSHCN Services Program may be billed on the same day as any non-face-to-face clinician-directed care coordination (procedure codes 99339, 99340, 99358, 99359, 99367, 99374, 99375, 99377, and 99378), when the client requires significant, separately identifiable E/M service by the same physician on the same day. Modifiers must be used for appropriate billing.

31.2.13.2 Non-Face-to-Face Clinician-Directed Care Coordination Services

Non-face-to-face care coordination services include:

- Prolonged services (procedure codes 99358 and 99359)
- Medical team conferences (procedure code 99367)
- Care plan oversight/supervision (procedure codes 99339, 99340, 99374, 99375, 99377, and 99378)

Non-face-to-face specialist or subspecialist telephone consultations (procedure code 99499 with modifier U9) are a benefit for a specialist or subspecialist when the clinician providing the medical home contacts the specialist for advice or a referral and the consultation is at least 15 minutes in duration.

Telephone consultations are defined by the CSHCN Services Program as the process where the specialist or subspecialist receives a telephone call from the clinician providing the medical home. During the telephone call, the specialist or subspecialist assesses and manages the client's condition by providing advice or referral to a more appropriate provider.

Specifically, non-face-to-face clinician supervision of the development or revision of a client's care plan (care plan oversight services) may include the following activities. These services do not have to be contiguous:

- Review of charts, reports, treatment plans, or lab or study results, except for the initial interpretation or review of lab or study results ordered during or associated with a face-to-face encounter
- Telephone calls with other clinicians (not employed in the same practice), including specialists or subspecialists involved in the care of the client
- Telephone or face-to-face discussions with a pharmacist about pharmacological therapies (not just ordering a prescription)
- Medical decision making
- Activities to coordinate services (if the coordination activities require the skill of a clinician)
- Documentation of the services provided, including writing a note in the client chart describing services provided, decision making performed, and amount of time spent performing the countable services, including time spent by the physician working on the care plan after the nurse has conveyed pertinent information from agencies or facilities to the physician, including the start and stop times

The following activities are not covered as non-face-to-face clinician oversight/supervision of the development or revision of the client's care plan (care plan oversight services):

- Time that staff spends getting or filing charts, calling the home health agencies, clients, etc.
- Clinician telephone calls to a client or family, except when necessary to discuss changes in client's care plan
- Clinician time spent telephoning prescriptions to the pharmacist (not a physician service; does not require a physician to perform)
- Clinician time getting or filing the chart, dialing the telephone, or time on hold (these activities do not require clinician work or meaningfully contribute to the treatment of the illness or injury)
- Travel time
- Time spent preparing claims and for claims processing
- Initial interpretation or review of lab or study results that were ordered during, or associated with, a face-to-face encounter
- Services included as part of other E/M service

- Consults with health professionals not involved in the client's case

These services may be reimbursed for the clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

Clinician-directed care coordination services must be documented in the client's medical record. Documentation must support the services being billed and must include a record of the clinician's time spent performing specific care coordination activities, including start and stop times. The documentation should include a formal care plan and emergency services plan.

The supporting documentation maintained in the client's medical records must be dated and include the following components and requirements:

- A current medical summary containing key information about the client's health (e.g., conditions, complexity, medications, allergies, past surgical procedures, etc.)
- A current list of the main concerns, key strengths and assets, and the related current clinical information
- Planned actions or interventions to address the concerns and to sustain or build strength, with the expected outcomes
- Persons responsible
- Timeframes and due dates

The supporting documentation must be reviewed and updated every 6 months, or more frequently, as needed.

Client medical records are subject to retrospective review.

Payment is made for care coordination to a clinician providing postsurgical care during the postoperative period only if the care coordination is documented to be unrelated to the surgery.

Care Plan Oversight

Clinician-directed care plan oversight services may be billed with one of the procedure codes listed in the following table.

Clinician supervision of a client in the home or domiciliary or under the care of a home health agency or hospice (care plan oversight) may be billed with the following procedure codes:

Procedure Codes				
99339	99340	99374	99375	99377
99378				

The clinician who bills for the care plan oversight must be the same clinician who signed the plan of care for the home or domiciliary (procedure codes 99339 and 99340), home health agency (procedure codes 99374 and 99375) or hospice (procedure codes 99377 and 99378).

Care plan oversight may be reimbursed for the clinician time involved in the coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

The following end-stage renal disease procedure codes apply to a full or partial month of services and are inclusive of all the clinicians supervision services described in care plan oversight (procedure codes 99339, 99340, 99374, 99375, 99377, and 99378):

Procedure Codes				
90951	90952	90953	90954	90955
90956	90957	90958	90959	90960
90961	90962	90963	90964	90965
90966	90967	90968	90969	90970

Care plan oversight may not be reimbursed to the same clinician during the same month as end-stage renal disease services.

The clinician may not have a significant financial or contractual relationship with the home health agency as defined in 42 *Code of Federal Regulations* (CFR) 424.

The clinician may not be the medical director or employee of the hospice and may not furnish services under arrangements with the hospice (including volunteering).

Medical Team Conference

Medical conferences may be billed with procedure code 99367.

One medical team conference (procedure code 99367) may be reimbursed every 6 months when the coordinating clinician attests that he or she is providing the medical home for the client. The coordinating clinician may be the client's primary care physician or a specialist.

The medical team conference time must be documented in the client's record.

Non-Face-to-Face Specialist or Subspecialist Telephone Consultations

Non-face-to-face specialist or subspecialist telephone consultations may be billed with procedure code 99499 and modifier U9.

A specialist or subspecialist telephone consultation is limited to two every 6 months by the same provider.

The clinician providing the medical home must maintain the following documentation in the client's medical record:

- The start and stop times indicating the consultation lasted at least 15 minutes
- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment or laboratory services
- The name of the consulted specialist or subspecialist

The specialist or subspecialist must maintain documentation of the telephone consultation using the CSHCN Services Program Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services or similar clinical record documentation. These records are subject to retrospective review. The supporting documentation must include, but is not limited to, the following:

- The client's name, date of birth, and CSHCN Services Program identification number
- The start and stop times indicating the consultation lasted at least 15 minutes
- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment or laboratory services
- The name and telephone number of the referring clinician providing the medical home
- The specialist's or subspecialist's and referring clinician's identifier information

Non-Face-to-Face Prolonged Services

Non-face-to-face prolonged services may be billed with procedure codes 99358 and 99359.

The client must be an established client and must have had a face-to-face encounter at least once during the 6 months immediately preceding provision of the first non-face-to-face prolonged service.

Non-face-to-face prolonged services (procedure code 99358 or 99359) are limited to a maximum of 90 minutes, once per client, for the same provider.

Procedure code 99358 must be used to report the first hour of prolonged services and must be billed with the appropriate physician E/M procedure code by the same provider.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Procedure code 99359 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Procedure code 99359 must be billed for the same date of service by the same provider as procedure code 99358 or it will be denied.

Authorization for Non-Face-to-Face Clinician-Directed Care Coordination Services

Authorization is required for non-face-to-face clinician-directed care coordination services. A CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services form, and the required documentation must be submitted.

Authorization of initial non-face-to-face clinician-directed care coordination services requires at least 1 covered face-to-face inpatient or outpatient E/M visit by the clinician directing the care coordination during the 6 months preceding the provision of the first non-face-to-face care coordination service.

Authorization for subsequent non-face-to-face clinician-directed care coordination services requires at least 1 covered face-to-face inpatient or outpatient E/M visit by the clinician directing the care coordination during the previous 12 months, or more frequently as indicated by the client's condition.

Authorization of medical team conferences (procedure code 99367) is limited to once every 6 months. Additional medical team conferences may be considered with documentation of a change in the client's medical home.

Authorization of non-face-to-face prolonged services (procedure codes 99358 and 99359) is limited to a maximum of 90 minutes once per client, per provider. Additional prolonged non-face-to-face services may be authorized (with documentation) if there is one of the following significant changes in the client's clinical condition:

- The client will soon be, or has recently been, discharged from a prolonged and complicated hospitalization requiring coordination of complex care with multiple providers in order for the client to be adequately cared for in the home.
- Documentation of recent trauma resulting in new medical complications that require complex interdisciplinary care.
- The client has a new diagnosis of a medically complex condition requiring additional interdisciplinary care with additional specialists.

Authorization of care plan oversight or supervision (procedure codes 99339, 99340, 99374, 99375, 99377, and 99378) is limited to one service a month in a 6-month authorization period.

In order for authorization to be considered, the client must require complex and multidisciplinary care modalities involving regular clinician development or revision of care plans, review of subsequent reports of client status, and review of related laboratory and other studies, such as:

- Medically complex health care: Health care provided by a clinician that requires coordination of various treatment modalities or a multidisciplinary approach due to the client's moderate or severe health condition, physical or functional limitations, or health risk factors.
- Multidisciplinary health care: The coordination of clinician-ordered medically necessary health care that requires the collaboration of two or more medical, educational, social, developmental, or other professionals in order to properly devise and implement the clinician-developed plan of medical care. For CSHCN Services Program coverage, multidisciplinary health care must include medically necessary services provided by program-enrolled clinical providers. Development and implementation of the plan of medical care may, in addition, need to take into account other related care provided by nonclinical providers as required to address the overall health needs of a client.

Documentation of the following components must be submitted with the authorization form to obtain an initial authorization or renewal:

- A current medical summary, containing key information about the client's health (e.g., conditions, complexity, medications, allergies, past surgical procedures)
- A current list of the main concerns as well as key strengths and assets, and the related current clinical information
- Planned action steps or interventions to address the concerns and to sustain or build strengths, with the expected outcomes
- Persons responsible

- Timeframes or due dates

The supporting documentation can be in the form of the following:

- Formal written care plan
- Progress note detailing the care coordination planning
- Letter of medical necessity detailing the care plan oversight and care coordination

Authorization is limited to a maximum of 6 months. Subsequent periods of authorization require submission of a new request with documentation supporting medical necessity for ongoing services.

Non-face-to-face specialist or subspecialist telephone consultations do not require authorization.

31.2.14 Cochlear Implants

Cochlear implants and auditory rehabilitation are benefits for CSHCN Services Program clients.

Refer to: Section 20.3.2, "Cochlear Implants," on page 20-13 for more information about cochlear implants.

31.2.15 Colorectal Cancer Screening

Procedure codes 74263, 82270, G0104, G0105, G0106, G0120, G0121, G0122, and G0328 are benefits of the CSHCN Services Program. Only one procedure code will be allowed per rolling year by any provider. An additional screening may be considered on appeal with documentation that indicates the provider was unable to obtain the previous screening results from a different provider or the provider was new to treating the client and was not aware the client had already received colorectal cancer screening.

Refer to: Chapter 25, "Laboratory Services," on page 25-1 for additional information about laboratory cancer screening or pathology procedures.

Colorectal cancer screening is recommended once every 2 years for individuals at high risk for colorectal cancer. High-risk individuals include clients with one or more of the following factors:

- A close relative who has had colorectal cancer or an adenomatous polyp

Note: *"Relative" means close blood relatives, including first-degree male or female relatives (parents, siblings, or children), second-degree relatives (aunts, uncles, grandparents, nieces, nephews), and third-degree relatives (first cousins, great grandparents) who are on the same side of the family as the client.*

- Family history of familial adenomatous polyposis
- Family history of hereditary nonpolyposis colorectal cancer
- Personal history of colorectal cancer
- Personal history of adenomatous polyps

A screening barium enema may be substituted for a screening flexible sigmoidoscopy or a screening colonoscopy if the effectiveness has been established by the physician for substitution. Procedure code G0106 may be used as an alternative to procedure code G0104, and procedure code G0120 may be used as an alternative to procedure code G0105.

During the course of a screening flexible sigmoidoscopy, if a lesion or growth is detected that results in a biopsy or removal of the growth, an appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be reported instead of procedure code G0104 or G0106.

During the course of a screening colonoscopy, if a lesion or growth is detected that results in a biopsy or removal of the growth, the procedure code for a colonoscopy with biopsy or removal of lesion should be reported instead of procedure code G0105 or G0121.

31.2.16 Critical Care Services

Critical care is a benefit of the CSHCN Services Program. Authorization is not required for these services.

Critical care is the care of a critically ill client who requires constant physician attention. Critical care involves high-complexity decision making to access, manipulate, and support vital system functions. If the physician is not at bedside, he or she must be immediately available to the client. The physician must devote his or her full attention to the client and therefore, cannot render E/M services to any other client during the same period of time. Critical care is usually given in a critical care area, such as a coronary care unit, respiratory care unit, intensive care unit, pediatric intensive care unit, neonatal intensive care unit, or emergency department care facility.

Noncritical intensive care is a benefit for infants who are very low birth weight, low birth weight, or normal weight and do not meet the definition of critically ill but continue to require intensive observation, frequent interventions, and other intensive services only available in the intensive care setting.

Neonatal critical care is the comprehensive care of the critically ill neonate. The neonatal period is defined as the period from birth through the 28th day of life. Neonatal critical care codes are comprehensive per diem (daily) care codes for providers personally delivering or supervising the delivery of care of the critically ill neonate as an inpatient.

Newborn resuscitation is a benefit for high-risk newborns who require resuscitation.

Physician standby service requiring prolonged physician attendance, each 30 minutes (procedure code 99360), is not a benefit of the CSHCN Services Program.

In accordance with CPT, critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the client, provided that the client's condition continues to require the level of physician attention as described above.

General Limitations

Services for a client who is not, or is no longer, critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes, such as continuing intensive care (procedure codes 99478, 99479, and 99480) or subsequent hospital care (procedure codes 99231, 99232, and 99233).

Neonatal critical care (procedure codes 99468 and 99469), pediatric critical care (procedure codes 99471, 99472, 99475, and 99476), and the initial critical care (procedure code 99291) are limited to once per day for the same provider. Subsequent critical care (procedure code 99292) is each additional 30 minutes beyond the first 74 minutes of critical care, and is limited to a quantity of 6 units (3 hours) per day.

Neonatal and pediatric critical care (procedure codes 99468, 99469, 99471, 99472, 99475, and 99476) and continuing intensive care services (procedure codes 99478, 99479, and 99480) are inpatient, per-day charges and only billable once per day by any provider. No other inpatient E/M services may be reimbursed on the same day when billed by the same provider.

When the present body weight of a neonate exceeds 5,000 grams, a subsequent hospital care service (procedure code 99231, 99232, or 99233) should be used.

If the same physician provides critical care for a neonatal or pediatric client in both the outpatient and inpatient settings on the same day, the provider should report only the appropriate inpatient neonatal or pediatric critical care service (procedure codes 99468, 99469, 99471, 99472, 99475, and 99476).

E/M services provided on the same day by the same provider as surgical procedures that meet the definition of separately identifiable and above and beyond usual preoperative and postoperative care may be billed with modifier 25. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Critical care (procedure codes 99291, 99292, 99468, 99469, 99471, 99472, 99475, and 99476) is only billable by the provider rendering the critical care service while the client is critically ill. While providers from various specialties (e.g., cardiology or neurology) may be consulted to render an opinion or assist in the management of a particular portion of the care, only the provider managing the care of the critically ill client during a life threatening crisis may bill the critical care.

If a second physician provides critical care services on the same day at a separate and distinct time, the physician should report the appropriate time-based critical care service (procedure code 99291 or 99292).

Critical care totaling less than 30 minutes in duration on a given date should be reported with the appropriate E/M procedure code.

Actual time spent with the individual client should be recorded in the client's record and reflect the time billed on the claim. The time that can be reported as critical care is the time spent engaged in work directly related to the individual client's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.

The time spent in the following activities may not be included in the time reported as critical care:

- Activities that occur outside of the unit or off the floor because the physician is not immediately available to the client
- Activities that do not directly contribute to the treatment of the client even if they are performed in the critical care unit
- Performing separately reportable procedures or services

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

APRNs, physician assistants, and CRNAs may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for physicians for the same service.

Critical Care Services

Procedure codes 99291 and 99292 are used to identify critical care services provided to clients who are 6 years of age or older.

Procedure code 99291 should be used per day for the first 30 to 74 minutes of critical care even if the time spent by the physician is not continuous on that day.

Critical care procedure codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous.

Critical care provided to a neonatal, pediatric, or adult client in an outpatient setting (e.g., emergency room) which does not result in admission, must be billed using procedure codes 99291 and 99292.

If outpatient critical care (procedure codes 99291 and 99292) is provided to a client at a distinctly separate time than another outpatient E/M service by the same provider, both services may be reimbursed with supporting medical record documentation.

If critical care (procedure code 99291) is provided by different physicians that meet the initial 30-minute time requirement, and the care is provided at separate distinct times, the initial provider's claim may be reimbursed. The second provider's claim will be denied but may be considered on appeal. The time spent by each physician cannot overlap (i.e., two physicians cannot bill critical care for care delivered at the same time). Supporting medical record documentation must be provided by the second physician that includes the time in which the critical care was rendered. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill client during the life-threatening crisis.

If the provider's time exceeds the 74-minute time threshold for procedure code 99291, procedure code 99292 may be billed in addition to procedure code 99291 for each additional 30 minutes.

Procedure code 99292 must be billed by the same performing provider or by a member of the same performing provider's group practice.

Procedure code 99292 is limited to six units per day (3 hours), any provider. If the number of units is not stated on the claim, only a quantity of one will be allowed.

Retrospective review may be performed to ensure the documentation supports the medical necessity of the service and any modifier used when billing the claim.

31.2.16.1 Pediatric Critical Care

Procedure codes 99471, 99472, 99475, and 99476 are used to identify pediatric critical care services provided to clients who are 29 days through 24 months of age.

Pediatric critical care services are comprehensive per diem (daily) care procedure codes for providers personally delivering or supervising the delivery of care of the critically ill infant or child.

Inpatient pediatric critical care (procedure codes 99471, 99472, 99475, and 99476) is a per-day charge.

31.2.16.2 Neonatal Critical Care

Procedure codes 99468 and 99469 are used to identify neonatal critical care services provided to clients who are 28 days of age or younger.

Procedure code 99468 is used for the first day of admission for a critically ill neonate, 28 days of age or younger, and may be reimbursed once per day, any provider.

Procedure code 99468 must be billed for the initial day of neonatal critical care irrespective of the time that the provider spends with the client.

Procedure code 99469 must be billed for subsequent neonatal critical care per day, irrespective of the time that the provider spends directing the care of the critically ill neonate or infant that is 28 days of age or younger.

Procedure code 99469 may be reimbursed once per day, any provider.

After the neonate is no longer considered critically ill, the E/M procedure codes for subsequent hospital care (procedure codes 99231, 99232, and 99233) or subsequent intensive care (procedure codes 99478, 99479, and 99480) must be used.

If the infant remains in critical care after the 28th day of age, on the 29th day of age, the provider must bill pediatric critical care codes (procedure codes 99471 and 99472).

Neonatal intensive or critical care procedure codes 99468, 99469, 99477, 99478, 99479, and 99480 are inpatient, per day charges and only billable once per day by any provider.

31.2.16.3 Intensive Care (Noncritical) Services

Initial hospital care provided to neonates who require intensive observation, frequent interventions, and other intensive services may be billed using procedure code 99477. Subsequent intensive care provided to very low birth weight, low birth weight, and normal weight infants who do not meet the definition of critically ill but continue to require intensive observation, frequent interventions, and other intensive services only available in the intensive care setting, may be billed using procedure codes 99478, 99479, and 99480.

31.2.16.4 Newborn Resuscitation

Newborn resuscitation may be billed using procedure code 99465.

Procedure code 99465 may be reimbursed for clients birth through 28 days of age. For cardiopulmonary resuscitation performed on clients 29 days of age or older, providers must bill procedure code 92950. Procedure code 92950 may be billed on the same day as critical care (procedure codes 99291, 99292, 99468, 99469, 99471, 99472, 99475, and 99476) when reported as a separately identifiable procedure.

Procedure code 99465 must be used by the provider who performs the resuscitation.

31.2.17 Echoencephalography

31.2.17.1 Intraoperative Echography

Procedure code 76506 is a benefit of the CSHCN Services Program with the following diagnosis codes:

Diagnosis Code	Description
0065	Amebic brain abscess
01300	Tuberculous meningitis, confirmation unspecified
01301	Tuberculous meningitis, bacteriological or histological examination not done
01302	Tuberculous meningitis, bacteriological or histological examination results unknown (at present)
01303	Tuberculous meningitis, tubercle bacilli found (in sputum) by microscopy
01304	Tuberculous meningitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01305	Tuberculous meningitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01306	Tuberculous meningitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01310	Tuberculoma of meninges, confirmation unspecified
01311	Tuberculoma of meninges, bacteriological or histological examination not done
01312	Tuberculoma of meninges, bacteriological or histological examination results unknown (at present)
01313	Tuberculoma of meninges, tubercle bacilli found (in sputum) by microscopy
01314	Tuberculoma of meninges, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01315	Tuberculoma of meninges, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01316	Tuberculoma of meninges, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01320	Tuberculoma of brain, confirmation unspecified
01321	Tuberculoma of brain, bacteriological or histological examination not done
01322	Tuberculoma of brain, bacteriological or histological examination results unknown (at present)
01323	Tuberculoma of brain, bacteriological or histological examination results unknown (at present)
01324	Tuberculoma of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01325	Tuberculoma of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01326	Tuberculoma of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01330	Tuberculous abscess of brain, confirmation unspecified
01331	Tuberculous abscess of brain, bacteriological or histological examination not done

Diagnosis Code	Description
01332	Tuberculous abscess of brain, bacteriological or histological examination results unknown (at present)
01333	Tuberculous abscess of brain, tubercle bacilli found (in sputum) by microscopy
01334	Tuberculous abscess of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01335	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01336	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01340	Tuberculoma of spinal cord, confirmation unspecified
01341	Tuberculoma of spinal cord, bacteriological or histological examination not done
01342	Tuberculoma of spinal cord, bacteriological or histological examination results unknown (at present)
01343	Tuberculoma of spinal cord, tubercle bacilli found (in sputum) by microscopy
01344	Tuberculoma of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01345	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01346	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01350	Tuberculous abscess of spinal cord, confirmation unspecified
01351	Tuberculous abscess of spinal cord, bacteriological or histological examination not done
01352	Tuberculous abscess of spinal cord, bacteriological or histological examination results unknown (at present)
01353	Tuberculous abscess of spinal cord, tubercle bacilli found (in sputum) by microscopy
01354	Tuberculous abscess of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01355	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01356	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01360	Tuberculous encephalitis or myelitis, confirmation unspecified
01361	Tuberculous encephalitis or myelitis, bacteriological or histological examination not done
01362	Tuberculous encephalitis or myelitis, bacteriological or histological examination results unknown (at present)
01363	Tuberculous encephalitis or myelitis, tubercle bacilli found (in sputum) by microscopy
01364	Tuberculous encephalitis or myelitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture

Diagnosis Code	Description
01365	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01366	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01380	Other specified tuberculosis of central nervous system, confirmation unspecified
01381	Other specified tuberculosis of central nervous system, bacteriological or histological examination not done
01382	Other specified tuberculosis of central nervous system, bacteriological or histological examination results unknown (at present)
01383	Other specified tuberculosis of central nervous system, tubercle bacilli found (in sputum) by microscopy
01384	Other specified tuberculosis of central nervous system, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01385	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01386	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
1700	Malignant neoplasm of bones of skull and face, except mandible
1901	Malignant neoplasm of orbit
1910	Malignant neoplasm of cerebrum, except lobes and ventricles
1911	Malignant neoplasm of frontal lobe of brain
1912	Malignant neoplasm of temporal lobe of brain
1913	Malignant neoplasm of parietal lobe of brain
1914	Malignant neoplasm of occipital lobe of brain
1915	Malignant neoplasm of ventricles of brain
1916	Malignant neoplasm of cerebellum NOS
1917	Malignant neoplasm of brain stem
1918	Malignant neoplasm of other parts of brain
1919	Malignant neoplasm of brain, unspecified site
1920	Malignant neoplasm of cranial nerves
1921	Malignant neoplasm of cerebral meninges
1943	Malignant neoplasm of pituitary gland and craniopharyngeal duct
1983	Secondary malignant neoplasm of brain and spinal cord
1984	Secondary malignant neoplasm of other parts of nervous system
1985	Secondary malignant neoplasm bone and bone marrow
19889	Secondary malignant neoplasm of other specified sites
2130	Benign neoplasm of bones of skull and face
2241	Benign neoplasm of orbit
2250	Benign neoplasm of brain
2251	Benign neoplasm of cranial nerves
2252	Benign neoplasm of cerebral meninges

Diagnosis Code	Description
2270	Benign neoplasm of adrenal gland
2340	Carcinoma in situ of eye
2348	Carcinoma in situ of other specified sites
2375	Neoplasm of uncertain behavior of brain and spinal cord
2376	Neoplasm of uncertain behavior of meninges
2379	Neoplasm of uncertain behavior of other and unspecified parts of nervous system
2380	Neoplasm of uncertain behavior of bone and articular cartilage
2388	Neoplasm of uncertain behavior of other specified sites
2392	Neoplasms of unspecified nature of bone, soft tissue, and skin
2396	Neoplasm of unspecified nature of brain
2397	Neoplasm of unspecified nature of endocrine glands and other parts of nervous system
29010	Presenile dementia, uncomplicated
3240	Intracranial abscess
3249	Intracranial and intraspinal abscess of unspecified site
325	Phlebitis and thrombophlebitis of intracranial venous sinuses
3310	Alzheimer's disease
33111	Pick's disease
33119	Other frontotemporal dementia
3312	Senile degeneration of brain
3313	Communicating hydrocephalus
3314	Obstructive hydrocephalus
3315	Idiopathic normal pressure hydrocephalus (INPH)
3317	Cerebral degeneration in diseases classified elsewhere
33181	Reye's syndrome
33182	Dementia with Lewy bodies
33189	Other cerebral degeneration
3319	Unspecified cerebral degeneration
3480	Cerebral cysts
3482	Benign intracranial hypertension
34830	Encephalopathy, unspecified
34831	Metabolic encephalopathy
34839	Other encephalopathy
3484	Compression of brain
3485	Cerebral edema
37700	Unspecified papilledema
37701	Papilledema associated with increased intracranial pressure
37702	Papilledema associated with decreased ocular pressure
37703	Papilledema associated with retinal disorder
37704	Foster-Kennedy syndrome
37710	Unspecified optic atrophy

Diagnosis Code	Description
37711	Primary optic atrophy
37712	Postinflammatory optic atrophy
37713	Optic atrophy associated with retinal dystrophies
37714	Glaucomatous atrophy (cupping) of optic disc
37715	Partial optic atrophy
37716	Hereditary optic atrophy
37721	Drusen of optic disc
37722	Crater-like holes of optic disc
37723	Coloboma of optic disc
37724	Pseudopapilledema
37730	Unspecified optic neuritis
37731	Optic papillitis
37732	Retrobulbar neuritis (acute)
37733	Nutritional optic neuropathy
37734	Toxic optic neuropathy
37739	Other optic neuritis
37741	Ischemic optic neuropathy
37742	Hemorrhage in optic nerve sheaths
37749	Other disorders of optic nerve
37751	Disorders of optic chiasm associated with pituitary neoplasms and disorders
37752	Disorders of optic chiasm associated with other neoplasms
37753	Disorders of optic chiasm associated with vascular disorders
37754	Disorders of optic chiasm associated with inflammatory disorders
37761	Disorders of other visual pathways associated with neoplasms
37762	Disorders of other visual pathways associated with vascular disorders
37763	Disorders of other visual pathways associated with inflammatory disorders
37771	Disorders of visual cortex associated with neoplasms
37772	Disorders of visual cortex associated with vascular disorders
37773	Disorders of visual cortex associated with inflammatory disorders
37775	Disorders of visual cortex associated with cortical blindness
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
4320	Nontraumatic extradural hemorrhage
4321	Subdural hemorrhage
4329	Unspecified intracranial hemorrhage
43400	Cerebral thrombosis without mention of cerebral infarction
43401	Cerebral thrombosis with cerebral infarction
43410	Cerebral embolism without mention of cerebral infarction
43411	Cerebral embolism with cerebral infarction
43490	Unspecified cerebral artery occlusion without mention of cerebral infarction
43491	Unspecified cerebral artery occlusion with cerebral infarction

Diagnosis Code	Description
436	Acute, but ill-defined, cerebrovascular disease
4371	Other generalized ischemic cerebrovascular disease
4373	Cerebral aneurysm, nonruptured
74100	Spina bifida with hydrocephalus, unspecified region
74101	Spina bifida with hydrocephalus, cervical region
74102	Spina bifida with hydrocephalus, dorsal (thoracic) region
74103	Spina bifida with hydrocephalus, lumbar region
7420	Encephalocele
7421	Microcephalus
7422	Congenital reduction deformities of brain
7423	Congenital hydrocephalus
7424	Other specified congenital anomalies of brain
74781	Congenital anomaly of cerebrovascular system
77210	Intraventricular hemorrhage, unspecified grade
77211	Intraventricular hemorrhage, Grade I
77212	Intraventricular hemorrhage, Grade II
77213	Intraventricular hemorrhage, Grade III
77214	Intraventricular hemorrhage, Grade IV
7722	Fetal and neonatal subarachnoid hemorrhage of newborn
7790	Convulsions in newborn
7797	Periventricular leukomalacia
78031	Febrile convulsions (simple), unspecified
78039	Other convulsions
7842	Swelling in the head and neck
8500	Concussion with no loss of consciousness
85011	Concussion with loss of consciousness of 30 minutes or less
85012	Concussion with loss of consciousness 31 to 59 minutes
8502	Concussion with moderate (1-24 hours) loss of consciousness
8503	Concussion with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
8504	Concussion with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
8505	Concussion with loss of consciousness of unspecified duration
8509	Unspecified concussion
85100	Cortex (cerebral) contusion without mention of open intracranial wound, state of consciousness unspecified
85101	Cortex (cerebral) contusion without mention of open intracranial wound, no loss of consciousness
85102	Cortex (cerebral) contusion without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness
85103	Cortex (cerebral) contusion without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness

Diagnosis Code	Description
85104	Cortex (cerebral) contusion without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-exisiting conscious level
85105	Cortex (cerebral) contusion without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85106	Cortex (cerebral) contusion without mention of open intracranial wound, loss of consciousness of unspecified duration
85109	Cortex (cerebral) contusion without mention of open intracranial wound, unspecified concussion
85110	Cortex (cerebral) contusion with open intracranial wound, without mention of specific state of consciousness
85111	Cortex (cerebral) contusion with open intracranial wound, no loss of consciousness
85112	Cortex (cerebral) contusion with open intracranial wound, brief (less than 1 hour) loss of consciousness
85113	Cortex (cerebral) contusion with open intracranial wound, moderate (1-24 hours) loss of consciousness
85114	Cortex (cerebral) contusion with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85115	Cortex (cerebral) contusion with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85116	Cortex (cerebral) contusion with open intracranial wound, loss of consciousness of unspecified duration
85119	Cortex (cerebral) contusion with open intracranial wound, unspecified concussion
85120	Cortex (cerebral) laceration without mention of open intracranial wound, unspecified state of consciousness
85121	Cortex (cerebral) laceration without mention of open intracranial wound, no loss of consciousness
85122	Cortex (cerebral) laceration without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness
85123	Cortex (cerebral) laceration without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness
85124	Cortex (cerebral) laceration without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85125	Cortex (cerebral) laceration without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85126	Cortex (cerebral) laceration without mention of open intracranial wound, loss of consciousness of unspecified duration
85129	Cortex (cerebral) laceration without mention of open intracranial wound, unspecified concussion
85130	Cortex (cerebral) laceration with open intracranial wound, unspecified state of consciousness
85131	Cortex (cerebral) laceration with open intracranial wound, no loss of consciousness

Diagnosis Code	Description
85132	Cortex (cerebral) laceration with open intracranial wound, brief (less than 1 hour) loss of consciousness
85133	Cortex (cerebral) laceration with open intracranial wound, moderate (1-24 hours) loss of consciousness
85134	Cortex (cerebral) laceration with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85135	Cortex (cerebral) laceration with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85136	Cortex (cerebral) laceration with open intracranial wound, loss of consciousness of unspecified duration
85139	Cortex (cerebral) laceration with open intracranial wound, unspecified concussion
85140	Cerebellar or brain stem contusion without mention of open intracranial wound, unspecified state of consciousness
85141	Cerebellar or brain stem contusion without mention of open intracranial wound, no loss of consciousness
85142	Cerebellar or brain stem contusion without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness
85143	Cerebellar or brain stem contusion without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness
85144	Cerebellar or brain stem contusion without mention of open intracranial wound, prolonged (more than 24 hours) loss consciousness and return to pre-existing conscious level
85145	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85146	Cerebellar or brain stem contusion without mention of open intracranial wound, loss of consciousness of unspecified duration
85150	Cerebellar or brain stem contusion with open intracranial wound, unspecified state of consciousness
85151	Cerebellar or brain stem contusion with open intracranial wound, no loss of consciousness
85152	Cerebellar or brain stem contusion with open intracranial wound, brief (less than 1 hour) loss of consciousness
85153	Cerebellar or brain stem contusion with open intracranial wound, moderate (1-24 hours) loss of consciousness
85154	Cerebellar or brain stem contusion with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85155	Cerebellar or brain stem contusion with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85156	Cerebellar or brain stem contusion with open intracranial wound, loss of consciousness of unspecified duration
85159	Cerebellar or brain stem contusion with open intracranial wound, unspecified concussion
85160	Cerebellar or brain stem laceration without mention of open intracranial wound, unspecified state of consciousness

Diagnosis Code	Description
85161	Cerebellar or brain stem laceration without mention of open intracranial wound, no loss of consciousness
85162	Cerebellar or brain stem laceration without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness
85163	Cerebellar or brain stem laceration without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness
85164	Cerebellar or brain stem laceration without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85165	Cerebellar or brain stem laceration without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85166	Cerebellar or brain stem laceration without mention of open intracranial wound, loss of consciousness of unspecified duration
85169	Cerebellar or brain stem laceration without mention of open intracranial wound, unspecified concussion
85170	Cerebellar or brain stem laceration with open intracranial wound, state of consciousness unspecified
85171	Cerebellar or brain stem laceration with open intracranial wound, no loss of consciousness
85172	Cerebellar or brain stem laceration with open intracranial wound, brief (less than one hour) loss of consciousness
85173	Cerebellar or brain stem laceration with open intracranial wound, moderate (1-24 hours) loss of consciousness
85174	Cerebellar or brain stem laceration with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85175	Cerebellar or brain stem laceration with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85176	Cerebellar or brain stem laceration with open intracranial wound, loss of consciousness of unspecified duration
85179	Cerebellar or brain stem laceration with open intracranial wound, unspecified concussion
85180	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, unspecified state of consciousness
85181	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, no loss of consciousness
85182	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, brief (less than one hour) loss of consciousness
85183	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness
85184	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85185	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

Diagnosis Code	Description
85186	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, loss of consciousness of unspecified duration
85189	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, unspecified concussion
85190	Other and unspecified cerebral laceration and contusion, with open intracranial wound, unspecified state of consciousness
85191	Other and unspecified cerebral laceration and contusion, open intracranial wound, no loss of consciousness
85192	Other and unspecified cerebral laceration and contusion, open intracranial wound, brief (less than 1 hour) loss of consciousness
85193	Other and unspecified cerebral laceration and contusion, open intracranial wound, moderate (1-24 hours) loss of consciousness
85194	Other and unspecified cerebral laceration and contusion, open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85195	Other and unspecified cerebral laceration and contusion, open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85196	Other and unspecified cerebral laceration and contusion, open intracranial wound, loss of consciousness of unspecified duration
85199	Other and unspecified cerebral laceration and contusion, open intracranial wound, unspecified concussion
85200	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, unspecified state of consciousness
85201	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, no loss of consciousness
85202	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, brief (less than one hour) loss of consciousness
85203	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness
85204	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85205	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85206	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, loss of consciousness of unspecified duration
85209	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, unspecified concussion
85210	Subarachnoid hemorrhage following injury, with open intracranial wound, unspecified state of consciousness
85211	Subarachnoid hemorrhage following injury, with open intracranial wound, no loss of consciousness
85212	Subarachnoid hemorrhage following injury, with open intracranial wound, brief (less than 1 hour) loss of consciousness
85213	Subarachnoid hemorrhage following injury, with open intracranial wound, moderate (1-24 hours) loss of consciousness

Diagnosis Code	Description
85214	Subarachnoid hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85215	Subarachnoid hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85216	Subarachnoid hemorrhage following injury, with open intracranial wound, loss of consciousness of unspecified duration
85219	Subarachnoid hemorrhage following injury, with open intracranial wound, unspecified concussion
85220	Subdural hemorrhage following injury, without mention of open intracranial wound, state of consciousness unspecified
85221	Subdural hemorrhage following injury, without mention of open intracranial wound, no loss of consciousness
85222	Subdural hemorrhage following injury, without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness
85223	Subdural hemorrhage following injury, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness
85224	Subdural hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85225	Subdural hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85226	Subdural hemorrhage following injury, without mention of open intracranial wound, loss of consciousness of unspecified duration
85229	Subdural hemorrhage following injury, without mention of open intracranial wound, unspecified concussion
85230	Subdural hemorrhage following injury, with open intracranial wound, state of consciousness unspecified
85231	Subdural hemorrhage following injury, with open intracranial wound, no loss of consciousness
85232	Subdural hemorrhage following injury, with open intracranial wound, brief (less than 1 hour) loss of consciousness
85233	Subdural hemorrhage following injury, with open intracranial wound, moderate (1-24 hours) loss of consciousness
85234	Subdural hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85235	Subdural hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85236	Subdural hemorrhage following injury, with open intracranial wound, loss of consciousness of unspecified duration
85239	Subdural hemorrhage following injury, with open intracranial wound, unspecified concussion
85240	Extradural hemorrhage following injury, without mention of open intracranial wound, state of consciousness unspecified

Diagnosis Code	Description
85241	Extradural hemorrhage following injury, without mention of open intracranial wound, no loss of consciousness
85242	Extradural hemorrhage following injury, without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness
85243	Extradural hemorrhage following injury, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness
85244	Extradural hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85245	Extradural hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85246	Extradural hemorrhage following injury, without mention of open intracranial wound, loss of consciousness of unspecified duration
85249	Extradural hemorrhage following injury, without mention of open intracranial wound, unspecified concussion
85250	Extradural hemorrhage following injury, with open intracranial wound, state of consciousness unspecified
85251	Extradural hemorrhage following injury, with open intracranial wound, no loss of consciousness
85252	Extradural hemorrhage following injury, with open intracranial wound, brief (less than 1 hour) loss of consciousness
85253	Extradural hemorrhage following injury, with open intracranial wound, moderate (1-24 hours) loss of consciousness
85254	Extradural hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85255	Extradural hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85256	Extradural hemorrhage following injury, with open intracranial wound, loss of consciousness of unspecified duration
85259	Extradural hemorrhage following injury, with open intracranial wound, unspecified concussion
85300	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, state of consciousness unspecified
85301	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, no loss of consciousness
85302	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness
85304	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to preexisting conscious level
85305	Other and unspecified intracranial hemorrhage following injury. without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

Diagnosis Code	Description
85306	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, loss of consciousness of unspecified duration
85309	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, unspecified concussion
85310	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, state of consciousness unspecified
85311	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, no loss of consciousness
85312	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, brief (less than 1 hour) loss of consciousness
85313	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, moderate (1-24 hours) loss of consciousness
85314	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85315	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85316	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, loss of consciousness of unspecified duration
85319	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, unspecified concussion
85400	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, state of consciousness unspecified
85401	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, no loss of consciousness
85402	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness
85403	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness
85404	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85405	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85406	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, loss of consciousness of unspecified duration
85409	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with unspecified concussion
85410	Intracranial injury of other and unspecified nature, with open intracranial wound, unspecified state of consciousness
85411	Intracranial injury of other and unspecified nature, with open intracranial wound, no loss of consciousness
85412	Intracranial injury of other and unspecified nature, with open intracranial wound, brief (less than 1 hour) loss of consciousness
85413	Intracranial injury of other and unspecified nature, with open intracranial wound, moderate (1-24 hours) loss of consciousness

Diagnosis Code	Description
85414	Intracranial injury of other and unspecified nature, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85415	Intracranial injury of other and unspecified nature, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85416	Intracranial injury of other and unspecified nature, with open intracranial wound, loss of consciousness of unspecified duration
85419	Intracranial injury of other and unspecified nature, with open intracranial wound, unspecified concussion
95901	Head injury nos

31.2.17.2 Ambulatory Electroencephalogram

Ambulatory electroencephalographic monitoring is a benefit of the CSHCN Services Program with the following diagnosis codes:

Diagnosis Code	Description
2930	Delirium due to conditions classified elsewhere
2948	Other persistent mental disorders due to conditions classified elsewhere
3315	Idiopathic normal pressure hydrocephalus (INPH)
3332	Myoclonus
34500	Generalized nonconvulsive epilepsy without mention of intractable epilepsy
34501	Generalized nonconvulsive epilepsy with intractable epilepsy
34510	Generalized convulsive epilepsy without mention of intractable epilepsy
34511	Generalized convulsive epilepsy with intractable epilepsy
3452	Epileptic petit mal status
3453	Epileptic grand mal status
34540	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy
34541	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy
34550	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy
34551	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy
34560	Infantile spasms without mention of intractable epilepsy
34561	Infantile spasms with intractable epilepsy
34570	Epilepsia partialis continua without mention of intractable epilepsy
34571	Epilepsia partialis continua with intractable epilepsy
34580	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy
34581	Other forms of epilepsy and recurrent seizures, with intractable epilepsy
34590	Unspecified epilepsy without mention of intractable epilepsy
34591	Unspecified epilepsy with intractable epilepsy
34881	Temporal sclerosis
34889	Other conditions of the brain

Diagnosis Code	Description
7797	Perventricular leukomalacia
78033	Post traumatic seizures
78039	Other convulsions
V1085	Personal history of malignant neoplasm of brain
V1086	Personal history of malignant neoplasm of other parts of nervous system
V1090	Personal history of unspecified type of malignant neoplasm
V1091	Personal history of malignant neuroendocrine tumor
V1240	Unspecified disorder of nervous system and sense organs
V1241	Benign neoplasm of the brain
V1249	Other disorders of nervous system and sense organs
V1363	Personal history of other (corrected) congenital malformations of nervous system
V1369	Personal history of other (corrected) congenital malformation

Procedure code 95950, 95951, 95953, 95956, or 95957 must be used when billing for ambulatory electroencephalograms. Authorization is not required for the diagnoses listed above. All other diagnoses require authorization and documentation of medical necessity. Documentation should include the diagnosis and the specific rationale for the request. Claims for ambulatory electroencephalographic monitoring are considered for payment on appeal for diagnoses other than those listed above or if the frequency of testing exceeds the limitation.

Ambulatory electroencephalograms are limited to three every 6 months, per client, same provider. Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid for the procedure.

31.2.18 Evaluation and Management (E/M) Services

E/M services are benefits of the CSHCN Services Program. Medical documentation for E/M services must consist of the appropriate components (e.g., history, physical exam, medical decision making) as designated in the *Evaluation and Management (E/M) Services Guidelines* as published by CMS and in the CPT manual.

Covered professional services provided by physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. This manual may not list all E/M procedure codes that may be reimbursed by the CSHCN Services Program.

31.2.18.1 New or Established Patient Visits

New patient visits will be allowed every 3 years for physician E/M services, per client, per provider.

A new patient is defined by the American Medical Association (AMA) as one who has not received any professional services from a physician or physician within the same group practice, of the same specialty, within the past 3 years. An established patient is one who has received professional services from a physician or physician within the same group practice, of the same specialty, within the last 3 years.

Providers may use procedure codes 99201, 99202, 99203, 99204, and 99205 when billing for new patient services provided in the office, or in an outpatient or other ambulatory facility.

Providers may use procedure codes 99211, 99212, 99213, 99214, and 99215 when billing for established patient services provided in the office, outpatient, or other ambulatory facility during regularly scheduled evening, weekend, holiday, or standard office hours.

Providers may use procedure codes 99341, 99342, 99343, 99344, and 99345 when billing for new patient services provided in the home.

Providers may use procedure codes 99347, 99348, 99349, and 99350 when billing for established patient services provided in the home.

If an established patient visit is billed on the same day as a new patient visit in any setting by the same provider for any diagnosis, the established patient visit will be denied as part of another procedure on the same day. New or established patient care visits are limited to one per day for the same provider regardless of diagnosis.

Office visits (procedure codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) provided on the same day as a planned procedure (minor or extensive), are included in the cost of the procedure and are not separately reimbursed.

Modifier 25 may be used to identify a significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request. The documentation must clearly indicate what the significant problem/abnormality was, including the important, distinct correlation with signs and symptoms to demonstrate a distinctly different problem that required additional work and must support that the requirements for the level of service billed were met or exceeded. The date and time of both services performed must be outlined in the medical record and the time of the second service must be different than the time of the first service, although a different diagnosis is not required.

31.2.18.2 Inpatient Professional Services

Initial and Subsequent Hospital Care (Nonintensive Care)

Initial or subsequent hospital visits (procedure codes 99221, 99222, 99223, 99231, 99232, and 99233), observation (procedure codes 99234, 99235, and 99236), and discharge (procedure codes 99238 and 99239) are limited to one per day for the same provider.

If a subsequent hospital visit (99231, 99232, and 99233) following admission is billed on the same day by the same provider as an emergency department visit (99281, 99282, 99283, 99284, and 99285), an office visit (procedure codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215), or an outpatient consultation (procedure codes 99241, 99242, 99243, 99244, and 99245), the subsequent hospital visit will be paid and the other visits will be denied.

Only one initial hospital care visit may be paid to the same provider within a 30-day period regardless of diagnosis. Subsequent care visits may be considered for reimbursement during this time period.

A subsequent hospital visit (procedure codes 99231, 99232, and 99233) may be reimbursed on the same day to the same provider when critical care services (procedure codes 99291 and 99292) are billed.

E/M services provided in a hospital setting following a major procedure, provided by the same provider or in direct follow-up for postsurgical care, are included in the surgeon's global surgical fee and are denied as included in another procedure.

A physician who did not perform the surgery and provides postoperative surgical care in the time frame that is included in the global surgical fee must bill with modifier 55. This may only be done when the surgeon submits a charge for surgical care only and there is an agreement between the physicians and the surgeon to split the care of the client.

Hospital Discharge Day Management

Discharge management (procedure codes 99238 and 99239) billed on the same date of service as the admission by the same provider will be denied.

Discharge management (procedure codes 99238 and 99239) billed on the same date of service as an emergency room visit by the same provider is denied, but may be considered for reimbursement upon appeal, if provided at a separate time.

Only one discharge management service will be considered for reimbursement per day. Subsequent hospital visits billed on the same day as discharge management, by the same provider, will be denied.

Initial or subsequent hospital visit codes (procedure codes 99221, 99222, and 99223) billed on the same day as hospital discharge day management (procedure code 99238) is denied as part of another procedure billed on the same day.

Concurrent Inpatient Care

Concurrent care exists when services are provided to a client by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances require the skills of different specialties to successfully manage the client in accordance with accepted standards of good medical practice.

Concurrent care will not be paid to providers of the same specialty for the same or related diagnoses. Diagnoses are considered to be related when there is a 3-digit match of the primary diagnosis code. Denied concurrent care may be considered on an appeal basis when accompanied by documentation of medical necessity.

Concurrent care may be considered for reimbursement to providers of different specialties when providing services for unrelated diagnoses involving different organ systems.

31.2.18.3 Emergency Services

An emergency medical condition is defined as a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that if not immediately treated must reasonably be expected to result in one of the following outcomes:

- Placing the client's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who require immediate medical attention. The facility must be available to provide services 24 hours a day, 7 days a week.

Hospital-Based Emergency Department Professional Services

Physicians may use procedure codes 99281, 99282, 99283, 99284, and 99285 to bill for services provided in the hospital-based emergency department. Office-based physicians may also use procedure codes 99201, 99202, 99203, 99204, and 99205 for new patients or procedure codes 99211, 99212, 99213, 99214, and 99215 for established patients, to bill for services provided in the office or in a hospital-based emergency department. These procedure codes are also appropriate for a physician who is attending a client in an outpatient observation room setting for less than 6 hours. Document the time for multiple visits in Block 24K of the CMS-1500 paper claim form.

Emergency department visits include the components of a diagnostic examination such as a pelvic or rectal examination. These components should not be billed with an unlisted procedure code in addition to the procedure code for the visit. These components are considered part of the examination and no separate reimbursement may be provided.

Multiple emergency department visits on the same day and billed by the same provider must have the times for each visit documented on the claim form. More than one visit on the same day can also be indicated by adding the appropriate modifier to the claim form. Medical documentation is required to support this charge.

Emergency department visits may be paid to different providers on the same day, when medically necessary, regardless of specialty and diagnosis.

Separate charges are allowed for emergency department treatment room and minor surgery or diagnostic procedures billed on the same day. Use the appropriate procedure code from the CPT manual.

Payment for an additional emergency department visit by an anesthesiologist following a surgical procedure is denied as part of the global anesthesia payment (base plus time). A distinct and separate diagnosis beyond the diagnosis for which the global anesthesia services were provided should be documented in order for payment to be considered on an appeal basis.

If an emergency department visit (procedure codes 99281, 99282, 99283, 99284, and 99285) is billed on the same day, by the same provider, as an office visit (procedure codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215), or outpatient consultation (procedure codes 99241, 99242, 99243, 99244, and 99245), the emergency department visit may be considered for reimbursement and the office or consultation visit is denied.

Emergency department visits (procedure codes 99281, 99282, 99283, 99284, and 99285) are denied when billed on the same day as an observation service (procedure code 99217) by the same provider.

Critical care provided on the same day as an emergency room visit may be billed when the services are rendered during a separate encounter. Medical documentation is required to support this charge.

Binocular microscopy (procedure code 92504) and noninvasive ear or pulse oximetry for oxygen (procedure code 94760) will be denied when billed on the same day, by the same provider, as emergency department visit (procedure code 99281, 99282, 99283, 99284, or 99285).

31.2.18.4 Consultations

A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. To be billed as such, a consultation must consist of the following:

- There must be a request from the referring provider for the evaluation of a particular condition or illness.
- There must be correspondence from the consulting provider back to the referring provider indicating the medical findings.

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary. If treatment is initiated and the client returns for follow up care, an established patient visit should be billed. If the purpose of the referral is to transfer care, a consultation may not be billed.

The medical records maintained by both the referring and consulting providers must identify their counterpart and reason for consultation.

Consultations may be billed using the following procedure codes:

Procedure Codes				
99241	99242	99243	99244	99245
99251	99252	99253	99254	99255

31.2.18.5 Services Outside of Business Hours

The CSHCN Services Program limits reimbursement for after hours charges (procedure codes 99050, 99056, and 99060) to office-based providers rendering services after routine office hours or on an emergency basis.

An office-based provider may bill an after hours charge in addition to a visit for providing services after routine office hours. After hours charges may be billed when the provider's clinical judgment deems it medically necessary to interrupt the routine schedule to care for a client with an emergent condition. A provider's routine office hours are those hours posted at the physician's office as the usual office hours. The CSHCN Services Program may reimburse office-based physicians when any of the following exists:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician's routine office hours.
- The physician is interrupted from routine office hours to attend to another client's emergency outside of the office.

Procedure codes 99050, 99056, and 99060 are not reimbursed separately to emergency department-based physicians or emergency department-based groups.

31.2.18.6 Prolonged Physician Services

Prolonged services (procedure codes 99354, 99355, 99356, and 99357) may be provided in an office, outpatient, or inpatient setting and involves direct (face-to-face) client contact that is beyond the usual service and exceeds the time threshold of the E/M procedure code (listed in the table below) being billed on that day:

Procedure Codes						
99201	99202	99203	99204	99205	99211	99212
99213	99214	99215	99221	99222	99223	99231
99232	99233	99241	99242	99243	99244	99245
99251	99252	99253	99254	99255	99341	99342
99343	99344	99345	99347	99348	99349	99350

Procedure codes 99354 and 99356 should be used in conjunction with the E/M code to report the first hour of prolonged service and are limited to one per day.

Procedure codes 99355 and 99357 should be used to report each additional 30 minutes and are limited to a quantity of three units or 1 ½ hours per day.

Prolonged services of less than 30 minutes duration should not be reported separately.

Prolonged services in the inpatient setting may be considered for reimbursement on the same day as an initial hospital visit (procedure codes 99221, 99222, 99223, 99251, 99252, 99253, 99254, or 99255) or a subsequent hospital visit (procedure codes 99231, 99232, 99233, 99251, 99252, 99253, 99254, or 99255).

Prolonged physician services are not reimbursed in addition to critical care and/or emergency room visits billed on the same day.

Procedure code 99360 is not a benefit of the CSHCN Services Program.

31.2.18.7 Observation Room Services

Physician outpatient hospital observation room services (procedure codes 99217, 99218, 99219, 99220, 99224, 99225, and 99226) are for professional services for a period of more than 6 hours, but less than 24 hours, regardless of the hour of the initial contact, whether or not the client remains under physician care past midnight. Observation may take place in any client care area of the hospital or outpatient setting.

When a client's status changes from observation to inpatient, the date of inpatient admission is the date the client was admitted to the hospital as an inpatient. Charges are to be billed as specified in Section 24.4, "Outpatient Services," on page 24-15.

Observation care discharge day management (procedure code 99217) may be used to report services provided to a client upon discharge from "observation status" if the discharge occurs on a day other than the initial date of admission.

The following limitations apply to these procedure codes:

- Only one observation (procedure code 99217, 99218, 99219, or 99220) may be reimbursed if billed on the same day by the same provider.
- Procedure codes 99211, 99212, 99213, 99214, 99215, 99218, 99219, and 99220 are denied if billed on the same day as procedure code 99217 by the same provider.
- If a physician observation visit (procedure codes 99217, 99218, 99219, 99220, 99234, 99235, and 99236) is billed on the same day as prolonged services (procedure codes 99354 and 99355) by the same provider, the prolonged services are denied as part of another procedure on the same day.
- After-hours and out-of-office services (procedure code 99050, 99056, and 99060) are denied if they are billed the same day as physician outpatient hospital observation room services (procedure codes 99217, 99218, 99219, and 99220) by the same provider.

- If procedure codes 99234, 99235, and 99236 are billed on the same day as a subsequent hospital visit (procedure codes 99231, 99232, and 99233) by the same provider, the subsequent visit is denied.
- If procedure codes 99234, 99235, and 99236 are billed on the same day as a consultation by the same provider, the consultation is paid and the physician inpatient hospital observation is denied.
- If a chemotherapy planning program (procedure codes 99213, 99214, or 99215) and physician outpatient hospital observation are billed on the same day by the same provider, the chemotherapy planning is paid and the physician outpatient hospital observation will be denied.
- Procedure codes 99234, 99235, and 99236 are not payable on the same day as procedure codes 99238 and 99239.
- Procedure codes 99234, 99235, and 99236 are subject to the global surgical fee pre-/postcare days assigned to certain surgical procedures.
- E/M services provided at any place of service (POS) other than an inpatient hospital and billed on the same day as a physician observation visit by the same provider are denied.
- If dialysis treatment and physician observation visits are billed the same day by the same provider, same specialty (other than nephrology and internal medicine specialists), the dialysis treatment may be paid and the physician observation visit is denied.

31.2.18.8 Preventive Care Services

The CSHCN Services Program may reimburse for preventive health-care services. Providers should submit claims with the following E/M procedure codes and include the appropriate diagnosis code. Diagnosis code V202 (routine infant or child health check) should be used for children's preventive care medical checkups and V700 (routine general medical examination at a health-care facility) should be used for an adult preventive care medical checkup.

Procedure Codes				
99381	99382	99383	99384	99385
99386	99387	99391	99392	99393
99394	99395	99396	99397	

Providers may be reimbursed for an acute care visit on the same day as a preventive care visit. The acute care visit should be billed as an established patient visit. Modifier 25 may be used to describe circumstances in which a visit was provided at the same time as other separately identifiable services (e.g., preventive visits, minor procedure). Both services must be documented as distinct, and documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request. This modifier may be appended to the evaluation procedure code when the services rendered are distinct, provided for different diagnosis, or are performed for different reasons.

Vaccinations, vaccine administration procedure codes, and laboratory services may be billed in addition to the preventive care E/M procedure code. Providers may append modifier 25 to one of the preventive care E/M procedure codes listed in the table above to identify a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the vaccine administration.

The CSHCN Services Program reimburses for only one preventive health visit per day per client for any provider. The program does not cover family planning services and inpatient newborn examinations.

31.2.18.9 Preventive Care Medical Checkups and Developmental Testing

When a new patient acute care E/M visit is billed for the same date of service as a new patient preventive care medical checkup, both new patient services may be reimbursed when billed by the same provider if that provider has not billed other acute care E/M visits or preventive care medical checkups for the client in the preceding 3 years.

Modifier 25 must be used to describe circumstances in which an acute care E/M visit was provided at the same time as a preventive care medical checkup. This modifier must be appended to the E/M procedure code when the services are distinct and provided for a different diagnosis. An appropriate level E/M procedure code must be billed with the diagnosis supporting the acute care claim.

If the provider or provider group has billed for a new patient preventive care medical checkup within the past 3 years, subsequent preventive care medical checkups and acute care visits billed as new patient services will be denied when billed by the same provider. Another new checkup will only be allowed when the client has not received any professional services from the same provider or another provider who belongs to the same group practice in the past 3 years, because subsequent acute care visits after the initial new patient preventive care medical checkup continue the established relationship with the provider. Subsequent preventive care medical checkups and acute care visits after the initial new patient preventive care medical checkup continue the established relationship with the provider.

Laboratory Tests

Documented laboratory results obtained prior to the current medical checkup may be used as follows to complete the laboratory testing requirement:

- Results obtained within 30 days before the current medical checkup for clients who are 2 years of age and younger
- Results obtained within 90 days before the current medical checkup for clients who are 3 years of age and older

Documentation must include the date of service and one of the following:

- A clear reference to the previous visit by the same provider
- Results obtained from a different provider

Medical Checkup Follow-up Visit

A follow-up checkup is a visit that is scheduled to complete checkup components that could not be completed at the original medical checkup due to circumstances beyond the provider's control. If the parent or guardian did not give consent for a missing component, a follow-up visit is not necessary. The most appropriate procedure code for the follow-up visit will be determined by the components that could not be completed during the original medical checkup.

Procedure code 99211 may be submitted for a follow-up visit that includes a separately identifiable evaluation and management (E/M) component. When the follow-up visit does not include a separately identifiable E/M component, the following procedure codes must be used instead of procedure code 99211:

- Developmental testing (procedure code 96110) and autism screening (procedure code 96110 with modifier U6)
- Hearing screening (procedure code 92551)
- Immunization administration (procedure codes 90460 and 90461)

If a separately identifiable E/M component is required before completing one of the above checkup components, claims for the follow-up visit (procedure code 99211) and the checkup component may be submitted.

Denied Medical Checkups

Providers may be reimbursed for denied medical checkups through the appeal process when all of the following criteria are met for clients who are birth through 3 years of age:

- The client changed to a new provider in a new practice.
- The previous provider billed the maximum number of checkups in the procedure code age range for that client.
- The new provider's claim was denied for exceeding periodicity.

Note: *In addition to the criteria listed above, at least 1 year must have elapsed since the last checkup for clients who are 3 years of age or older.*

Developmental Screening and Testing

Developmental screening and testing may be a benefit when the services are provided during a preventive care medical checkup in accordance with accepted guidelines or when a parent expresses concern with a client's developmental progress. If the developmental screening was not completed during a previous checkup, or if the provider is seeing the client for the first time at a checkup for birth through 6 years of age, a standardized developmental screening must be completed.

Standardized developmental screening and testing may also be a benefit when they are performed outside of a preventive care medical checkup.

Clients with abnormal screening results must be referred to an appropriate provider for further testing. Clients who are birth through 35 months of age with suspected developmental delay must be referred to Texas Early Childhood Intervention (ECI) as soon as possible, but no longer than 7 days after identification, even if the client is referred to an appropriate provider for further testing.

Developmental Screening

Developmental screening (procedure code 96110) is a required component of each checkup for clients who are birth through 6 years of age. Procedure code 96110 is a benefit when performed by an APRN or physician in the office, home, or outpatient hospital setting.

Providers must submit modifier U6 with procedure code 96110 to bill for autism screening. Autism screening is generally recommended at 18 and 24 months of age.

If the provider administers a standardized developmental screening at an additional checkup, the provider must document the rationale for the additional screen(s), which may be due to provider or parental concern. Retrospective review may be performed to ensure documentation supports medical necessity.

Additional parental or guardian consent may be required if online or web-based screening tools are used, which could result in client data being stored electronically in an outside database other than the provider's electronic medical record system, or if the data is used for purposes other than CSHCN Services Program screening. The provider should seek legal advice regarding the need for this consent.

Procedure code 96110, with or without modifier U6, must be billed with the appropriate E/M procedure code. Providers must use a standardized tool to complete the developmental screening. The CSHCN Services Program recognizes the following standardized tools:

- Ages and Stages Questionnaire (ASQ), Ages or Stages Questionnaire - SE (ASQ SE)
- Parents' Evaluation of Developmental Status (PEDS)
- Modified Checklist for Autism for toddlers - (MCHAT)

A provider who chooses a standardized developmental screening tool different from those listed above must provide medical documentation that supports the use of the tool.

Procedure codes 96110 and 96110 with modifier U6 are each limited to once per day, per provider. Providers may be reimbursed for both procedures on the same day.

Developmental screening, which is not expected to last longer than 30 minutes, is included in the limitation of 12 hours of behavioral health services per day, per provider. Physicians are not limited to the 12-hour limitation since they can delegate services and may submit claims in excess of 12 hours per day. The individuals delegated by a physician to perform these services are subject to the 12-hour limitation.

A Mini Mental State Examination is considered part of any E/M service and is not separately reimbursed.

Developmental Testing

Procedure code 96111, which consists of an extended evaluation, requires the use of a standardized tool and is limited to clients who are birth through 20 years of age. Procedure code 96111 will be a benefit when performed by an APRN, physician, or psychologist in the office, home, or outpatient hospital setting. Developmental testing is medically necessary when there is suspected developmental delay that is supported by the following clinical evidence:

- Suspected developmental delay or atypical development when the diagnosis cannot be clearly identified through clinical interview or standardized screening tools alone

- Retesting of a client to evaluate a change in developmental status that results in a change of treatment plan

The following procedure codes will be denied when billed on the same day as procedure code 96111:

Procedure Codes				
99201	99202	99203	99204	99205
99211	99212	99213	99214	99215
99217	99218	99219	99220	

Developmental testing, which is not expected to last longer than 60 minutes, is included in the limitation of 12 hours of behavioral health services per day, per provider. Retrospective review may be performed on billed hours and total hours worked per day since providers who perform developmental testing may possibly bill in excess of 12 hours per day. Providers must maintain clinical documentation in the client's medical record to support medical necessity.

Developmental testing that is performed when a development delay or change in the client's developmental status is not suspected would constitute developmental screening and is not covered. Providers may not bill clients for developmental testing that is considered developmental screening.

31.2.18.10 Preventive Care Medical Checkup Components

Referral to Establish a Dental Home

The American Academy of Pediatric Dentistry's (AAPD) definition of a dental home, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. In Texas, establishment of a client's dental home begins at 6 months of age but no later than 12 months of age and includes referral to dental specialists when appropriate.

The provider must refer clients to establish a dental home beginning at 6 months of age or earlier if trauma or early childhood caries are identified. For established clients after the six-month medical checkup visit, the provider must confirm whether a dental home has been established and is on-going. If a dental home has not been established, the provider must make additional referrals at subsequent medical checkup visits until the parent or guardian confirms that a dental home has been established for the client. A parent or guardian of the client may self-refer for dental care at any age, including 12 months of age or younger.

Oral Evaluation and Fluoride Varnish in the Medical Home (OEFV)

An intermediate oral evaluation with fluoride varnish application (procedure code 99429) is a benefit for clients 6 months of age through 35 months of age. Procedure code 99429 must be submitted with modifier U5 and diagnosis V202.

The intermediate oral evaluation with fluoride varnish application must be billed on the same date of service as a medical checkup or an exception to the periodicity visit (procedure codes 99381, 99382, 99391, or 99392) and is limited to six services per lifetime by any provider.

An intermediate oral evaluation with fluoride varnish application is limited to preventive care medical checkup providers who have completed the required benefit education and who are certified by the DSHS Oral Health Program to perform an intermediate oral evaluation with fluoride varnish application.

The intermediate oral evaluation with fluoride varnish application add-on includes the following component:

- Intermediate oral evaluation
- Fluoride varnish application
- Dental anticipatory dental guidance to include:
  - The need for thorough daily oral hygiene practices
  - Education in potential gingival manifestations for clients with diabetes and clients under

long-term medication therapy
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Antimicrobials, medications, and oral health
- Referral to a dentist to establish a dental home
- Additional dental anticipatory guidance if the client has no erupted teeth

Note: *The provider must complete the intermediate oral evaluation but can delegate all other components.*

Sensory Screening

Providers may use test results from a different provider or a school vision and hearing screening program to replace the required visual acuity or hearing screening that requires the use of calibrated electronic equipment as long as the previous screening was performed within 12 months preceding the current medical checkup.

Procedure code 92551 may be reimbursed separately for a hearing screening (for hearing loss) with pure tone audiometric testing that is performed with the use of calibrated electronic equipment.

31.2.18.11 Teaching Physicians

Teaching physicians who provide E/M services may bill the CSHCN Services Program for lower- and mid-level E/M services (procedure codes 99201, 99202, 99203, 99211, 99212, and 99213) that are provided by residents if they meet the primary care exception under Medicare.

31.2.19 Evoked Response Tests and Neuromuscular Procedures

The following services are a benefit of the CSHCN Services Program:

- Autonomic function test (AFT)
- Electromyography (EMG)
- Nerve conduction studies (NCS)
- Evoked potential (EP) procedures
- Motion analysis (MA) studies

All procedures must be medically indicated and testing must be performed using appropriate equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening, rather than diagnosis, are not benefits of the CSHCN Services Program.

Client medical records must clearly document the medical necessity for all procedures and must reflect the actual results of specific procedures. All client medical records are subject to retrospective review.

31.2.19.1 Autonomic Function Tests

AFTs are a benefit of the CSHCN Services Program when submitted with procedure codes 95921, 95922, 95923, 95924, and 95943.

Procedure codes 95921, 95922, 95923, 95924, and 95943 are limited to once per date of service, by the same provider.

Autonomic disorders may be congenital or acquired (primary or secondary). Some of the conditions under which autonomic function testing may be appropriate include, but are not limited to, the following:

- Amyloid neuropathy
- Diabetic autonomic neuropathy
- Distal small fiber neuropathy

- Excessive sweating
- Gastrointestinal dysfunction
- Idiopathic neuropathy
- Irregular heart rate
- Multiple system atrophy
- Orthostatic symptoms
- Pure autonomic failure
- Reflex sympathetic dystrophy or causalgia (sympathetically maintained pain)
- Sjogren's syndrome

31.2.19.2 Electromyography and Nerve Conduction Studies

EMG and NCS are a benefit of the CSHCN Services Program when billed with the following procedure codes:

EMG Procedure Codes				
51784	51785	95860	95861	95863
95864	95865	95866	95867	95868
95869	95870	95872	95873	95874
95875				

NCS Procedure Codes				
95885	95886	95887	95905	95907
95908	95909	95910	95911	95912
95913	95933	95937		

Surface or macro-EMG testing is considered experimental and is not a benefit of the CSHCN Services Program.

EMG and NCS are restricted to the following diagnosis codes:

Diagnosis Code	Description
1922	Malignant neoplasm of spinal cord
1923	Malignant neoplasm of spinal meninges
25060	Diabetes with neurological manifestations; type II or unspecified type, not stated as uncontrolled
25061	Diabetes with neurological manifestations; type I (juvenile type), not stated as uncontrolled
25062	Diabetes with neurological manifestations; type II or unspecified type, uncontrolled
25063	Diabetes with neurological manifestations; type I (juvenile type), uncontrolled
2650	Beriberi
2651	Other and unspecified manifestations of thiamine deficiency
2691	Deficiency of other vitamins
2725	Lipoprotein deficiencies
27730	Amyloidosis, unspecified
27739	Other amyloidosis
33383	Spasmodic torticollis
33399	Other extrapyramidal diseases and abnormal movement disorders

Diagnosis Code	Description
3350	Werdnig-Hoffmann disease
33510	Spinal muscular atrophy, unspecified
33511	Kugelberg-Welander disease
33519	Other spinal muscular atrophy
33520	Amyotrophic lateral sclerosis
33521	Progressive muscular atrophy
33522	Progressive bulbar palsy
33523	Pseudobulbar palsy
33524	Primary lateral sclerosis
33529	Other motor neuron disease
3358	Other anterior horn cell diseases
3359	Anterior horn cell disease, unspecified
3360	Syringomyelia and syringobulbia
3361	Vascular myelopathies
3362	Subacute combined degeneration of spinal cord in diseases classified elsewhere
3363	Myelopathy in other diseases classified elsewhere
3368	Other myelopathy
3369	Unspecified disease of spinal cord
33700	Idiopathic peripheral autonomic neuropathy, unspecified
33709	Other idiopathic peripheral autonomic neuropathy
3371	Peripheral autonomic neuropathy in disorders classified elsewhere
33720	Reflex sympathetic dystrophy, unspecified
33721	Reflex sympathetic dystrophy of the upper limb
33722	Reflex sympathetic dystrophy of the lower limb
33729	Reflex sympathetic dystrophy of other specified site
3373	Autonomic dysreflexia
3379	Unspecified disorder of autonomic nervous system
3410	Neuromyelitis optica
3411	Schilder's disease
34460	Cauda equina syndrome without mention of neurogenic bladder
34461	Cauda equina syndrome with neurogenic bladder
34489	Other specified paralytic syndrome
3449	Paralysis, unspecified
3502	Atypical face pain
3510	Bell's palsy
3518	Other facial nerve disorders
3519	Facial nerve disorder, unspecified
3523	Disorders of pneumogastric (10th) nerve
3524	Disorders of accessory (11th) nerve
3525	Disorders of hypoglossal (12th) nerve
3526	Multiple cranial nerve palsies

Diagnosis Code	Description
3530	Brachial plexus lesions
3531	Lumbosacral plexus lesions
3532	Cervical root lesions, not elsewhere classified
3533	Thoracic root lesions, not elsewhere classified
3534	Lumbosacral root lesions, not elsewhere classified
3535	Neuralgic amyotrophy
3538	Other nerve root and plexus disorders
3539	Unspecified nerve root and plexus disorder
3540	Carpal tunnel syndrome
3541	Mononeuritis of upper limb and mononeuritis multiplex; Other lesion of median nerve
3542	Lesion of ulnar nerve
3543	Lesion of radial nerve
3544	Causalgia of upper limb
3545	Mononeuritis multiplex
3548	Other mononeuritis of upper limb
3549	Mononeuritis of upper limb, unspecified
3550	Lesion of sciatic nerve
3551	Meralgia paresthetica
3552	Other lesion of femoral nerve
3553	Lesion of lateral popliteal nerve
3554	Lesion of medial popliteal nerve
3555	Tarsal tunnel syndrome
3556	Lesion of plantar nerve
35571	Causalgia of lower limb
35579	Other mononeuritis of lower limb
3558	Mononeuritis of lower limb, unspecified
3559	Mononeuritis of unspecified site
3560	Hereditary peripheral neuropathy
3561	Peroneal muscular atrophy
3562	Hereditary sensory neuropathy
3563	Refsum's disease
3564	Idiopathic progressive polyneuropathy
3568	Other specified idiopathic peripheral neuropathy
3569	Unspecified hereditary and idiopathic peripheral neuropathy
3570	Acute infective polyneuritis
3571	Polyneuropathy in collagen vascular disease
3572	Polyneuropathy in diabetes
3573	Polyneuropathy in malignant disease
3574	Polyneuropathy in other diseases classified elsewhere
3575	Alcoholic polyneuropathy

Diagnosis Code	Description
3576	Polyneuropathy due to drugs
3577	Polyneuropathy due to other toxic agents
35781	Chronic inflammatory demyelinating polyneuritis
35782	Critical illness polyneuropathy
35789	Other inflammatory and toxic neuropathy
3579	Unspecified inflammatory and toxic neuropathies
35800	Myasthenia gravis without (acute) exacerbation
35801	Myasthenia gravis with (acute) exacerbation
3581	Myasthenic syndromes in diseases classified elsewhere
3582	Toxic myoneural disorders
35830	Lambert-Eaton syndrome, unspecified
35831	Lambert-Eaton syndrome in neoplastic disease
35839	Lambert-Eaton syndrome in other diseases classified elsewhere
3588	Other specified myoneural disorders
3589	Myoneural disorders, unspecified
3590	Congenital hereditary muscular dystrophy
3591	Hereditary progressive muscular dystrophy
35921	Myotonic muscular dystrophy
35922	Myotonia congenita
35923	Myotonic chondrodystrophy
35924	Drug-induced myotonia
35929	Other specified myotonic disorder
3593	Periodic paralysis
3594	Toxic myopathy
3595	Myopathy in endocrine diseases classified elsewhere
3596	Symptomatic inflammatory myopathy in diseases classified elsewhere
35971	Inclusion body myositis
35979	Other inflammatory and immune myopathies, nec
35981	Critical illness myopathy
35989	Other myopathies
3599	Myopathy, unspecified
4476	Arteritis, unspecified
4580	Orthostatic hypotension
47830	Unspecified paralysis of vocal cords or larynx
47831	Unilateral partial paralysis of vocal cords or larynx
47832	Unilateral complete paralysis of vocal cords or larynx
47833	Bilateral partial paralysis of vocal cords or larynx
47834	Bilateral complete paralysis of vocal cords or larynx
56032	Fecal impaction
56400	Constipation, unspecified
56402	Outlet dysfunction constipation

Diagnosis Code	Description
56409	Other constipation
5646	Anal spasm
56481	Neurogenic bowel
5692	Stenosis of rectum and anus
56942	Anal or rectal pain
6256	Stress incontinence, female
62570	Vulvodynia, unspecified
7100	Systemic lupus erythematosus
7101	Systemic sclerosis
7103	Dermatomyositis
7104	Polymyositis
7105	Eosinophilia myalgia syndrome
7140	Rheumatoid arthritis
7210	Cervical spondylosis without myelopathy cervical
7211	Cervical spondylosis with myelopathy
7212	Thoracic spondylosis without myelopathy
7213	Lumbosacral spondylosis without myelopathy
72141	Spondylosis with myelopathy, thoracic region
72142	Spondylosis with myelopathy, lumbar region
7220	Displacement of cervical intervertebral disc without myelopathy
72210	Displacement of lumbar intervertebral disc without myelopathy
72211	Displacement of thoracic intervertebral disc without myelopathy
7222	Displacement of intervertebral disc, site unspecified, without myelopathy
7224	Degeneration of cervical intervertebral disc
72251	Degeneration of thoracic or thoracolumbar intervertebral disc
72252	Degeneration of lumbar or lumbosacral intervertebral disc
7226	Degeneration of intervertebral disc, site unspecified
72270	Intervertebral disc disorder with myelopathy, unspecified region
72271	Intervertebral disc disorder with myelopathy, cervical region
72272	Intervertebral disc disorder with myelopathy, thoracic region
72273	Intervertebral disc disorder with myelopathy, lumbar region
72280	Postlaminectomy syndrome, unspecified region
72281	Postlaminectomy syndrome, cervical region
72282	Postlaminectomy syndrome, thoracic region
72283	Postlaminectomy syndrome, lumbar region
72291	Other and unspecified disc disorder, cervical region
72292	Other and unspecified disc disorder, thoracic region
72293	Other and unspecified disc disorder, lumbar region
7230	Spinal stenosis in cervical region
7234	Brachial neuritis or radiculitis NOS
7235	Torticollis, unspecified

Diagnosis Code	Description
72400	Spinal stenosis, unspecified region
72401	Spinal stenosis, thoracic region
72402	Spinal stenosis, lumbar region, without neurogenic claudication
72403	Spinal stenosis, lumbar region, with neurogenic claudication
72409	Spinal stenosis, other region other than cervical
7241	Pain in thoracic spine
7242	Lumbago
7243	Sciatica
7244	Thoracic or lumbosacral neuritis or radiculitis, unspecified
7245	Backache, unspecified
7249	Other unspecified back disorders
7280	Infective myositis
7282	Muscular wasting and disuse atrophy, not elsewhere classified
72881	Interstitial myositis
72887	Muscle weakness (generalized)
7289	Unspecified disorder of muscle, ligament, and fascia
7291	Myalgia and myositis, unspecified
7292	Neuralgia, neuritis, and radiculitis, unspecified
7295	Pain in limb
73605	Wrist drop (acquired)
73606	Claw hand (acquired)
73609	Other acquired deformities of forearm, excluding fingers
73679	Other acquired deformities of ankle and foot
7812	Abnormality of gait
7814	Transient paralysis of limb
7817	Tetany
7820	Disturbance of skin sensation
78449	Other voice and resonance disorders
78451	Dysarthria
78459	Other speech disturbance
78492	Jaw pain
78760	Full incontinence of feces
78761	Incomplete defecation
78762	Fecal smearing
78763	Fecal urgency
78821	Incomplete bladder emptying
78830	Urinary incontinence, unspecified
78831	Urge incontinence
78832	Stress incontinence, male
78833	Mixed incontinence (male) (female)
78834	Incontinence without sensory awareness

Diagnosis Code	Description
78835	Post-void dribbling
78836	Nocturnal enuresis
78837	Continuous leakage
78838	Overflow incontinence
78839	Other urinary incontinence
95200	C1-C4 level with unspecified spinal cord injury
95201	C1-C4 level with complete lesion of spinal cord
95202	C1-C4 level with anterior cord syndrome
95203	C1-C4 level with central cord syndrome
95204	C1-C4 level with other specified spinal cord injury
95205	C5-C7 level with unspecified spinal cord injury
95206	C5-C7 level with complete lesion of spinal cord
95207	C5-C7 level with anterior cord syndrome
95208	C5-C7 level with central cord syndrome
95209	C5-C7 level with other specified spinal cord injury
95210	T1-T6 level with unspecified spinal cord injury
95211	T1-T6 level with complete lesion of spinal cord
95212	T1-T6 level with anterior cord syndrome
95213	T1-T6 level with central cord syndrome
95214	T1-T6 level with other specified spinal cord injury
95215	T7-T12 level with unspecified spinal cord injury
95216	T7-T12 level with complete lesion of spinal cord
95217	T7-T12 level with anterior cord syndrome
95218	T7-T12 level with central cord syndrome
95219	T7-T12 level with other specified spinal cord injury
9522	Lumbar spinal cord injury without evidence of spinal bone injury
9523	Sacral spinal cord injury without evidence of spinal bone injury
9524	Cauda equina spinal cord injury without evidence of spinal bone injury
9528	Multiple sites of spinal cord injury without evidence of spinal bone injury
9529	Unspecified site of spinal cord injury without evidence of spinal bone injury
9530	Injury to cervical nerve root
9531	Injury to dorsal nerve root
9532	Injury to lumbar nerve root
9533	Injury to sacral nerve root
9534	Injury to brachial plexus
9535	Injury to lumbosacral plexus
9538	Injury to multiple sites of nerve roots and spinal plexus
9539	Injury to unspecified site of nerve roots and spinal plexus
9540	Injury to cervical sympathetic nerve, excluding shoulder and pelvic girdles
9541	Injury to other sympathetic nerve, excluding shoulder and pelvic girdles
9548	Injury to other specified nerve(s) of trunk, excluding shoulder and pelvic girdles

Diagnosis Code	Description
9549	Injury to unspecified nerve of trunk, excluding shoulder and pelvic girdles
9550	Injury to axillary nerve
9551	Injury to median nerve
9552	Injury to ulnar nerve
9553	Injury to radial nerve
9554	Injury to musculocutaneous nerve
9555	Injury to cutaneous sensory nerve, upper limb
9556	Injury to digital nerve, upper limb
9557	Injury to other specified nerve(s) of shoulder girdle and upper limb
9558	Injury to multiple nerves of shoulder girdle and upper limb
9559	Injury to unspecified nerve of shoulder girdle and upper limb
9560	Injury to sciatic nerve
9561	Injury to femoral nerve
9562	Injury to posterior tibial nerve
9563	Injury to peroneal nerve
9564	Injury to cutaneous sensory nerve, lower limb
9565	Injury to other specified nerve(s) of pelvic girdle and lower limb
9568	Injury to multiple nerves of pelvic girdle and lower limb
9569	Injury to unspecified nerve of pelvic girdle and lower limb
9570	Injury to superficial nerves of head and neck
9571	Injury to other specified nerve(s)
9578	Injury to multiple nerves in several parts
9579	Injury to nerves, unspecified site

The electrodiagnostic testing must be guided by accepted practice parameters and physician guidelines. The number of studies performed is expected to be tailored to the clinical findings of the individual client.

Any electrodiagnostic testing procedures may be reimbursed up to four distinct dates of service per calendar year by the same provider.

Any evaluation and management service will be denied as part of another service when billed for the same date of service as EMG or NCS service by the same provider.

EMG

The needle EMG examination must be performed by a physician specially trained in electrodiagnostic medicine.

The following procedure codes may be reimbursed for one service per day for each procedure by the same provider:

Procedure Codes				
51784	51785	95860	95861	95863
95864	95865	95867	95868	95869
95872	95875			

Procedure code 95866 may be reimbursed up to two services per day, same provider.

Procedure code 95870 may be reimbursed in multiple quantities of up to four services per day, if specific muscles are documented.

NCS

NCS must be performed by a physician or a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the electrodiagnostic laboratory while testing is underway, immediately available to provide the trained individual with assistance and direction, and responsible for selecting the appropriate NCS to be performed.

When the same studies are performed on unique sites by the same provider for the same date of service, studies for the first site must be billed without a modifier and studies for each additional site must be billed with modifier XE, XP, XS, XU, or 59. Modifier 59 should be used only when modifier XE, XP, XS, or XU is not appropriate.

Procedure codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 may be reimbursed only once when multiple sites on the same nerve are stimulated or recorded.

Procedure codes 95885 and 95886 may be reimbursed once per extremity up to 4 units, any combination of procedure codes, per day, by any provider.

Procedure codes 95885, 95886, and 95887 must be billed with one of the primary procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913.

Prior authorization is required for NCS for any diagnosis other than those listed above or when the number of studies performed during an evaluation exceeds the following maximum number of studies, per date of service, by the same provider:

NCS Procedure Codes	Studies Allowed per Date of Service	NCS Procedure Codes	Studies Allowed per Date of Service
95905*	1 per limb	95933	2
95937	3		

*Claims for procedure code 95905 may be submitted with a quantity of no more than 2 per detail line.

If the need for additional NCS or alternate procedures is determined during an evaluation, a request for retrospective authorization must be submitted for reimbursement no later than 7 calendar days beginning the day after testing is completed.

Medical record documentation must establish medical necessity for any additional studies, including:

- Other diagnosis in the differential requires consideration. The provider should note the additional diagnoses considered and the clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.
- Multiple diagnoses are established by NCS, and the limitations listed above for a single diagnostic category do not apply. Providers must document all diagnoses established as a result of electrodiagnostic testing.
- Testing of an asymptomatic contralateral limb to establish normative values for an individual client (particularly the elderly, diabetic, and clients with a history of ethyl alcohol usage) has been conducted.
- Comorbid clinical conditions are identified. The clinical condition must be one that may cause sensory or motor symptoms. Some examples include underlying metabolic disease (e.g., thyroid condition or diabetes mellitus), nutritional deficiency (alcoholism), malignant disease, or inflammatory disorder (including, but not limited to, lupus, sarcoidosis, or Sjögren's syndrome).

Providers must complete the CSHCN Services Program Authorization and Prior Authorization Request Form for NCS prior authorization requests.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

31.2.19.3 Evoked Potential Procedures

Evoked potential (EP) procedures are a benefit of the CSHCN Services Program. The most common EP procedures are:

- Brainstem auditory evoked potentials (BAEPs)

- Motor evoked potentials (MEPs)
- Somatosensory evoked potentials (SEPs)
- Visual evoked potentials (VEPs)

Each EP test (procedure codes 92585, 92586, 95925, 95926, 95927, 95928, 95929, 95930, 95938, or 95939) is considered a bilateral procedure and is limited to once per date of service any provider regardless of modifiers that indicate multiple sites were tested.

EP tests may be reimbursed up to four services per rolling year, any combination of services by any provider. Claims that exceed the limitation of four services per rolling year may be considered for reimbursement on appeal with documentation that supports the medical necessity.

Intraoperative Neurophysiology Testing

Intraoperative neurophysiology testing (procedure codes 95940 and 95941) are a benefit when performed in addition to each evoked potential test on the same day.

The documentation for the intraoperative neurophysiology testing must include the time for which each test is performed.

Procedure code 95940 and 95941 are limited to a maximum of two hours per date of service, per client.

Procedure code 95940 and 95941 must be billed in conjunction with one of the following procedure codes or the service will be denied:

Procedure Codes				
92585	95822	95860	95861	95867
95868	95870	95907	95908	95909
95910	95911	95912	95913	95925
95926	95927	95928	95929	95930
95933	95934	95936	95937	

Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

31.2.19.4 Motion Analysis Studies

MA studies (procedure codes 96000, 96001, 96002, and 96003) will be considered for reimbursement through the CSHCN Services Program with prior authorization for clients who are 3 through 20 years of age and have a diagnosis of, but not limited to, cerebral palsy.

Prior authorization requests for MA studies must include documentation with the following information that indicates the client meets all the requirements for MA studies:

- Diagnosis of cerebral palsy
- Ambulatory for a minimum of ten consecutive steps, with or without assistive devices
- Client is 3 through 20 years of age
- Physically able to tolerate up to three hours of testing
- Clear documentation that indicates the study is performed as part of a preoperative or postoperative assessment based on the surgical plan of the client

Procedure codes 96000, 96001, 96002, and 96003 are limited to one per date of service by the same provider and two per year, any provider.

Prior authorization requests for a diagnosis other than cerebral palsy or for more than two MA studies per year must be referred for medical review by the CSHCN Services Program Medical Director or designee for consideration.

Providers must complete the CSHCN Services Program Authorization and Prior Authorization Request Form for MA studies prior authorization requests.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

31.2.19.5 Prior Authorization for Unlisted Procedure Code 95999

Prior authorization is required for unlisted neurological procedure code 95999; the following information is required to determine coverage:

- The client's diagnosis
- A clear description of the neurological procedure that will be performed
- Documentation that indicates medical necessity of the neurological procedure
- Place of service where the neurological procedure is to be performed
- The physician's intended fee for the neurological procedure being requested or a CPT or HCPCS procedure code that is comparable to the procedure.

Providers must complete the CSHCN Services Program Authorization and Prior Authorization Request Form for prior authorization requests.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

31.2.20 Extracorporeal Shock Wave Lithotripsy (ESWL)

Procedure code 50590 is a benefit for the following diagnosis codes:

Diagnosis Code	Description
591	Hydronephrosis
5920	Calculus of kidney
5921	Calculus of ureter
5929	Unspecified urinary calculus

All claims received for ESWL must include one of these diagnoses.

31.2.21 Gastrostomy Devices

Low-profile gastrostomy devices are a benefit of the CSHCN Services Program when prescribed by a physician. Authorization is required.

Physicians may be reimbursed for nonobturated and obturated gastrostomy devices.

Refer to: Section 18.2.2.1, "Gastrostomy Devices," on page 18-12 for more information about documentation requirements, limitations, and additional devices.

Chapter 18, "Expendable Medical Supplies," on page 18-1 for more information about related supplies and equipment.

Section 4.2, "Authorizations," on page 4-3 for detailed information about authorization requirements.

31.2.22 Genetics

Genetic services are a benefit of the CSHCN Services Program.

Genetic services may be used to diagnose a condition, optimize disease treatment, predict future disease risk, and prevent adverse drug response.

Genetic services may be provided by a physician and typically include one or more of the following:

- Comprehensive physical exams
- Diagnosis, management, and treatment for clients with genetically-related health problems
- Evaluation of family histories for the client and the client's family members
- Genetic risk assessment
- Interpretation and evaluation of laboratory test results

- Education and counseling of clients, their families, and other medical professionals on the causes of genetic disorders
- Consultation with other medical professionals to provide treatment

The following procedure codes may be reimbursed for geneticists when provided in the office, inpatient hospital, or outpatient hospital setting:

Procedure Codes				
96040	99213	99214	99215	99244
99245	99254	99255	99402	99404

Consultation, procedure codes 99244, 99245, and 99404, are limited to once every 3 years. One office consultation (procedure codes 99244 or 99245) may be reimbursed if an office/outpatient/inpatient consultation has not been reimbursed in the previous 3 years.

Inpatient consultations (procedure codes 99254 and 99255) may be reimbursed once every 3 years regardless of whether an office consultation was reimbursed in the previous 3 years.

A comprehensive follow up visit (procedure code 99215) is limited to once per year.

No authorization is required for genetic services that are a benefit of the CSHCN Services Program.

31.2.22.1 Family History

It is important for primary care providers to recognize potential genetic risk factors in a client so that they can make appropriate referrals to a genetic specialist.

Obtaining an accurate family history is an important part of clinical evaluations, even when genetic abnormalities are not suspected. Knowing the family history may help health-care providers identify single-gene disorders or chromosomal abnormalities that occur in multiple family members or through multiple generations. Some genetic disorders that can be traced through an accurate family history include diabetes, hypertension, certain forms of cancer, and cystic fibrosis. Early identification of the client's risk for one of these diseases can lead to early intervention and preventive measures that can delay onset or improve health conditions.

Using a genetics-specific questionnaire helps to obtain the information needed to identify possible genetic patterns or disorders. The most commonly used questionnaires are provided by the American Medical Association and include the "Prenatal Screening Questionnaire," the "Pediatric Clinical Genetics Questionnaire," and the "Adult History Form."

31.2.22.2 Genetic Tests

Diagnostic tests to check for genetic abnormalities must be performed only if the test results will affect treatment decisions or provide prognostic information. Tests for conditions that are treated symptomatically are not appropriate since the treatment would not change. Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to discuss the client's needs.

Any genetic testing and screening procedure must be accompanied by appropriate nondirective counseling, both before and after the procedure. Information must be provided to the client and family (if appropriate) about the possible risks and purpose and nature of the tests being performed.

Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to confer about the client and his or her needs.

The interpretation of certain tests, such as nuchal translucency, requires additional education and experience. The CSHCN Services Program supports national certification standards when available.

31.2.22.3 Laboratory Practices

For many heritable diseases and conditions, test performance and interpretation of test results require information about client race and ethnicity, family history, and other pertinent clinical and laboratory information. To facilitate test requests and ensure prompt initiation of appropriate testing procedures and accurate interpretation of test results, the requesting provider must be aware of the specific client information needed by the laboratory before tests are ordered.

To help providers make appropriate test selections and requests, handle and submit specimens, and provide clinical care, laboratories that perform molecular genetic testing for heritable diseases and conditions must educate providers that request services about the molecular genetic tests that the laboratory performs. For each molecular genetic test, the laboratory must provide the following information:

- Indications for testing
- Relevant clinical and laboratory information
- Client race and ethnicity
- Family history
- Pedigree

Testing performed on a client to provide genetic information for a family member, and testing performed on a non-CSHCN Services Program client to provide genetic information for a CSHCN Services Program client are not benefits of the CSHCN Services Program.

31.2.22.4 Genetic Counselors

Genetic counselor services may be billed by a physician when the genetic counselor is an employee of the physician. Services provided by independent genetic counselors are not a benefit of the CSHCN Services Program.

Refer to: Section 25.2.5.1, "Cytogenetics Testing," on page 25-7 for more information on cytogenetic testing.

31.2.23 Hyperbaric Oxygen Therapy (HBOT)

Hyperbaric oxygen therapy is a type of treatment that increases the environmental oxygen pressure to promote the movement of oxygen from the environment into the client's body tissues. HBOT is a benefit when it is performed in specially constructed hyperbaric chambers, pressurized to 1.4 atmospheric absolute (atm.abs) or higher, that may hold one or several clients.

The CSHCN Services Program recognizes the following indications for HBOT, as approved by the Undersea & Hyperbaric Medical Society (UHMS):

- Air or gas embolism
- Carbon monoxide poisoning
- Central retinal artery occlusion
- Compromised skin grafts and flaps
- Crush injuries, compartment syndrome, and other acute traumatic ischemias
- Decompression sickness
- Diabetic foot ulcer
- Severe anemia
- Clostridial myositis and myonecrosis (gas gangrene)
- Necrotizing soft tissue infections
- Delayed radiation injury (soft tissue and bony necrosis)
- Refractory osteomyelitis
- Acute thermal burn injury
- Intracranial abscess

CSHCN Services Program considers HBOT experimental and investigational for any indications other than the ones approved by UHMS and outlined in this section. Non-covered indications, include, but are not limited to, autism and traumatic brain injury.

Oxygen administered outside of a hyperbaric chamber, by any means, is not considered hyperbaric treatment.

HBOT services must be provided in facilities that have experience in HBOT treatment of pediatric clients. The physician must be in constant attendance of hyperbaric oxygen therapy during compression and decompression of the chamber, and may not delegate this service.

Both the facility's medical record and the client's medical record must contain documentation to support that there was a physician in attendance who provided supervision of the compression and decompression phases of the HBOT treatment. All documentation pertaining to HBOT is subject to retrospective review.

Physicians who bill for the professional component of HBOT must use procedure code 99183.

Hospital providers who bill for the chamber time must use procedure code G0277 with revenue code 413.

31.2.23.1 Prior Authorization Requirements

HBOT procedure codes 99183 and G0277 require prior authorization. When requesting prior authorization, providers should use the CSHCN Services Program Authorization and Prior Authorization Request Form.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

The prior authorization request must include documentation that supports medical necessity and is specific to each appropriate covered indication as listed in the following table:

Covered Indication	Total Number of 30 Minute Intervals Allowed for Procedure Code G0277	Total Number of Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Air or gas embolism	6	2	Evidence that gas bubbles are detectable by ultrasound, Doppler or other diagnostics
Carbon monoxide poisoning - initial authorization	15	5	Persistent neurological dysfunction secondary to carbon monoxide inhalation
Carbon monoxide poisoning - one subsequent authorization	9	3	Evidence of continuing improvement in cognitive functioning
Central retinal artery occlusion	36	6	Evidence of central retinal artery occlusion with treatment initiated within 24 hours of the occlusion
*__Note:__ The following Wagner wound classification grades apply only to the diabetic foot ulcer indications: • Grade 1: Superficial diabetic ulcer • Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis) • Grade 3: Deep ulcer with abscess or osteomyelitis • Grade 4: Gangrene to portion of forefoot • Grade 5: Extensive gangrene of foot			

Covered Indication	Total Number of 30 Minute Intervals Allowed for Procedure Code G0277	Total Number of Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Compromised skin grafts and flaps - initial authorization	80	10	Evidence the flap or graft is failing because tissue is/has been compromised by irradiation or there is decreased perfusion or hypoxia
Compromised skin grafts and flaps - one subsequent authorization	40	5	Evidence of stabilization of graft or flap
Crush injury, compartment syndrome and other acute traumatic ischemias	36	12	Adjunct to standard medical and surgical interventions
Decompression sickness	28	1	Diagnosis based on signs and/or symptoms of decompression sickness after a dive or altitude exposure
Diabetic foot ulcer -initial authorization	60	30	After at least 30 days of standard medical wound therapy, with a wound pO2 less than 40 mmHg AND wound classified as Wagner grade 3 or higher. *
Diabetic foot ulcer - two subsequent authorizations	60	20	Evidence of continuing healing and wound pO2 less than 40 mmHg
Severe anemia	50	10	Hgb less than 6.0 sustained secondary to hemorrhage, hemolysis, or aplasia, when the client is unable to be cross matched or refuses transfusion because of religious beliefs
Clostridial myositis and myonecrosis (gas gangrene)	39	13	Evidence of unsuccessful medical and/or surgical wound treatment and positive Gram-stained smear of the wound fluid
Necrotizing soft tissue infections – initial authorization	36	12	Evidence of unsatisfactory response to standard medical and surgical treatment and advancement of dying tissue

***Note:** The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:

- Grade 1: Superficial diabetic ulcer
- Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)
- Grade 3: Deep ulcer with abscess or osteomyelitis
- Grade 4: Gangrene to portion of forefoot
- Grade 5: Extensive gangrene of foot

Covered Indication	Total Number of 30 Minute Intervals Allowed for Procedure Code G0277	Total Number of Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Necrotizing soft tissue infections - two subsequent authorizations	15	5	Evidence that advancement of dying tissue has slowed
Delayed radiation injury (soft tissue and bony necrosis) - initial authorization	40	10	Evidence of unsatisfactory response to conventional treatment
Delayed radiation injury - one subsequent authorization	40	10	Evidence of improvement demonstrated by clinical response
Refractory osteomyelitis - initial authorization	40	10	Evidence of unsatisfactory clinical response to conventional multidisciplinary treatment
Refractory osteomyelitis - one subsequent authorization	15	5	Evidence of improvement demonstrated by clinical response
Acute thermal burn injury - initial authorization	45	15	Partial or full thickness burns covering greater than 20% of total body surface area OR with involvement of the hands, face, feet or perineum
Acute thermal burn injury – three subsequent authorizations	30	10	Evidence of continuing improvement demonstrated by clinical response

*__Note:__ The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:

- Grade 1: Superficial diabetic ulcer
- Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)
- Grade 3: Deep ulcer with abscess or osteomyelitis
- Grade 4: Gangrene to portion of forefoot
- Grade 5: Extensive gangrene of foot

Covered Indication	Total Number of 30 Minute Intervals Allowed for Procedure Code G0277	Total Number of Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Intracranial abscess - initial authorization	15	5	Adjunct to standard medical and surgical interventions when one or more of the following conditions exist: • Multiple abscesses • Abscesses in a deep or dominant location • Compromised host • Surgery contraindicated or client is a poor surgical risk
Intracranial abscess - one subsequent authorization	15	5	Evidence of improvement demonstrated by clinical response and radiological findings
*__Note:__ The following Wagner wound classification grades apply only to the diabetic foot ulcer indications: • Grade 1: Superficial diabetic ulcer • Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis) • Grade 3: Deep ulcer with abscess or osteomyelitis • Grade 4: Gangrene to portion of forefoot • Grade 5: Extensive gangrene of foot			

Procedure code 99183 is authorized according to the number of professional sessions (total HBOT treatments), and procedure code G0277 is authorized according to the number of 30-minute intervals of chamber time. The units in the columns for procedure codes 99183 and G0277 represent the maximum number of sessions and intervals that are allowed for that procedure code per authorization

Example: *In accordance with recommended protocols, a client with an air/gas embolus may receive up to 6 units (180 minutes) of HBOT over two treatments.*

- One prior authorization number may be issued for a quantity of 6 units for procedure code G0277 for the facility and 2 professional sessions for procedure code 99183.
- The 6 units of chamber time for procedure code G0277 may be divided in any manner across the two professional sessions. For procedure code 99183, the usual protocol is two 90-minute treatments.
- The facility bills 90 consecutive minutes (3 units) per HBOT treatment for procedure code G0277. The physician bills per treatment, which in this case would be 2 professional sessions for procedure code 99183.

Limitations beyond those listed in the table above are considered experimental and investigational.

31.2.24 Immunizations (Vaccines and Toxoids)

The CSHCN Services Program may reimburse for immunizations administered to program-eligible clients and encourages all providers to appropriately immunize clients. Immunizations must be provided in accordance with the routine immunization schedules developed by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC). All routine immunizations, pneumococcal vaccines, influenza vaccines, and selected other vaccines and toxoids are benefits of the CSHCN Services Program. Providers may refer to the CDC website at www.cdc.gov/vaccines/default.htm for additional information.

31.2.24.1 Texas Vaccines for Children (TVFC) Program

Providers can enroll in the TVFC Program to obtain vaccines and toxoids at no charge. The CSHCN Services Program encourages providers to participate in the TVFC Program, but it is not a requirement. Providers interested in obtaining current immunization information or enrollment information for the TVFC Program may call the Department of State Health Services (DSHS) Immunizations Branch at 1-800-252-9152 or access the TVFC website at www.dshs.state.tx.us/immunize/tvfc/.

If the provider is enrolled in TVFC, the provider is responsible for screening the client, determining if the client is TVFC eligible, and, if indicated, immunizing the client using vaccine obtained by TVFC.

31.2.24.2 Reporting

DSHS

All administered vaccines and toxoids must be reported to DSHS by all providers and payers. DSHS submits all vaccines and toxoids reported with parental consent to a centralized repository of immunization histories for children 17 years of age or younger. This repository is known in Texas as ImmTrac.

Vaccine Adverse Event Reporting System (VAERS)

The *National Childhood Vaccine Injury Act* (NCVIA) requires health-care providers to report any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine as well as any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from http://vaers.hhs.gov/resources/vaersmaterialspublications.

Clinically-significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Documentation of the injection site is recommended, but not required. For additional information regarding documentation, providers can refer to www.vaers.hhs.gov/esub/index and www.cdc.gov/vaccinesafety/.

31.2.24.3 Assessment

All providers must assess the immunization status of the client at every encounter and administer any medically indicated immunizations unless they are medically contraindicated or because of a parent's reason of conscience, including a religious belief. The reason that the indicated vaccine or toxoid was not administered must be documented in the client's medical record.

31.2.24.4 Vaccine Information Statement

Providers must provide clients the appropriate vaccine information statements (VISs) produced by the CDC. VISs explain the benefits and risks of the vaccine or toxoid. Providers must document the following information in the client's medical record:

- The vaccine or toxoid given
- The date of the vaccine or toxoid administration (day, month, year)
- The name of the vaccine or toxoid manufacturer and the vaccine or toxoid lot number
- The signature and title of the person who administered the vaccine or toxoid
- The provider's organization name and the address of the clinic location
- The publication date of the VIS issued to the client, parent, or guardian

The client's medical records are subject to retrospective review to determine whether the utilization and reimbursement of this service was appropriate.

31.2.24.5 Authorization Requirements

Authorization is not required for any vaccine, toxoid, or its associated administration fee.

31.2.24.6 Immunizations During an Office Visit

When a client is immunized during an initial or follow-up office visit for a medical condition, the office visit may be reimbursed in addition to any vaccine or toxoid not obtained through TVFC and its administration fee. An appropriate medical diagnosis must be submitted with the claim.

When the client visit is only for immunization, the office visit will not be reimbursed. The administration fee and any vaccine or toxoid not obtained through TVFC (identified by modifier U4) may be reimbursed when an appropriate diagnosis code referencing an immunization (i.e., a "V" series diagnosis code) is submitted with the claim.

31.2.24.7 Administration Fee

Vaccine and toxoid administration fees may be reimbursed based on the following:

- If counseling was provided for the immunization
- The age of the client
- The number of components identified in the immunization

The administration fee may be reimbursed even if the vaccine or toxoid is distributed through TVFC. Providers are expected to follow the ACIP recommendations for the administration of vaccines and toxoids.

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are 18 years of age and younger when counseling is provided for the immunization administered.

Procedure codes 90471, 90472, 90473, and 90474 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

31.2.24.8 Administration Fee Billing Examples

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid procedure code must be submitted with the appropriate “administration with counseling” procedure code(s) (procedure codes 90460 and 90461) or the most appropriate “administration without counseling” procedure code (procedure code 90471, 90472, 90473, or 90474). If an “administration with counseling” procedure code is submitted with an “administration without counseling” procedure code for the same vaccine or toxoid, the second administration of the vaccine or toxoid will be denied, based on the claim order.

Note: *If a claim includes both “with counseling” and “without counseling” administration procedure codes, providers should follow National Correct Coding Initiative (NCCI) guidelines to determine which administration procedure codes to submit.*

Administration With Counseling

Providers must submit claims for immunization administration procedure codes 90460 or 90461 based on the number of components per vaccine. Providers must specify the number of components per vaccine by billing 90460 and 90461 as defined by the procedure code descriptions:

- Procedure code 90460 is submitted for the administration of the 1st component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine or toxoid.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client’s medical record.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code with 1 component	1
90460 (1st component)	1
Vaccine or toxoid procedure code with 3 components	1
90460 (1st component)	1
90461 (2nd and 3rd components)	2
Vaccine or toxoid procedure code with 2 components	1
90460 (1st component)	1
90461 (2nd component)	1
Vaccine or toxoid procedure code with 4 components	1
90460 (1st component)	1
90461 (2nd, 3rd, and 4th components)	3
Vaccine or toxoid procedure code with 5 components	1
90460 (1st component)	1
90461 (2nd, 3rd, 4th, and 5th components)	4

Note: *The term "components" refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

Administration Without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the rout of administration.

The following is an example of how to submit claims for injection administration procedure codes when counseling is not provided:

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code	1
90471 (Injection administration)	1
Vaccine or toxoid procedure code	1
90472 (Injection administration)	1
Vaccine or toxoid procedure code	1
90472 (Injection administration)	1

The following is an example of how to submit claims for oral or nasal administration procedure codes when counseling is not provided:

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code	1
90473 (Oral/nasal administration)	1
Vaccine or toxoid procedure code	1
90474 (Oral/nasal administration)	1

31.2.24.9 Vaccine and Toxoid Procedure Codes

The vaccines and toxoids listed in the following table are benefits of the CSHCN Services Program:

Procedure Code	Number of Components**	Procedure Code	Number of Components**
90630	1	90687*	1
90632	1	90688*	1
90633*	1	90696*	4
90636	2	90698*	5
90644	2	90700*	3
90647*	1	90702*	2
90648*	1	90703	1
90649*	1	90707*	3
90650*	1	90710*	4
90654	1	90713*	1
90655*	1	90714*	2
90656*	1	90715*	3
90657*	1	90716*	1
90658*	1	90721	4
90660*	1	90723*	5
90661	1	90732*	1
90662	1	90733	1
90670*	1	90734*	1
90672*	1	90736	1
90673	1	90743	1
90680*	1	90744*	1
90681*	1	90746	1
90685*	1	90748*	2
90686*	1	90749	1

* Distributed through TVFC.

** The number of components applies if counseling is provided and procedure codes 90460 and 90461 are submitted

Claims must be submitted with the appropriate vaccine and toxoid procedure code and the appropriate administration procedure code(s).

If the vaccine or toxoid is obtained from TVFC, the appropriate diagnosis codes, administration procedure codes, and the vaccine or toxoid procedure code(s) must be billed, but only the administration fee may be reimbursed.

Vaccines and toxoids that are purchased by a provider may be reimbursed if modifier U4 is billed with the vaccine or toxoid and one of the following conditions is met:

- The provider is not enrolled in TVFC.
- The client does not meet the TVFC criteria.
- TVFC resolutions do not match the ACIP's general usage recommendations.
- The provider purchases an ACIP-recommended vaccine that is not distributed by TVFC.

The following immunizations are not a benefit of the CSHCN Services Program:

- Cholera vaccine, injectable
- Plague vaccine, intramuscular (IM)

- Typhoid vaccines
- Yellow fever vaccine, subcutaneous (SC)

31.2.24.10 Reimbursement for Vaccines and Toxoids

Vaccines and toxoids and their administration may be reimbursed if they have been recommended by the ACIP and approved by the Health and Human Services Commission (HHSC).

Providers purchasing vaccines and toxoids may be reimbursed the lower of the billed amount for the vaccine, the amount allowed by Texas Medicaid, or the maximum fee established by the CSHCN Services Program. The maximum fee is determined from the least average wholesale price (AWP) per vaccine dose according to the current edition of the *Red Book*, published by Thomson Reuters. An online version of the *Red Book* is available at http://redbook.solutions.aap.org/redbook.aspx/.

31.2.24.11 Bacille Calmette-Guerin (BCG) Vaccine

BCG vaccine (procedure code 90585) is a benefit of the CSHCN Services Program for diagnosis code V032 (need for prophylactic vaccination with tuberculosis BCG vaccine).

31.2.24.12 Botulinum Antitoxin

Procedure code 90287 is a benefit of the CSHCN Services Program for the following diagnosis codes:

Diagnosis Code	Description
0051	Exposure to botulism food poisoning
04041	Infant botulism
04042	Wound botulism
9799	Poisoning by other and unspecified vaccines and biological substances

Procedure code 90288 will be denied when billed on the same date of service by the same provider as procedure code 90287.

31.2.24.13 Hepatitis B Vaccine

Procedure codes 90740 and 90747 are not considered routine vaccines and must be billed using administration procedure code 96372 or 96374.

31.2.24.14 Rabies Postexposure Prophylaxis

Postexposure prophylaxis for rabies (procedure codes 90375, 90376, and 90675) is a benefit of the CSHCN Services Program.

An exposed person who has never received a complete pre- or postexposure rabies vaccine series will first receive a dose of rabies immune globulin (HRIG). This is a blood product that contains antibodies against rabies and gives immediate, short-term protection. The recommended dose of HRIG is 20 IU/kg body weight. This formula is applicable to all age groups, including children. The injection should be given in or near the wound area.

The postexposure treatment will also include 5 doses of rabies vaccine (1.0 ml. intramuscular). The first dose should be given as soon as possible after the exposure (day 0). Additional doses should be given on days 3, 7, 14, and 28 after the first shot. For an exposed person who has previously been vaccinated with a complete pre- or postexposure vaccine series, 2 doses of rabies vaccine should be given, one on day 0 and one on day 3.

HRIG that is not administered when vaccination begins can be administered up to 7 days after the administration of the first dose of vaccine. Beyond the seventh day, HRIG is not recommended since an antibody response to the vaccine is presumed to have occurred, and HRIG may inhibit the immune response to the vaccine.

Reimbursement for postexposure rabies vaccine is limited to 1 per client, per day, by any provider, not to exceed a total of 5 per 90 rolling days.

Animal bites to people must be reported as soon as possible to the local rabies control authority. Postexposure prophylaxis for rabies is not necessary following exposure to an animal that tests negative for the rabies virus. Health-care providers who determine that their client requires the preventive rabies vaccination series after valid rabies exposure may obtain the biologicals directly from the manufacturer or through one of the DSHS depots around the state. The physician must maintain documentation of the exposure in the client's medical record.

Postexposure rabies treatment is limited to clients with diagnosis code V015.

Injection administration is a benefit for administration of postexposure rabies vaccine.

31.2.24.15 Respiratory Synctial Virus (RSV) Prophylaxis

The RSV prophylaxis drug palivizumab (Synagis) must be obtained through the Texas Vendor Drug Program (VDP). Providers must obtain prior authorization through the CSHCN Services Program using the CSHCN Synagis® Request Form.

Providers may refer to the Texas Health and Human Services Commission Texas Medicaid/CHIP Vendor Drug Program website at www.txvendordrug.com/dur/prior-approval.shtml for a copy of the prior authorization form and more information about obtaining palivizumab for CSHCN Services Program clients.

31.2.25 Injections and Oral Medications

Oral medication must be used in preference to injectable medication in the office and outpatient hospital unless one of the following circumstances applies:

- No acceptable oral equivalent is available.
- Injectable medication is the standard treatment of choice.
- The oral route is contraindicated.
- The client has a temperature over 102°F (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly.
- The client has demonstrated noncompliance with orally prescribed medication (documented on the claim and in the medical record).
- Previously attempted oral medication regimens have proven ineffective and are supported by the medical record.
- An emergency situation occurs.

Claims submitted for antibiotic or steroid injections billed in a physician's office or in the outpatient hospital setting must include modifiers AT, ET, or KX.

31.2.25.1 Injection Administration Billed by a Physician

Injection administration billed by a physician may be reimbursed separately from the medication. Injection administration must be billed using procedure code 96372. Procedure code 96372 is limited to one per day unless documentation clearly indicates that the medications must not be mixed. Procedure code 96372 may be reimbursed in addition to an E/M or consultation visit. This ensures that each injection receives one administration fee regardless of the dosage.

Most injectable medications may be reimbursed the average wholesale price (AWP) minus 10.5 percent. However, the CSHCN Services Program reserves the option to use other data services when the AWP results have been determined as unreasonable or inefficient.

31.2.25.2 Unit Calculations for Billing Drugs

Providers must calculate the number of units to be billed on the claim based on the number of units indicated in the procedure code description and the amount of the drug actually administered. Providers should refer to the procedure code description for the unit amount to calculate the number of units to be billed.

The formula to calculate the appropriate quantity of units to bill is the amount administered divided by the units indicated in the procedure code description. For example:

Units Indicated in the Description	Amount Administered by the Provider	Calculation	Quantity to Bill on the Claim
50 mg	100 mg	100/50 = 2	2 units
per unit	20 units	20/1 = 20	20 units
per 100 units	2500 units	2500/100 = 25	25 units
per 50 mg	250 mg	250/50 = 5	5 units

Claims submitted with incorrect unit calculations may cause delayed or incorrect payment.

The specific National Drug Code (NDC) of the drug actually dispensed should be entered on the claim form.

Refer to: Section 5.6.2.6, "National Drug Codes (NDC)," on page 5-20 for more information.

Section 5.6.2.7, "Drug Rebate Program," on page 5-22 for information about the reimbursement of clinician-administered drugs and biologicals

Additional information about NDC code requirements is also available on the NDC page of the TMHP website at www.tmhp.com.

31.2.25.3 Injection Procedure Codes

The following injections are benefits of the CSHCN Services Program and are subject to the indicated limitations:

Name of Injection	Procedure Code(s)	Limitation(s)
Adalimumab Injection	J0135	Benefit for clients 18 years of age or older Diagnosis limitations: 5550, 5551, 5552, 5559, 5560, 5561, 5562, 5563, 5564, 5565, 5566, 5568, 5569, 6960, 6961, 7140, 7141, 7142, 71430, 7200
Alglucosidase alfa	J0220	Diagnosis limitation: 2710 (Glycogenosis)
Antithrombin	J7197	Diagnosis limitation: 28981 (Primary hypercoagulable state)
Azacitidine (Vidaza)	J9025	Benefit for clients 13 years of age or older Diagnosis limitations: 20502, 20510, 20512, 20522, 20532, 20582, 20592, 23872, 23873, 23874, 23875, 2850 Must be submitted with an 11-digit NDC
Cidofovir	J0740	N/A
Clofarabine (Clorar)	J9027	Prior authorization is required using the CSHCN Services Program Authorization and Prior Authorization Request Form. Documentation of the following must be submitted with the prior authorization request form: • Refractory or relapsed acute lymphoblastic leukemia (diagnosis code 20400) • At least 2 prior failed regimens
Dalteparin sodium	J1645	N/A
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Denileukin Diftitox	J9160	Diagnosis limitations: 20210, 20211, 20212, 20213, 20214, 20215, 20216, 20217, 20218, 20220, 20270, 20271, 20272, 20273, 20274, 20275, 20276, 20277, 20278
Eculizumab	J1300	Diagnosis limitations: 28311 (Hemolytic-uremic syndrome) and 2832 (Hemoglobinuria due to hemolysis from external causes)
Enoxaparin sodium	J1650	N/A
Epirubicin hydrochloride	J9178	Diagnosis limitations: 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1748, 1749, 1750, 1759 (malignant neoplasm of male or female breast)
Epoprostenol	J1325	Diagnosis limitation: 4160 (primary pulmonary hypertension only)
Fondaparinux sodium	J1652	N/A
Granisetron hydrochloride	J1626	Diagnosis limitations: V580, V5811, V5812 (encounter of radiotherapy and chemo-therapy diagnosis codes) The quantity used must appear on the claim.
Ibutilide fumarate	J1742	Diagnosis limitations: 42731, 42732
Infliximab	J1745	Diagnosis limitations: 5550, 5551, 5552, 5559, 5651, 56981, 7140, 7141, 7142, 71430
Ixabepilone	J9207	Diagnosis limitations: 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1748, 1749, 2330
Lioresal	J0475 J0476	Separate payment for the device is not a benefit for the physician or the hospital.
Natalizumab injection	J2323	Diagnosis limitations: 340, 5550, 5551, 5552, 5559
Porfimer sodium	J9600	Diagnosis limitations: 1500, 1501, 1502, 1503, 1504, 1505, 1508, 1509, 1978
Rituximab	J9310	N/A
Sumatriptan succinate	J3030	Limited to treatment of classical migraines Diagnosis limitation: 34600, 34602, 34603, 34612, 34613, 34622, 34623, 34630, 34631, 34632, 34633, 34640, 34641, 34642, 34643, 34650, 34651, 34652, 34653, 34660, 34661, 34662, 34663, 34670, 34671, 34672, 34673, 34682, 34683, 34692, 34693 (classical migraine without mention of intractable migraine)
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Trastuzumab	J9355	A benefit of the CSHCN Services Program as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel for the adjuvant treatment of clients with HER2 overexpressing, node positive breast cancer. Diagnosis limitations: 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1748, 1749, 1750, 1759
Valrubicin	J9357	Diagnosis limitation: 2337 (Carcinoma in situ of bladder)
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

In addition to the injections listed in the above table, the following sections indicate additional injections that may be reimbursed by the CSHCN Services Program and the applicable limitations.

31.2.25.4 Ado-Trastuzumab Emtansine

Ado-trastuzumab emtansine (procedure code J9354) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes				
1740	1741	1742	1743	1744
1745	1746	1748	1749	1750
1759				

Documentation must support the administration of Ado-trastuzumab emtansine and include all of the following:

- Evidence of HER2 positive breast cancer as evidenced by an immunochemistry (IHC) test or fluorescent in situ hybridization (FISH) test
- Evidence of metastatic breast cancer
- Evidence of prior treatment for HER2 positive metastatic breast cancer with trastuzumab and a taxane oncology agent given separately or in combination
- Evidence demonstrating receipt of prior therapy for HER2 positive metastatic breast cancer or recurrent disease, including previous treatment protocol, within six months of completing adjuvant therapy.

All documentation must be maintained in the client's medical record and is subject to retrospective review.

31.2.25.5 Bevacizumab

Bevacizumab (procedure code J9035) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Code	Description
1530	Malignant neoplasm of hepatic flexure
1531	Malignant neoplasm of transverse colon
1532	Malignant neoplasm of descending colon
1533	Malignant neoplasm of sigmoid colon
1534	Malignant neoplasm of cecum
1535	Malignant neoplasm of appendix
1536	Malignant neoplasm of ascending colon

Diagnosis Code	Description
1537	Malignant neoplasm of splenic flexure
1538	Malignant neoplasm of other specified sites of large intestine
1539	Malignant neoplasm of colon, unspecified site
1540	Malignant neoplasm of rectosigmoid junction
1541	Malignant neoplasm of rectum
1542	Malignant neoplasm of anal canal
1543	Malignant neoplasm of anus, unspecified site
1548	Malignant neoplasm of other sites of rectum, rectosigmoid junction, and anus
1622	Malignant neoplasm of main bronchus
1623	Malignant neoplasm of upper lobe, bronchus, or lung
1624	Malignant neoplasm of middle lobe, bronchus, or lung
1625	Malignant neoplasm of lower lobe, bronchus, or lung
1628	Malignant neoplasm of other parts of bronchus or lung
1629	Malignant neoplasm of bronchus and lung, unspecified site
1808	Malignant neoplasm of other specified sites of cervix
1809	Malignant neoplasm of cervix uteri, unspecified site
1890	Malignant neoplasm of kidney, except pelvis
1910	Malignant neoplasm of cerebrum, except lobes and ventricles
1911	Malignant neoplasm of frontal lobe of brain
1912	Malignant neoplasm of temporal lobe of brain
1913	Malignant neoplasm of parietal lobe of brain
1914	Malignant neoplasm of occipital lobe of brain
1915	Malignant neoplasm of ventricles of brain
1916	Malignant neoplasm of cerebellum NOS
1917	Malignant neoplasm of brain stem
1918	Malignant neoplasm of other parts of brain
1919	Malignant neoplasm of brain, unspecified site
V1005	Personal history of malignant neoplasm of large intestine
V1006	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
V1011	Personal history of malignant neoplasm of bronchus and lung
V103	Personal history of malignant neoplasm of breast

31.2.25.6 Botulinum Toxin (Type A and Type B)

The CSHCN Services Program may reimburse botulinum toxin, types A and B, for clients with specific diagnoses. Botulinum toxin, type A (procedure codes J0585 and J0586) are payable when billed with the following diagnosis codes:

Diagnosis Code	Description
3336	Genetic torsion dystonia
33371	Athetoid cerebral palsy
33372	Acute dystonia due to drugs
33379	Other acquired torsion dystonia

Diagnosis Code	Description
33381	Blepharospasm
33382	Orofacial dyskinesia
33383	Spasmodic torticollis
33384	Organic writers' cramp
33385	Subacute dyskinesia due to drugs
33389	Other fragments of torsion dystonia
3341	Hereditary spastic paraplegia
33821	Chronic pain due to trauma
340	Multiple sclerosis
3410	Neuromyelitis optica
3411	Schilder's disease
34120	Acute (transverse) myelitis NOS
34121	Acute (transverse) myelitis in conditions classified elsewhere
34122	Idiopathic transverse myelitis
3418	Other demyelinating diseases of central nervous system
3419	Demyelinating disease of the CNS, unspecified
34211	Spastic hemiplegia affecting dominant side
34212	Spastic hemiplegia affecting nondominant side
34281	Other specified hemiplegia affecting the dominant side
34282	Other specified hemiplegia affecting the nondominant side
34291	Unspecified hemiplegia affecting the dominant side
34292	Unspecified hemiplegia affecting the nondominant side
3430	Diplegic infantile cerebral palsy
3431	Hemiplegic infantile cerebral palsy
3432	Quadriplegic infantile cerebral palsy
3433	Monoplegic infantile cerebral palsy
3434	Infantile hemiplegia
3438	Other specified infantile cerebral palsy
3439	Unspecified infantile cerebral palsy
34400	Unspecified quadriplegia
34401	Quadriplegia and quadriparesis, C1-C4, complete
34402	Quadriplegia and quadriparesis, C1-C4, incomplete
34403	Quadriplegia and quadriparesis, C5-C7, complete
34404	Quadriplegia and quadriparesis, C5-C7, incomplete
34409	Other quadriplegia and quadriparesis
3441	Paraplegia
3442	Diplegia of upper limbs
34430	Monoplegia of lower limb affecting unspecified side
34431	Monoplegia of lower limb affecting dominant side
34432	Monoplegia of lower limb affecting nondominant side
34440	Monoplegia of upper limb affecting unspecified side

Diagnosis Code	Description
34441	Monoplegia of upper limb affecting dominant side
34442	Monoplegia of upper limb affecting nondominant side
3445	Unspecified monoplegia
34460	Cauda equina syndrome without mention of neurogenic bladder
34461	Cauda equina syndrome with neurogenic bladder
3518	Other facial nerve disorders
37800	Unspecified esotropia
37801	Monocular esotropia
37802	Monocular esotropia with A pattern
37803	Monocular esotropia with V pattern
37804	Monocular esotropia with other noncomitancies
37805	Alternating esotropia
37806	Alternating esotropia with A pattern
37807	Alternating esotropia with V pattern
37808	Alternating esotropia with other noncomitancies
37810	Unspecified exotropia
37811	Monocular exotropia
37812	Monocular exotropia with A pattern
37813	Monocular exotropia with V pattern
37814	Monocular exotropia with other noncomitancies
37815	Alternating exotropia
37816	Alternating exotropia with A pattern
37817	Alternating exotropia with V pattern
37818	Alternating exotropia with other noncomitancies
37820	Unspecified intermittent heterotropia
37821	Intermittent esotropia, monocular
37822	Intermittent esotropia, alternating
37823	Intermittent exotropia, monocular
37824	Intermittent exotropia, alternating
37830	Unspecified heterotropia
37831	Hypertropia
37832	Hypotropia
37833	Cyclotropia
37834	Monofixation syndrome
37835	Accommodative component in esotropia
37840	Unspecified heterophoria
37841	Esophoria
37842	Exophoria
37843	Vertical heterophoria
37844	Cyclophoria
37845	Alternating hyperphoria

Diagnosis Code	Description
37850	Unspecified paralytic strabismus
37851	Paralytic strabismus, third or oculomotor nerve palsy, partial
37852	Paralytic strabismus, third or oculomotor nerve palsy, total
37853	Paralytic strabismus, fourth or trochlear nerve palsy
37854	Paralytic strabismus, sixth or abducens nerve palsy
37855	Paralytic strabismus, external ophthalmoplegia
37856	Paralytic strabismus, total ophthalmoplegia
37860	Unspecified mechanical strabismus
37861	Mechanical strabismus from Brown's (tendon) sheath syndrome
37862	Mechanical strabismus from other musculofascial disorders
37863	Mechanical strabismus from limited duction associated with other conditions
37871	Duane's syndrome
37872	Progressive external ophthalmoplegia
37873	Strabismus in other neuromuscular disorders
37881	Palsy of conjugate gaze
37882	Spasm of conjugate gaze
37883	Convergence insufficiency or palsy in binocular eye movement
37884	Convergence excess or spasm in binocular eye movement
37885	Anomalies of divergence in binocular eye movement
37886	Internuclear ophthalmoplegia
37887	Other dissociated deviation of eye movements
3789	Unspecified disorder of eye movements
47875	Laryngeal spasm
47879	Other diseases of larynx
5277	Disturbance of salivary secretions
5300	Achalasia and cardiospasm
5646	Anal spasm
5650	Anal fissure
7235	Torticollis, unspecified
72885	Spasm of muscle
72982	Cramp of limb
78072	Functional quadriplegia

Procedure code J0585 is also payable when billed with diagnosis code 59651 (Hypertonicity of bladder), 59654 (Neurogenic bladder NOS), or 59655 (Detrusor sphincter dyssynergia).

Claims must indicate the number of units used. If the number of units is not specified, a quantity of one is allowed. Prior authorization is required when procedure code J0585 is billed with a quantity greater than 300 units. Documentation supporting medical necessity for the larger quantity must be submitted with the prior authorization request.

The denervation procedure codes in the following table are a benefit in addition to botulinum toxin type A:

Procedure Codes				
64600	64605	64610	64612	64615
64620	64630	64632	64680	67345

Procedure code J0588 is a benefit and is limited to the following diagnosis codes:

Diagnosis Code	Description
33381	Blepharospasm
33383	Spasmodic torticollis
34210	Spastic hemiplegia affecting unspecified side
34211	Spastic hemiplegia affecting dominant side
34212	Spastic hemiplegia affecting nondominant side

If a quantity greater than 120 units of procedure code J0588 is billed with the same date of service, documentation supporting medical necessity for the larger quantity must be submitted with the claim.

Procedure code J0587 must be submitted for reimbursement of the type B botulinum toxin (per 100 units) and is limited to the following diagnosis codes:

Diagnosis Code	Description
33383	Spasmodic torticollis
33821	Chronic pain due to trauma

Providers must bill the toxin injection quantity (procedure code J0587) per 100 units used for type B (e.g., 2,500 units would be billed as quantity 25). If the units are not specified, a quantity of one is allowed.

Procedure code J0587 is limited to a billed quantity of 100 units. Any claim billed in excess of 100 billing units will be denied.

The CSHCN Services Program requires a trial of type A botulinum toxin prior to the use of type B botulinum toxin.

Injections of either toxin are limited to no more than once every 3 months. Supplies used to administer the toxins will not be reimbursed separately.

Prior Authorization Requirements

Prior authorization and medical review is required for diagnoses other than those listed above. Documentation for consideration of other diagnoses must include the diagnosis, clinical course, clinical history, and other treatments with an explanation of ineffective results. This documentation to support medical necessity must be submitted to the TMHP-CSHCN Services Program Authorization Department with the CSHCN Services Program Authorization and Prior Authorization Request Form. Prior authorization requests may be approved for a 12-month period. All extension requests must include diagnosis, clinical course, and result of previous botulinum toxin therapy and expected length of treatment.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for more information about authorization and prior authorization requirements.

Procedures incidental to the administration of botulinum toxin, such as EMGs, do not require authorization and may be reimbursed in the quantity billed.

APRNs and physician assistants administering botulinum toxin therapy must be supervised by a physician who is board eligible or board certified in the physician's specialty. Documentation of the APRN's and physician assistant's training must be kept in the supervising physician's records and be available for review on request by the CSHCN Services Program or its designee.

Reimbursement

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

An E/M code billed by the same provider and with the same date of service as the administration of botulinum toxin is denied as part of another procedure.

31.2.25.7 Erythropoietin Alfa (EPO) and Darbepoetin

EPO and darbepoietin (procedure codes J0881 and J0885) are benefits of the CSHCN Services Program for the following diagnosis codes:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV)
20300	Multiple myeloma without mention of remission
20301	Multiple myeloma in remission
2733	Macroglobulinemia
2800	Iron deficiency anemia secondary to blood loss (chronic)
2801	Iron deficiency anemia secondary to inadequate dietary iron intake
2808	Other specified iron deficiency anemias
2809	Unspecified iron deficiency anemia
2810	Pernicious anemia
2811	Other vitamin B12 deficiency anemia
2812	Folate-deficiency anemia
2813	Other specified megaloblastic anemias not elsewhere classified
2814	Protein-deficiency anemia
2818	Anemia associated with other specified nutritional deficiency
2819	Unspecified deficiency anemia
2820	Hereditary spherocytosis
2821	Hereditary elliptocytosis
2822	Anemias due to disorders of glutathione metabolism
2823	Other hemolytic anemias due to enzyme deficiency
28241	Sickle-cell thalassemia without crisis
28242	Sickle-cell thalassemia with crisis
28249	Other thalassemia
2825	Sickle-cell trait
28260	Sickle-cell disease, unspecified
28261	Hb-SS disease without crisis
28262	Hb-SS disease with crisis
28263	Sickle-cell/Hb-C disease without crisis
28264	Sickle-cell/Hb-C disease with crisis
28268	Other sickle-cell disease without crisis
28269	Other sickle-cell disease with crisis
2827	Other hemoglobinopathies
2828	Other specified hereditary hemolytic anemias
2829	Unspecified hereditary hemolytic anemia
2830	Autoimmune hemolytic anemias
28310	Unspecified nonautoimmune hemolytic amenia
28311	Hemolytic-uremic syndrome
28319	Other nonautoimmune hemolytic anemias
2832	Hemoglobinuria due to hemolysis from external causes
2839	Acquired hemolytic anemia, unspecified

Diagnosis Code	Description
28401	Constitutional red blood cell aplasiac
28409	Other constitutional aplastic anemia
2842	Myelophthisis
28481	Red cell aplasia (acquired) (adult) (with thymoma)
28489	Other specified aplastic anemias
2849	Unspecified aplastic anemia
2850	Sideroblastic anemia
2851	Acute posthemorrhagic anemia
28521	Anemia in chronic kidney disease
28522	Anemia in neoplastic disease
28529	Anemia of other chronic illness
2853	Antineoplastic chemotherapy induced anemia
2858	Other specified anemias
2859	Unspecified anemia
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified
40301	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end-stage renal disease
40310	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
40311	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end-stage renal disease
40390	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
40391	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end-stage renal disease
40402	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end-stage renal disease
40403	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end-stage renal disease
40412	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end-stage renal disease
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end-stage renal disease
40492	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end-stage renal disease
40493	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end-stage renal disease
586	Unspecified renal failure
58889	Other specified disorders resulting from impaired renal function
7140	Rheumatoid arthritis
99811	Hemorrhage complicating a procedure
V4983	Awaiting organ transplant status
V5811	Encounter for antineoplastic chemotherapy

Diagnosis Code	Description
V5812	Encounter for antineoplastic immunotherapy
V5844	Aftercare following organ transplant

In addition to the diagnosis codes listed above, procedure code J0885 may also be considered for reimbursement with the following diagnosis codes:

Diagnosis Code	Description
5851	Chronic kidney disease, Stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5856	End-stage renal disease
5859	Chronic kidney disease, unspecified

Procedure codes J0882 and J0886 are benefits of the CSHCN Services Program for the following diagnosis codes:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV)
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified
40301	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end-stage renal disease
40310	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
40311	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end-stage renal disease
40390	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
40391	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end-stage renal disease
40402	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end-stage renal disease
40403	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end-stage renal disease
40412	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end-stage renal disease
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end-stage renal disease
40492	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end-stage renal disease
40493	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end-stage renal disease
5851	Chronic kidney disease, Stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V

Diagnosis Code	Description
5856	End-stage renal disease
5859	Chronic kidney disease, unspecified
586	Unspecified renal failure
V420	Kidney replaced by transplant
V560	Aftercare involving extracorporeal dialysis
V5631	Encounter for adequacy testing for hemodialysis
V5632	Encounter for adequacy testing for peritoneal dialysis
V568	Encounter other dialysis

EPO is limited to three injections per calendar week (Sunday through Saturday). Procedure code J0885 and J0886 must be submitted with an 11-digit NDC.

31.2.25.8 Growth Hormone

The Vendor Drug Program (VDP) reimburses growth hormone (hGH) injections for CSHCN Services Program clients for any of the following diagnosis codes:

Diagnosis Codes				
1933	2370	2532	2533	2537
5851	5852	5853	5854	5855
5856	5859	58889	7586	75981

Pharmacies must submit claims to the VDP. Pharmacies are reimbursed the same drug costs and dispensing fees allowed by the Texas Medicaid VDP.

Providers may refer to the Texas Health and Human Services Commission Texas Medicaid/CHIP Vendor Drug Program website at www.txvendordrug.com/dur/prior-approval.shtml for more information about the VDP, including available drugs.

Prior Authorization Requirements

Requests for prior approval of the medical criteria for growth hormone therapy must be submitted to the Texas Medicaid VDP by a program-approved endocrinologist using the "Growth Hormone Approval Request Form." The following criteria must be met:

- Normal thyroid function or may be corrected with medication
- Normal pituitary function studies or may be corrected with medication
- Documentation of open epiphyses (done in last 12 months)
- Evidence of deficient growth hormone (GH) production on two pharmacological provocative tests (GH peak less than 10 ng/ml)
- Physical stature less than the 3rd percentile
- Growth velocity 4cm or less per year
- Below normal somatomedin C level or insulin-like growth factor binding protein 3 (IGF/BP3)

Nutropin® is the only product approved for the treatment of chronic renal failure, and Genotropin® is the only product approved for the treatment of Prader-Willi syndrome.

Note: *Clients with Turner's syndrome or Prader-Willi syndrome may be approved without evidence of deficient growth hormone production on provocative testing if other criteria are met.*

Initial approval is for a 6-month period. Requests for extensions may be granted for an additional 12 months at a time. Approval for continued growth hormone therapy may be granted if the following criteria are met:

- Growth chart documents growth equal to a minimum of 4cm per year and documents a significant increase from pretreatment levels
- Epiphyses must be open

- Bone age must be documented annually after a boy has reached a chronological age of 16 years and a girl has reached a chronological age of 14 years.

If an initial or extension request cannot be approved based on the above criteria, the approval request may be sent for medical review and reconsideration to the CSHCN Services Program.

Refer to: Section 3.1.1, "Prescription Drug Benefits," on page 3-3 for more information about the VDP.

31.2.25.9 Immune Globulins

Immune globulins may be indicated for treatment of certain immune disorders and states of immunodeficiency.

Immune and gamma globulins and the administration of immune and gamma globulins are benefits of the CSHCN Services Program.

Providers are responsible for administering immune globulins based on the Food and Drug Administration (FDA)-approved guidelines. In the absence of FDA indications, a drug must meet the following criteria for consideration of coverage:

- The drug is recognized by the American Hospital Formulary Service Drug Information, the U.S. Pharmacopoeia Dispensing Information, Vol. I., or two articles from major peer-reviewed journals that have validated data supporting the proposed use for the specific medical condition is safe and effective.
- It is medically necessary to treat the specific medical condition, including life-threatening conditions or chronic debilitating conditions.
- The drug is not experimental or investigational.

The following procedure codes may be used to submit claims for immune and gamma globulin injections:

Procedure Codes				
90281	90283	90284	90291	90371
90389	90396	90399	J0850	J1459
J1460	J1556	J1557	J1560	J1561
J1566	J1568	J1569	J1571	J1572
J1573	J1670	J2788	J2791	J2792

The following conditions apply when billing immune globulin procedure codes:

- If procedure codes 90389 and J1670 are billed with the same date of service by any provider, only one is considered for reimbursement.
- If procedure codes J1571 and 90371 are billed with the same date of service by any provider, only one may be reimbursed.

Administration procedure codes 96369, 96370, 96372, and 96374 may be billed with the immune globulins listed in this section.

Procedure code 96370 must be billed with the same date of service as procedure code 96369.

Reimbursement for the following procedure codes will be based on the lowest AWP, minus 10.5 percent, according to the prices in the current edition of the *Red Book*, published by Thomson Healthcare, on file with the CSHCN Services Program.

Procedure Codes				
90281	90283	90291	90371	90389
90396	J1560			

All other procedure codes for immune and gamma globulins may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service submitted on the claim.

Authorization Requirements

Unlisted procedure code 90399 may be considered for reimbursement with prior authorization. The requesting provider must submit the following documentation with the authorization request:

- The client's diagnosis
- Medical records that indicate any prior treatments for this diagnosis
- A clear, concise description of the medical necessity of the immune globulin and the rationale for the recommendation of this particular immune globulin
- A procedure code that is comparable to the immune globulin being requested
- Documentation that this immune globulin is not investigational or experimental
- The place of service at which the immune globulin is to be administered
- The provider's intended fee for this immune globulin

31.2.25.10 Leuprolide Acetate Injection

Procedure code J9217 is allowed for use in monthly, 3-month, 4-month, and 6-month doses.

Providers must bill the following dosage increments:

Dose Period	Dose Quantity	Quantity Billed	Limitation
Monthly	7.5 mg	1	Once per month
3-month	22.5 mg	3	Once every 3 months
4-month	30 mg	4	Once every 4 months
6-month	45 mg	6	Once every 6 months

31.2.25.11 Omalizumab

Omalizumab (procedure code J2357) is a benefit of the CSHCN Services Program when medically necessary for the treatment of clients 12 years of age or older with moderate to severe and persistent asthma, or moderate to severe chronic idiopathic urticaria (CIU). Omalizumab must be prior authorized.

Doses are determined by body weight and dosing frequency is determined by clinical severity.

Providers may not bill separately for an office visit if the only reason for the visit was the omalizumab injection.

Prior Authorization Requirements

Procedure code J2357 must be used to request prior authorization and the exact dosage must be indicated on the CSHCN Services Program Prior Authorization Request for Omalizumab form.

Prior authorization of omalizumab may be granted for clients who are 12 years of age or older with moderate to severe asthma (as defined by by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma) or moderate to severe CIU.

Documentation of the following medical necessity criteria must be submitted with a request for treatment of asthma:

- A positive skin test or RAST to a perennial (not seasonal) aeroallergen within the past 36 months
- Total IgE level greater than 30 IU/ml but less than 700 IU/ml within the past 12 months

Note: *Total IgE level is required only for the initial prior authorization request and is not required for subsequent prior authorization requests.*

- The client has been compliant with an inhaled steroid regimen
- Clinical evidence of inadequate asthma control. A pulmonary function test must have been performed within a three-month period and be documented for all clients when requesting prior authorization for omalizumab. Clinical evidence of inadequate asthma control may include any of the following:
  - Dependence on daily systemic steroids or maximal inhaled steroid regimen with frequent

systemic steroid pulses

- Frequent hospitalizations or acute care visits for severe asthma exacerbations in the face of adequate maximal standard therapy . The client must also have been on daily therapy for persistent asthma for at least one year with frequent use of beta agonist
- Persistence of significantly decreased pulmonary function testing (spirometry) demonstrating refractory lower airways' obstruction and hyper-activity, overtime, despite the rigorous medical regimen previously documented
- Exceptions may be considered with documentation of medical reasons explaining why pulmonary function tests cannot be performed

- The client is not currently smoking

Prior authorization requests for clients with CIU must include the following documentation of medical necessity:

- Documented failure of, or contraindication to, antihistamine, leukotriene inhibitor, and immunosuppressive therapies
- Evidence of an evaluation that excludes other medical diagnoses associated with chronic urticaria

Prior authorization requests for clients who are 11 years of age or younger or with other exceptions may be considered on an individual basis.

Omalizumab approvals are for intervals of 6 months at a time. Clients must be fully compliant with their omalizumab regimen in order to qualify for any additional authorizations. The provider must submit a statement documenting full compliance with the requests for each renewal in order to qualify for any additional authorizations. After 12 continuous months of authorizations, the provider must submit documentation of satisfactory clinical response to omalizumab in order to qualify for additional authorizations.

Refer to: CSHCN Services Program Prior Authorization Request for Omalizumab form.

31.2.26 Intracranial Pressure Monitoring

Intracranial pressure monitoring is a benefit of the CSHCN Services Program.

Authorization is not required for intracranial pressure monitoring and is not limited to specific diagnoses. Physicians should use procedure code 61210 to submit a claim for intracranial pressure monitoring. Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.27 Laboratory Services

31.2.27.1 Physician Laboratory Services

The CSHCN Services Program may reimburse laboratory services ordered by a physician and provided under the direct supervision of the physician in the physician's office laboratory.

A physician office laboratory is a laboratory maintained by a physician or group of physicians for performing diagnostic tests in connection with the physician practice.

If a physician performs more than 100 laboratory tests per year for other providers in his or her laboratory, the lab must be certified by Medicare and the provider must enroll as an independent laboratory with TMHP.

CSHCN Services Program laboratory benefits are provided for medically necessary professional and technical services ordered by a practitioner who is licensed to do so and provided under the direct supervision of a physician. Direct supervision is defined as the presence of the physician in the building where the services are performed. All laboratory services must be documented in the client's medical record as medically necessary and referenced to an appropriate diagnosis.

Laboratory tests generally performed as a panel (chemistries, complete blood counts [CBCs], or urinalyses [UAs]) and performed on the same day by the same provider must be billed as a panel regardless of the method used to perform the test.

31.2.27.2 Laboratory Handling Fee

Physicians may be reimbursed for only one lab-handling fee (procedure code 99000) per day, per client, when collected by venipuncture or catheterization unless multiple specimens are obtained and sent to different laboratories. Laboratory services must be documented in the client's medical record as medically necessary and must reference an appropriate diagnosis code. In addition, the laboratory's name and address or unique provider identifier must be included on the claim form.

The lab handling fee covers the expense of obtaining the specimen and packaging it to be sent to a reference laboratory. When billing for a lab handling fee, the physician must document that a specimen was sent to a reference laboratory in Block 20 of the CMS-1500 paper claim form and indicate the reference laboratory name and address or CSHCN Services Program provider identifier in Block 32 of the CMS-1500 paper claim form. The physician is required to forward the client's name, address, client number, and diagnosis with the specimen to the reference laboratory so that the laboratory may bill the CSHCN Services Program for its services. When billing for laboratory services, providers should use the date the specimen was collected as the date of service. If the specimen is sent to a reference laboratory and the client is an inpatient, the hospital is responsible for payment of these services to the reference laboratory.

Refer to: Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26.

31.2.27.3 Claims Filing for Laboratory Tests

Physicians may only be reimbursed for the total component of laboratory tests that are actually performed in their office laboratories.

Interpretation of laboratory tests is considered part of a physician's professional services (hospital, office, or emergency room visits) and must not be billed separately.

The claim must indicate the specific type of laboratory procedure performed. Providers who perform only the technical service must bill for the technical component.

31.2.27.4 Clinical Pathology Services and Pathology Consultations

Clinical pathology consultations (procedure codes 80500 and 80502) are a benefit when they are performed by a clinical pathologist or geneticist. A geneticist may submit claims for procedure codes 80500 and 80502 using their physician provider identifier.

Routine conversations between a consultant and an attending physician about test orders or results are not considered consultations.

The service does not qualify as a consultation if the information could ordinarily be furnished by a non-physician laboratory specialist.

Claims for clinical pathology consultations must be submitted with the following documentation:

- The name and address, or the CSHCN Services Program provider identifier for the physician requesting the consultation, must be included on the claim. The national provider identifier (NPI) of the physician requesting the consultation should also be included, if known.
- A copy of the written narrative report describing the consultation findings.
- Documented interaction that clearly outlines that the consultant interpreted the test results and made specific recommendations to the ordering physician.

If the claim does not include all of this information, the clinical pathology consultation will be denied.

31.2.27.5 Reimbursement

Clinical laboratory services performed in a physician's office may be reimbursed 60 percent of the prevailing charge levels.

Refer to: Chapter 25, "Laboratory Services," on page 25-1 for additional information concerning coding and reimbursement for laboratory procedures.

31.2.27.6 Cytopathology Studies (Gynecological, Pap Smears)

Pap smears for early detection of cancer are a benefit of the CSHCN Services Program.

Procurement and handling of the Pap smears are considered part of the E/M of the client and will not be reimbursed separately. Physicians interpreting a cytopathology specimen (Pap smears) must report the place of service according to where the cytopathology specimen is interpreted (office, inpatient hospital, outpatient hospital, or independent lab).

Because of the technical nature of processing and interpreting Pap smears or specimens for cytopathology, pathologists are the only physician specialty that may be reimbursed for these services.

Refer to: Section 25.2.5.2, "Genetic Testing for Colorectal Cancer," on page 25-23 for additional information concerning coding and reimbursement for gynecological cytopathology studies.

31.2.27.7 Cytogenetics Testing

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias, lymphomas, and other tumors, especially in children. The detection of the well-defined, recurring, genetic abnormalities often enables a correct diagnosis along with important prognostic information affecting the treatment protocol. Cytogenetics testing may be a part of an evaluation for unusual physical features or learning difficulties.

Refer to: Section 25.2.5.1, "Cytogenetics Testing," on page 25-7 for additional information about reimbursement for cytogenetics testing.

31.2.27.8 Helicobacter pylori (H. pylori)

The following procedure codes are benefits for physicians in the office setting.

Procedure Codes				
78267	78268	83009	83013	83014
86677	87338			

Refer to: Section 25.2.9, "Helicobacter pylori (H. pylori)," on page 25-28 for additional information about reimbursement for H. pylori testing.

31.2.27.9 CLIA Requirement

Refer to: Section 2.1.5.6, "Clinical Laboratory Improvement Amendments (CLIA) of 1988," on page 2-7.

Section 25.1.1, "Clinical Laboratory Improvement Amendments (CLIA) of 1988," on page 25-3 for additional information regarding CLIA regulations.

31.2.28 Neurostimulator Devices and Supplies

Neurostimulator devices and supplies are benefits of the CSHCN Services Program.

Refer to: Chapter 27, "Neurostimulators and Neuromuscular Stimulators," on page 27-1, for information about benefits for neurostimulator devices and supplies.

31.2.29 Ophthalmological Services

Ophthalmological services are benefits of the CSHCN Services Program.

Refer to: Chapter 39, "Vision Services," on page 39-1 for additional information about reimbursement for ophthalmology.

31.2.29.1 Intraocular Lenses (IOL)

An ophthalmologist who performs cataract extractions and IOL implants in the office may be reimbursed for the lens. The provider must submit a copy of the manufacturer's invoice for the IOL with the claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (minus any discount) plus a handling fee not to exceed 5 percent of the actual acquisition cost.

Note: *The CSHCN Services Program does not reimburse physicians who supply IOLs to ASCs or HASCs. Payment for the IOL is included in the facility fee.*

31.2.29.2 Vitrasert Ganciclovir Implant

Procedure code 67027 is a benefit with diagnosis code 36320 (Chorioretinitis, unspecified) or diagnosis code 0785 (cytomegaloviral disease). If a provider bills vitrectomy and implantation of intravitreal drug delivery system with the same date of service, the insertion code may be reimbursed and the vitrectomy code payment is denied as part of the other service.

31.2.30 Osteopathic Manipulative Treatment (OMT)

OMT, performed by a physician, is a benefit for acute musculoskeletal conditions, acute exacerbations of a chronic condition, and acute pre or postsurgery treatments when they are directly related to surgery.

Refer to: Chapter 30, "Physical Medicine and Rehabilitation," on page 30-1 for more information about OMT services.

31.2.31 Physical Medicine and Physical Therapy (PT) Services

PT performed by a physician or physical therapist is a benefit of the CSHCN Services Program.

Refer to: Chapter 30, "Physical Medicine and Rehabilitation," on page 30-1 for more information about PT services.

The CSHCN Services Program may reimburse physicians for therapy services performed in their offices.

The following procedure codes may be used for physical medicine and rehabilitation services:

Procedure Codes				
97001	97002	97003	97004	97012
97016	97018	97022	97024	97026
97028	97032	97033	97034	97035
97036	97039	97110	97112	97113
97116	97124	97139	97140	97150
97530	97535	97537	97542	97750
97755	97760	97761	97762	97799
S8990				

Physical therapy services must be billed with the GP modifier.

31.2.32 Podiatry

Services provided by a licensed podiatrist (DPM) are a benefit of the CSHCN Services Program. Podiatry services may be reimbursed when provided by a physician (MD or DO).

Surgery procedure codes 11055, 11056, 11057, 11719, and G0127 are limited to one service every 6 months per client.

Supportive devices such as molds, inlays, shoes, or supports and all services connected with the fitting or application of these devices must meet the CSHCN Services Program requirements for foot orthotics.

Refer to: Section 28.2.2, "Orthoses and Prostheses (Not All-Inclusive)," on page 28-3 and Section 28.3.7.2, "Prescription Shoes," on page 28-11 for additional information about foot orthotics.

Podiatrists may be reimbursed for medically necessary laboratory services and radiological procedures that include the foot, ankle, toes, or heel.

Podiatrists may prescribe medications, supplies, braces, and prosthetic devices for conditions of the foot and ankle.

Authorization and prior authorization requirements applied to services provided by physicians also apply to services provided by a podiatrist. All CSHCN Services Program requirements concerning reimbursement for surgical procedures, such as the global fee concept, apply to podiatrists.

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

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for detailed information about authorization and prior authorization requirements.

31.2.33 Psychological Testing

Procedure codes 96101, 96116, and 96118 are benefits of the CSHCN Services Program. Providers must bill the units of each half hour of testing and indicate that number of units on the claim form. Procedure codes 96101, 96116, and 96118 may be reimbursed up to 4 hours per day and 8 hours per calendar year, per client, for any provider. Submissions for over 4 hours per day and 8 hours per calendar year must include documentation of medical necessity.

Interpretation and documentation time, including time to document test results in the client's medical record, is not reimbursed separately and is included in the procedure codes for psychological testing, neuropsychological testing, and neurobehavioral status exams. The number of units on the claim must reflect the time spent face-to-face testing with the client, as well as the time spent scoring and interpreting the results in one hour increments.

If the performance, interpretation, and reporting of the testing are performed on different dates of service, then the date of service on the claim must reflect the date and time spent for each service performed. Even if scoring and interpretation are completed on a different date from the testing, providers must submit only one claim for each psychological or neuropsychological test performed. If necessary, providers can submit the claim with multiple details for each date of service. A claim must not be submitted until performance, interpretation, and reporting of the testing is complete.

Behavioral health testing and neurobehavioral status exams may be performed during an assessment by an APRN or physician assistant but will not be reimbursed separately.

Psychological testing, neuropsychological testing, and neurobehavioral status exams may be reimbursed on the same date of service as procedure code 90791 or procedure code 90792.

Psychological testing (procedure code 96101) performed on the same date of service as neuropsychological testing (procedure code 96118) will be denied as part of another service.

Refer to: Section 24.3.1.1, "Inpatient Behavioral Health," on page 24-7 for additional information about behavioral health services.

Chapter 29, "Outpatient Behavioral Health," on page 29-1 for additional information about behavioral health services.

31.2.34 Sign Language Interpreting Services

Sign language interpreting services are available to CSHCN Services Program clients who are deaf or hard of hearing or to a parent or guardian of a person receiving CSHCN Services Program benefits, who is deaf or hard of hearing.

The sign language interpreting services must be requested by a physician and provided by a qualified interpreter. A physician's determination of the need for sign language interpreting services must give primary consideration to the needs of the individual who is deaf or hard of hearing.

Sign language interpreting services are benefits of the CSHCN Services Program. Providers must use procedure code T1013 with modifier U1 for the first hour of service, and modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, per provider, and procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day.

Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from the CSHCN Services Program for providing this service.

Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels a through h) issued by either the Department of Assistive and Rehabilitative Services (DARS), the Office for Deaf and Hard of Hearing Services, the Board for Evaluation of Interpreters (BEI), or the National Registry of Interpreters for the Deaf (RID):

a) BEI Level I/Ii and BEI OC: B (Oral Certificate: Basic).

b) BEI Basic and RID NIC (National Interpreter Certificate) Certified.

c) BEI Level II/IIi, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate).

d) BEI Level III/IIIi, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter).

e) BEI Advanced and RID NIC Advanced.

f) BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal).

g) EI V/VI.

h) BEI Master; and RID NIC Master.

Interpreting services include the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.

The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the client's medical record and must include the name of the sign language interpreter and the interpreter's certification level. Documentation must be made available if requested by the CSHCN Services Program or its designee.

31.2.35 Skin Therapy

Procedure codes 96900, 96910, 96912, and 96913 are benefits of the CSHCN Services Program for the following diagnosis codes:

Diagnosis Code	Description
0780	Molluscum contagiosum
07812	Plantar wart
0850	Visceral leishmaniasis
0851	Cutaneous leishmaniasis, urban
0852	Cutaneous leishmaniasis, Asian desert
0853	Cutaneous leishmaniasis, Ethiopian
0854	Cutaneous leishmaniasis, American
0855	Mucocutaneous (American) leishmaniasis

Diagnosis Code	Description
0859	Leishmaniasis, unspecified
1032	Pinta late lesions
20210	Mycosis fungoides, unspecified site, extranodal and solid organ sites
20211	Mycosis fungoides of lymph nodes of head, face, and neck
20212	Mycosis fungoides of intrathoracic lymph nodes
20213	Mycosis fungoides of intra-abdominal lymph nodes
20214	Mycosis fungoides of lymph nodes of axilla and upper limb
20215	Mycosis fungoides of lymph nodes of inguinal region and lower limb
20216	Mycosis fungoides of intrapelvic lymph nodes
20217	Mycosis fungoides of spleen
20218	Mycosis fungoides of lymph nodes of multiple sites
37453	Hypopigmentation of eyelid
69010	Seborrheic dermatitis, unspecified
69011	Seborrhea capitis
69012	Seborrheic infantile dermatitis
69018	Other seborrheic dermatitis
6908	Other erythematosquamous dermatosis
6910	Diaper or napkin rash
6918	Other atopic dermatitis and related conditions
6920	Contact dermatitis and other eczema due to detergents
6921	Contact dermatitis and other eczema due to oils and greases
6922	Contact dermatitis and other eczema due to solvents
6923	Contact dermatitis and other eczema due to drugs and medicines in contact with skin
6924	Contact dermatitis and other eczema due to other chemical products
6925	Contact dermatitis and other eczema due to food in contact with skin
6926	Contact dermatitis and other eczema due to plants [except food]
69272	Acute dermatitis due to solar radiation
69273	Acute reticuloid and actinic granuloma
69275	Disseminated superficial actinic porokeratosis [DSAP]
69281	Dermatitis due to cosmetics
69282	Dermatitis due to other radiation
69283	Dermatitis due to metals
69284	Contact dermatitis and other eczema due to animal (cat) (dog) dander
69289	Contact dermatitis and other eczema, other
6929	Contact dermatitis and other eczema, unspecified cause
6930	Dermatitis due to drugs and medicines
6931	Dermatitis due to food
6938	Dermatitis due to other specified substances taken internally
6939	Dermatitis due to unspecified substance taken internally
6940	Dermatitis herpetiformis
6941	Subcorneal pustular dermatosis

Diagnosis Code	Description
6942	Juvenile dermatitis herpetiformis
6943	Impetigo herpetiformis
6944	Pemphigus
6945	Pemphigoid
69460	Benign mucous membrane pemphigoid, without mention of ocular involvement
69461	Benign mucous membrane pemphigoid, with ocular involvement
6948	Other specified bullous dermatoses
6949	Unspecified bullous dermatoses
7060	Acne varioliformis
7061	Other acne
70900	Dyschromia, unspecified
70901	Vitiligo

31.2.36 Sleep Studies

Polysomnography, multiple sleep latency tests, and pediatric pneumograms are benefits of the CSHCN Services Program.

Sleep facilities that perform services for CSHCN Services Program clients must be accredited with the American Academy of Sleep Medicine (AASM) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Documentation of accreditation must be maintained in the facility and be available for review. Sleep facilities must also follow current AASM practice parameters and clinical guidelines. Providers may refer to the AASM website at www.aasmnet.org for AASM facility certification requirements or to the JCAHO website at www.jointcommission.org for JCAHO facility accreditation information.

Sleep facility technicians and technologists must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

The sleep facility must have one or more supervision physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of the non-physician staff who use the equipment.

31.2.36.1 Polysomnography

Polysomnography is the recording, analysis, and interpretation of the multiple simultaneous physiological measurements of sleep for 6 or more hours. The studies are performed to diagnose a variety of sleep disorders, such as sleep apnea, and are considered part of the clinical workup performed before the surgical procedure uvulopalatopharyngoplasty.

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which includes a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG).

Additional parameters of sleep include, but are not limited to:

- Airflow.
- Body positions.
- Continuous blood pressure monitoring.
- Electrocardiogram (ECG).
- Extended EEG monitoring.
- Extremity/motor activity movement.

- Gas exchange by oximetry.
- Gastroesophageal reflux.
- Penile tumescence.
- Snoring.
- Ventilation and respiratory effort.

For a study to be reported as polysomnography, sleep must be recorded and staged.

Polysomnographic technologists, technicians, and trainees must meet the following supervision requirements:

- A polysomnographic trainee provides basic polysomnographic testing and associated interventions under the direct supervision of a polysomnographic technician, polysomnographic technologist or physician.

Note: *Direct supervision means that the supervising licensed/certified professional must be present in the office suite or building and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the supervising professional must be present in the room while the service is being provided.*

- A polysomnographic technologist provides comprehensive evaluation and treatment of sleep disorders under the general supervision of the clinical director (M.D. or D.O.).
- A polysomnographic technician provides comprehensive polysomnographic testing and analysis, and associated interventions under the general supervision of a polysomnographic technologist or clinical director (M.D. or D.O.).

Note: *The supervising physician must be readily available to the performing technologist throughout the duration of the study but is not required to be in the building.*

Services provided without the required level of supervision are not considered medically appropriate and will be recouped upon retrospective record review.

Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is restricted to the following diagnosis codes:

Diagnosis Code	Description
27803	Obesity hypoventilation syndrome
3073	Stereotypic movement disorder
30740	Nonorganic sleep disorder, unspecified
30741	Transient disorder of initiating or maintaining sleep
30742	Persistent disorder of initiating or maintaining sleep
30743	Transient disorder of initiating or maintaining wakefulness
30744	Persistent disorder of initiating or maintaining wakefulness
30745	Circadian rhythm sleep disorder of nonorganic origin
30746	Sleep arousal disorder
30747	Other dysfunctions of sleep stages or arousal from sleep
30748	Repetitive intrusions of sleep
32700	Organic insomnia, unspecified
32710	Organic hypersomnia, unspecified
32711	Idiopathic hypersomnia with long sleep time
32712	Idiopathic hypersomnia without long sleep time
32713	Recurrent hypersomnia
32714	Hypersomnia due to medical condition classified elsewhere
32715	Hypersomnia due to mental disorder
32719	Other organic hypersomnia

Diagnosis Code	Description
32720	Organic sleep apnea, unspecified
32721	Primary central sleep apnea
32723	Obstructive sleep apnea (adult) (pediatric)
32724	Idiopathic sleep related non-obstructive alveolar hypoventilation
32725	Congenital central alveolar hypoventilation syndrome
32726	Sleep related hypoventilation/hypoxemia in conditions classifiable elsewhere
32727	Central sleep apnea in conditions classified elsewhere
32729	Other organic sleep apnea
32730	Circadian rhythm sleep disorder, unspecified
32731	Circadian rhythm sleep disorder, delayed sleep phase type
32732	Circadian rhythm sleep disorder, advanced sleep phase type
32733	Circadian rhythm sleep disorder, irregular sleep-wake type
32734	Circadian rhythm sleep disorder, free-running type
32735	Circadian rhythm sleep disorder, jet lag type
32736	Circadian rhythm sleep disorder, shift work type
32737	Circadian rhythm sleep disorder in conditions classified elsewhere
32739	Other circadian rhythm sleep disorder
32740	Organic parasomnia, unspecified
32741	Confusional arousals
32742	REM sleep behavior disorder
32743	Recurrent isolated sleep paralysis
32744	Parasomnia in conditions classified elsewhere
32749	Other organic parasomnia
32751	Periodic limb movement disorder
32759	Other organic sleep related movement disorders
3278	Other organic sleep disorders
3332	Myoclonus
33399	Other extrapyramidal disease and abnormal movement disorders
34700	Narcolepsy, without cataplexy
34701	Narcolepsy, with cataplexy
34710	Narcolepsy in conditions classified elsewhere, without cataplexy
34711	Narcolepsy in conditions classified elsewhere, with cataplexy
51883	Chronic respiratory failure
78050	Unspecified sleep disturbance
78051	Insomnia with sleep apnea, unspecified
78052	Insomnia, unspecified
78053	Hypersomnia with sleep apnea, unspecified
78054	Hypersomnia, unspecified
78055	Disruptions of 24 hour sleep wake cycle, unspecified
78056	Dysfunctions associated with sleep stages or arousal from sleep
78057	Unspecified sleep apnea

Diagnosis Code	Description
78058	Sleep related movement disorder, unspecified
78059	Other sleep disturbances
78609	Other dyspnea and respiratory abnormalities
79901	Asphyxia

Polysomnography is payable to physicians in outpatient hospital and office settings. Procedure codes 95782, 95783, 95808, 95810, and 95811 are limited to one per day by any provider. When multiple procedure codes are billed on the same day, the most inclusive code is paid and all other codes are denied.

31.2.36.2 Multiple Sleep Latency Test

Multiple sleep latency tests involve the client being given a chance to sleep every 2 hours during normal wake time. Observations are made of the time taken to reach stages of sleep. This test measures the degree of daytime sleepiness and how soon rapid eye movement (REM) sleep begins. This test is a benefit for diagnosing narcolepsy.

Multiple sleep latency tests (procedure code 95805) are restricted to the following diagnosis codes:

Diagnosis Code	Description
27803	Obesity hypoventilation syndrome
32710	Organic hypersomnia, unspecified
32711	Idiopathic hypersomnia with long sleep time
32712	Idiopathic hypersomnia without long sleep time
32723	Obstructive sleep apnea (adult) (pediatric)
34700	Narcolepsy, without cataplexy
34701	Narcolepsy, with cataplexy
34710	Narcolepsy in conditions classified elsewhere, without cataplexy
34711	Narcolepsy in conditions classified elsewhere, with cataplexy
78050	Unspecified sleep disturbance
78052	Insomnia, unspecified
78054	Hypersomnia, unspecified
78055	Disruptions of 24 hour sleep wake cycle, unspecified
78056	Dysfunctions associated with sleep stages or arousal from sleep
78059	Other sleep disturbances

Multiple sleep latency tests are payable to physicians in outpatient hospital and office settings. Procedure code 95805 is limited to one per day by any provider. Sleep study procedure codes 95806 and 95807 are not a benefit of the CSHCN Services Program.

31.2.36.3 Pediatric Pneumogram

A pneumogram is a 12- to 24-hour recording of breathing effort, heart rate, oxygen level, and airflow to the lungs during sleep. The study is useful in identifying abnormal breathing patterns, with or without bradycardia, especially in premature infants.

Procedure code 94772 is a benefit for CSHCN Services Program clients from birth through 12 months of age with one of the following diagnosis codes:

Diagnosis Code	Description
5300	Achalasia and cardiospasm
53010	Unspecified esophagitis

Diagnosis Code	Description
53011	Reflux esophagitis
53012	Acute esophagitis
53019	Other esophagitis
53081	Esophageal reflux
7685	Severe birth asphyxia
7686	Mild or moderate birth asphyxia
7689	Unspecified birth asphyxia in liveborn infant
769	Respiratory distress syndrome in newborn
7707	Chronic respiratory disease arising in the perinatal period
77081	Primary apnea of newborn
77082	Other apnea of newborn
77083	Cyanotic attacks of newborn
77084	Respiratory failure of newborn
77087	Respiratory arrest of newborn
77088	Hypoxemia of newborn
77089	Other respiratory problems of newborn after birth
78603	Apnea
78606	Tachypnea
78607	Wheezing
78609	Other dyspnea and respiratory abnormalities
79982	Apparent life threatening event in infant

Pediatric pneumograms are payable to physicians in office, inpatient hospital, and outpatient hospital settings. A pediatric pneumogram is limited to two services without authorization based on the diagnoses listed above. Authorization is required for more than two pneumograms.

EMGs, polysomnography, EEGs, and ECGs are denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms may be reimbursed on the same date of service as an apnea monitor (rented monthly) if documentation supports the medical necessity.

Pneumogram supplies are considered part of the technical component of the reimbursement and are denied if billed separately.

31.2.36.4 Home Sleep Study Test

Home sleep study tests are unattended studies that are performed in the client's home using a portable monitoring device. The portable monitoring device must meet AASM practice parameters and clinical guidelines.

Home sleep study testing is a benefit of the CSHCN Services Program only when performed in conjunction with a comprehensive sleep evaluation that has been performed by a physician who is board-certified or board-eligible, as outlined in the AASM guidelines. Documentation of the comprehensive sleep evaluation must be kept in the client's medical record. The evaluation must indicate probability of moderate to severe obstructive sleep apnea to support medical necessity for home sleep study testing.

Procedure codes G0398, G0399, and G0400 are a benefit for CSHCN Services Program clients who are 18 years of age and older with suspected or proven simple, uncomplicated obstructive sleep apnea. Procedure codes G0398, G0399, and G0400 are restricted to diagnosis code 32723, Obstructive sleep apnea (adult) (pediatric).

Home sleep study tests are payable to physicians in the office setting. Procedure codes G0398, G0399, and G0400 are limited to one per day and a combined total of two tests per rolling year, with any provider. If a client needs more than two tests in a rolling year, subsequent tests must be performed in a sleep facility.

31.2.37 Surgery

Surgical services, including surgical procedures involving an assistant surgeon or cosurgeon, are a benefit of the CSHCN Services Program.

Authorization of cosurgeon and assistant surgeon services is not required; however, all other authorization requirements associated with the surgical procedure must be met.

Reminder: *An authorization request can be submitted up to 95 days after the date of service. The completed authorization form can be attached to the paper claim.*

Specific surgical procedures, as specified throughout this section, require prior authorization. If a prior authorization is not obtained for the procedure, the facility's services, the surgeon's services, and the assistant surgeon's services are denied; however, anesthesia services may be paid.

Prior authorization must be obtained for procedures that are completed by a specialty team or in a specialty center. Criteria unique to specific surgical procedures must be satisfied as indicated in the appropriate sections below.

Unless otherwise stated, no additional reimbursement is provided to physicians who elect to use special instruments or advanced technology to accomplish a surgical procedure.

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

31.2.37.1 Anesthesia Administered by Surgeon

If the physician submits a surgical procedure and anesthesia for the same surgery for reimbursement, the anesthesia procedure code is denied as part of the surgical procedure.

31.2.37.2 Primary Surgeons

The primary surgeon is the lead surgeon who participates and directs the technical aspects of a surgical case.

Physicians cannot provide services as a surgeon and assistant surgeon, or as a surgeon and anesthesiologist during the same surgical procedure. A physician may bill as a surgeon and assistant surgeon on the same client, if two separate procedures are performed. Full payment is allowed for surgery, and the assistant surgical procedure may be reimbursed half of the reimbursement amount for an assistant surgery.

If the physician is an anesthesiologist who is billing for general anesthesia and a surgical procedure which is considered part of the anesthesia, the surgical procedure is not reimbursed.

31.2.37.3 Assistant Surgeons

An assistant surgeon assists the primary surgeon during a complex surgical procedure that warrants an assistant to safely and effectively accomplish the procedure.

Assistant surgeons may be reimbursed 16 percent of the prevailing fee for the surgical procedure performed.

The CSHCN Services Program follows the *Tax Equity and Fiscal Responsibility Act (TEFRA)* of 1982 regulation for assistant surgeons in teaching hospitals.

An assistant surgeon is not paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician's specialty. These claims are paid only if modifiers 82 or 80 (assistant surgeon) and KX (documentation on file) are present on the claim. These modifiers should be used in the following situations:

- There are exceptional medical circumstances, such as emergency or life-threatening situations that require immediate attention.

- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of their clients.
- The surgical procedure is complex and qualifies for more than one physician.
- Use modifier 82 when no qualified resident was available to assist with the surgery.

If the physician seeks an exception to the TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or be attached to the claim form:

> "I understand that Section 1842(b)(6)(D) of the *Social Security Act* generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP-CSHCN."

Payment to an assistant surgeon for multiple surgical procedures follows the same guidelines as payment to the primary surgeon.

If an assistant surgeon bills separate charges for local or regional anesthesia and assistant surgery on the same day, the anesthesia is included as part of the surgical procedure and not reimbursed separately.

31.2.37.4 Cosurgery

Cosurgery is a benefit of the CSHCN Services Program if the CMS fee schedule indicates that the procedure allows for cosurgeons.

When billing for cosurgery, each surgeon must bill the same procedure codes and modifier 62 (cosurgeon).

Cosurgery occurs when two surgeons, usually with different specialties or skills, work together as primary surgeons performing distinct parts of a single reportable procedure. Neither surgeon is acting as an assistant surgeon; both have comparable roles in the procedure. When two surgeons work together as primary surgeons performing distinct parts of the procedure, each surgeon should report their distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes for that procedure, as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the cosurgery once using the same procedure codes. If additional procedures (including add-on procedures) are performed during the same surgical session, separate codes may be reported without modifier 62 added.

Authorization is not specifically required for procedures using cosurgeons, although all other authorization requirements must be met. Prior authorization must be obtained for those procedures completed by a specialty team or in a specialty center. Criteria unique to specific surgical procedures must be satisfied as indicated in Section 31.2.37.11, "Cleft/Craniofacial Procedures," on page 31-115, and Section 31.2.39.2, "Transplants - Nonsolid Organ," on page 31-130.

If a cosurgeon acts as an assistant in the performance of additional procedures during the same surgical session, those services can be reported using separate procedure codes with the modifier 80 or 81 (minimum assistant surgeon) added, as appropriate.

Each surgeon receives 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure's fee. Additional payment is not made for an assistant surgeon on the same procedure being reimbursed as cosurgery.

Claims submitted without the cosurgery modifier 62 are not considered cosurgery. Reimbursement for these claims is determined by other surgery reimbursement methodology.

Note: *Each surgeon that performs cosurgery must bill only the appropriate procedure code for the specific surgery performed.*

The CSHCN Services Program does not reimburse for team surgery. Surgeons and assistant surgeons participating in a team surgery should bill for procedures they personally completed, and may be reimbursed based on the multiple surgery guidelines.

31.2.37.5 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral procedure code is not available, a unilateral procedure code must be used. The unilateral procedure code must be billed twice with a quantity of one for each procedure code. For all procedures, modifiers LT (left side), and RT (right side) must be used as appropriate.

Bilateral procedures performed on separate limbs are paid the full allowance for the major procedure and half the allowance for subsequent procedures performed on the same day, when medically justified.

31.2.37.6 Global Fees

The CSHCN Services Program uses global surgical periods to determine reimbursement for surgical procedures. The following services are included in the global surgical period:

- Preoperative care, including history and physical
- Hospital admission work-up
- Anesthesia (when administered and monitored by the primary surgeon)
- Surgical procedure (intraoperative)
- Postoperative follow-up and related services
- Complications following the surgical procedure that do not require return trips to the operating room

The CSHCN Services Program will adhere to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows:

- 0-day Global Period—Reimbursement includes the surgical procedure and all associated services that are provided on the same day.
- 10-day Global Period—Reimbursement includes the surgical procedure and all associated services provided on the day of the surgery through 10 days after the surgical procedure.
- 90-day Global Period—Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, and all associated services that are provided on the day of the surgery through 90 days after the surgical procedure.

Procedure codes that are designated as "Carrier Discretion" will have their global periods determined by the CSHCN Services Program.

The global surgical fee period applies to both emergency and nonemergency surgical procedures. Physicians who are in the same group practice and specialty must bill, and are reimbursed, as if they were a single provider.

Radiology and laboratory services related to the surgical procedure are not subject to the global period and are reimbursed separately.

Modifiers

To align with CMS, the CSHCN Services Program will add certain modifiers that are related to surgical services. For services that are rendered in the preoperative, intraoperative, or postoperative period to be correctly reimbursed, providers must use the appropriate modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

Modifiers Related to Surgical Fees				
24	25	54	55	56
57	58	62	76	77
78	79			

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the provider performing preoperative or postoperative care. Reimbursement for claims associated with modifiers 54, 55, and 56 is limited to the same total amount as would have been paid if only one physician provided all of the care, regardless of the number of physicians who actually provide the care.

If a physician provided all of the preoperative, intraoperative, and postoperative care, claims may be considered for reimbursement when they are submitted without a modifier.

Documentation Requirements

For services that are billed with any of the listed modifiers to be considered for reimbursement, providers must maintain documentation in the client's medical record that supports the medical necessity of the services. Acceptable documentation includes, but is not limited to:

- Progress notes.
- Operative reports.
- Laboratory reports.
- Hospital records.

On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed.

Note: *Retrospective review may be performed to ensure documentation supports the medical necessity of the surgical procedure and any modifier used to bill the claim.*

Preoperative Services

Preoperative physician E/M services (such as office or hospital visits) that are directly related to the planned surgical procedure and provided during the preoperative limitation period will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a separately identifiable service and are above and beyond the usual preoperative and postoperative care, may be billed with modifier 25 if they are provided on the same day by the same provider as the surgical procedure.

Modifier 25 is not used to report an E/M service that results in a decision to perform a surgical procedure. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request. If the decision to perform a minor procedure is made during an E/M visit immediately before the surgical procedure, the E/M visit is considered a routine preoperative service and is not separately billable.

Physicians who provide only preoperative services for surgical procedures with a 10- or 90-day global period may submit claims using the surgical procedure code with identifying modifier 56. Reimbursement will be limited to a percentage of the fee for the surgical procedure.

E/M services that are provided during the preoperative period (one day before or the same day) of a major surgical procedure (90-day global period) and result in the initial decision to perform the surgical procedure may be considered for reimbursement when they are billed with modifier 57. The client's medical record should clearly indicate when the initial decision to perform the procedure was made.

Intraoperative Services

Physicians who perform a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with modifier 54. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

Postoperative Services

Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not reimbursed separately. Postoperative services include, but are not limited to, all of the following:

- Follow-up visits (any place of service)
- Pain management
- Miscellaneous services, including:
  - Dressing changes
  - Local incision care

- Platelet gel
- Removal of operative packs
- Removal of cutaneous sutures, staples, lines, wires, drains, casts, or splints
- Replacement of vascular access lines
- Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes
- Changes or removal of tracheostomy tubes

Note: *Removal of postoperative dressings or anesthetic devices is not eligible for separate reimbursement as the removal is considered part of the allowance for the primary surgical procedure.*

If the surgeon provides the surgery and only the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

- The surgical procedure, date of surgery, and modifier 54, which indicates that he or she was the surgeon
- The surgical procedure, date of service, and modifier 55 to denote the postoperative care

Note: *Providers must not submit a claim for a procedure until after the client has been seen during a face-to-face follow-up visit.*

When transfer of care occurs for postoperative care for procedures that have a 10- or 90-day global period, the following conditions apply:

- When transfer of care occurs immediately after surgery, the surgeon or other provider who assumes in-hospital postoperative care must bill subsequent care procedure code 99231, 99232, or 99233.
- The surgeon or other provider who provides postdischarge care must bill the appropriate surgical code with modifier 55. Reimbursement will be limited to a percentage of the allowable fee for the surgical procedure.
- Documentation in the medical record must include all of the following:
  - A copy of the written transfer agreement
  - The dates the care was assumed and relinquished
- The claim must indicate in the comments field of the claim form the dates on which care was assumed and relinquished, and the units field must reflect the total number of postoperative care days provided. Claims that are submitted on the CMS-1500 paper claim form must include the date of surgery in Block 14 and the dates on which care was assumed and relinquished in Block 19.

When a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until at least one service has been provided.

Staged or related surgical procedures or services that are performed during the postoperative period may be reimbursed when they are billed with modifier 58. A postoperative period will be assigned to the subsequent procedure. Documentation must indicate that the subsequent procedure or service was not the result of a complication and was one of the following:

- It was planned at the time of the initial surgical procedure
- It is more extensive than the initial surgical procedure
- It is for therapy following an invasive diagnostic surgical procedure

Note: *Modifier 58 does not apply to procedure codes that are already defined as staged or sessioned services in the Current Procedural Terminology (CPT) Manual (e.g., 65855 or 66821).*

Hospital visits by the surgeon during the same hospitalization as the surgery are considered to be related to the surgery and, as a result, not separately billable; however, separate payment for such visits can be allowed if any of the following conditions apply:

- Immunotherapy management is provided by the transplant surgeon. Immunosuppressant therapy following transplant surgery is covered separately from other postoperative services, so postoperative immunosuppressant therapy is not part of the global fee allowance for the transplant surgery. This coverage applies regardless of the setting.

- Critical care is provided by the surgeon for a burn or trauma patient.
- The hospital visit is for a diagnosis that is unrelated to the original surgery.

E/M services that are provided by the same provider for reasons that are unrelated to the operative surgical procedure may be considered for reimbursement if they are billed with modifier 24. Documentation must substantiate the reasons for providing E/M services.

- Modifier 24 may be billed with modifier 25 if a significant, separately identifiable E/M service that was performed on the day of a procedure falls within the postoperative period of another unrelated procedure.
- Modifier 24 may be billed with modifier 57 if an E/M service that was performed within the postoperative period of another unrelated procedure results in the decision to perform major surgery.

Return Trips to the Operating Room

Return trips to the operating room for a repeat surgical procedure may be considered for reimbursement when billed with modifiers 76 and 77. Billing with modifiers 76 and 77 initiates the beginning of a new global period. Medical record documentation must support the need for a repeat procedure.

All surgical procedure codes with a predefined limitation (e.g., once per lifetime, one every 5 years) must not be submitted with modifier 76 or 77.

For modifiers 76 and 77, the repeated procedure must be the same as the initial surgical procedure. The repeat procedure should be billed with the appropriate modifier. The reason for the repeat surgical procedure should be entered in the narrative field on the claim form.

Return trips to the operating room for surgical procedures that are related to the initial surgery (i.e., complications) may be considered for reimbursement when they are billed with modifier 78 by the same provider.

- When a surgical procedure has a 0-day global period, the full value of the surgical procedure will be reimbursed; when the procedure has a 10- or 90-day global period, only the intraoperative portion will be reimbursed.
- When an unlisted procedure is billed because no code exists to describe the treatment for the complications, reimbursement is a maximum of 50 percent of the value of the intraoperative services that were originally performed.

Reimbursement for the postoperative period of the first surgical procedure includes follow-up services from both surgical procedures, and no additional postoperative reimbursement is allotted. The global period will be based on the first surgical procedure.

Billing with modifier 78 does not begin a new global period.

Surgical procedures that are performed by the same provider during the postoperative period may be considered for reimbursement when they are billed with modifier 79 for any of the following:

- When the same procedure is performed with a different diagnosis
- When the same procedure is performed on the left and right side of the body in different operative sessions and that procedure is billed with the RT or LT modifier
- When a different procedure is performed with the same diagnosis
- When a different procedure is performed with a different diagnosis

Billing with modifier 79 initiates a new global surgical period.

31.2.37.7 Multiple Surgeries

The CSHCN Services Program payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day, the major procedure (e.g., the highest paying procedure) is paid at the full amount allowed by Texas Medicaid. Secondary procedures performed on the same day are paid at half of the amount allowed by Texas Medicaid when medically justified.

- When a surgical procedure and a biopsy on the same organ or structure are performed on the same day, the procedures are reviewed and only the service with the higher of the allowed amounts may be reimbursed.

31.2.37.8 Second Opinions

CSHCN Services Program benefits include payment to physicians when a CSHCN Services Program client requests a second opinion regarding surgery. The claim must be coded with the appropriate office or hospital visit procedure code, and the notation "Client Initiated Second Opinion" must be noted in Block 24D of the CMS-1500 paper claim form.

31.2.37.9 Unlisted Surgical Procedure Code Considerations

Unlisted surgical procedure codes are commonly used when a matching description of a procedure performed *cannot* be found within HCPCS. These unlisted procedure codes always end with 99 (e.g., procedure code 37799).

Providers may use the procedure code that best matches the surgery performed. If an unlisted procedure code is used, the following must be included with the claim:

- A complete description of all procedures performed
- An operative report of procedures

Providers must verify whether a procedure requires authorization. Filing a claim correctly the first time helps ensure that the claim is processed in a timely manner.

Refer to: "Authorization and Prior Authorization Requirements" on page 31-7, "Cleft/Craniofacial Procedures," on page 31-115, and "Transplants - Nonsolid Organ," on page 31-130, for specific information on procedures that must be performed by an approved specialty team/center.

31.2.37.10 Circumcision

Circumcision (procedure codes 54150, 54160, and 54161) is a benefit of the CSHCN Services Program when medically necessary.

Conditions that may require circumcision include, but are not limited to, the following:

- Congenital obstructive urinary tract anomalies
- Neurogenic bladder
- Spina bifida
- History of recurrent urinary tract infections
- Vesicoureteral reflux of at least a Grade III
- Paraphimosis
- Phimosis causing urinary obstruction

Elective circumcision of a newborn male for cosmetic, routine, or ritual purposes is not a benefit of the CSHCN Services Program. The newborn period is defined as the first 28 days of life. Circumcision of a female of any age is not a benefit of the CSHCN Services Program.

Authorization is required for a circumcision. Documentation should include the diagnosis and the specific medical necessity for the circumcision.

Refer to: Section 4.2, "Authorizations," on page 4-3 for detailed information about authorization requirements.

Procedure codes 54162 and 54163 are also a benefit of the CSHCN Services Program when medically necessary and do not require authorization.

When anesthesia or analgesia stronger than topical analgesia is used during the procedure, providers must follow applicable modifier guidelines and bill their usual and customary charges.

If a circumcision is billed in addition to a hypospadias or epispadias repair, the circumcision is denied as part of another procedure. A circumcision billed in addition to other surgical procedures on the male genital or urinary system is paid according to multiple surgery reimbursement guidelines. Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Claims submitted by an assistant surgeon for a circumcision are denied.

31.2.37.11 Cleft/Craniofacial Procedures

Cleft and craniofacial services provided by a cleft and craniofacial (C/C) team or through a coordinated multidisciplinary team, including surgical interventions required to treat cleft lip, cleft palate, and craniofacial anomalies, are benefits of the CSHCN Services Program.

The CSHCN Services Program recognizes the standard of care needed to appropriately address the repair of C/C anomalies, as outlined in the guidelines prepared by the American Cleft Palate-Craniofacial Association (www.acpa-cpf.org).

A comprehensive, multidisciplinary approach is medically necessary to meet all of the needs of clients who have complex medical conditions that require treatment by a broad range of medical specialists. The standard of care for the comprehensive repair or reconstruction of craniofacial anomalies for CSHCN Services Program clients requires a team approach by either a C/C team or an equivalent coordinated multidisciplinary team. The following exceptions to this requirement may be considered:

- A C/C or equivalent multidisciplinary team is not available in the area and the client is unable to travel. Medical record documentation must explain the reasons for which the client is unable to travel.
- A C/C or equivalent multidisciplinary team is not available in the area and the team approach cannot be coordinated over multiple locations. Medical record documentation must describe the attempts that were made to coordinate a team approach.
- A C/C or equivalent multidisciplinary team is available but the client or the client's parent or guardian refuses care from the team. Medical record documentation must document the reason that the client or the client's parent or guardian gave for refusing care from the team.

The C/C or equivalent coordinated multidisciplinary team must have surgical and medical specialists, including, but not limited to the following:

- Operating surgeon
- Orthodontist
- Speech-language pathologist
- At least one of the following specialists:
  - Otolaryngologist
  - Audiologist
  - Pediatrician
  - Geneticist
  - Social worker
  - Psychologist
  - General pediatric or prosthetic dentist

Each C/C or equivalent coordinated multidisciplinary team must identify the following:

- An administrator who is responsible for coordinating and maintaining C/C team records and ensuring that the C/C team adheres to CSHCN Services Program rules and regulations
- A team care coordinator to ensure that the focus of the service is client and family oriented, and that the client, family, and C/C team jointly develop a comprehensive treatment plan for the client

The comprehensive treatment plan must be maintained in the client's medical record and must be provided to the client and family, the referring physician, other collaborating providers, and the Department of State Health Services (DSHS) regional social worker upon request.

The plan will include the specific services that will be provided by the members of the C/C team, action steps, persons responsible, and time-frame objectives for meeting treatment outcomes.

Documentation of medical necessity must be kept in the client's medical record if the requested surgical procedure is being performed because of injury or other trauma that is not associated with the repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies.

The following procedure codes must be prior authorized:

Surgery and Assistant Surgery Procedure Codes				
20902	21120	21121	21122	21123
21125	21127	21137	21138	21139
21141	21142	21143	21145	21146
21147	21150	21151	21154	21155
21159	21160	21172	21175	21179
21180	21181	21182	21183	21184
21188	21193	21194	21195	21196
21198	21199	21206	21209	21210
21230	21244	21247	21255	21256
21260	21261	21263	21267	21268
21275	21299	40799	42210	61550
61552	61556	61557	61558	61559
62115	62117			

Surgery Only Procedure Codes				
14040	14041	14060	14061	15120
15121	15135	15136	15155	15156
15157	15240	15241	15260	15261
15576	21076	21077	21079	21080
21081	21082	21083	21084	21085
21086	21087	21088	21089	21100
21110	21208	21215	21235	21245
21246	21248	21249	21270	21280
21282	21295	21296	21497	30400
30410	30420	30435	30450	30460
30462	30465	30520	30540	30545
30560	30580	30600	30620	30630
40527	40650	40652	40654	40700
40701	40702	40720	40761	42145
42200	42205	42215	42220	42225
42226	42227	42235	42260	42280
42281	67950	67961	67966	67971
67973	67974	67975		

Documentation of medical necessity must be submitted with the prior authorization request form if the surgical procedure is to be performed for reasons unrelated to the repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies.

Prior authorization is also required for orthodontic services that are performed in conjunction with C/C services.

Refer to: CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons

31.2.37.12 Mastectomy and Related Services

The following services are benefits of the CSHCN Services Program:

- Mastectomy for the treatment of breast cancer
- Prophylactic mastectomy
- Excision or destruction of a benign lesion, cyst, or lipoma
- Reduction Mammoplasty
- Breast Reconstruction and treatment of complications of breast reconstruction
- Procedure codes for mastectomy and breast reconstruction must be submitted with one of the following diagnosis codes:

Diagnosis Code	Description
1740	Malignant neoplasm of the female breast, nipple and areola
1741	Malignant neoplasm of the female breast, central portion
1742	Malignant neoplasm of the female breast, upper-inner quadrant
1743	Malignant neoplasm of the female breast, lower-inner quadrant
1744	Malignant neoplasm of the female breast, upper-outer quadrant
1745	Malignant neoplasm of the female breast, lower-outer quadrant
1746	Malignant neoplasm of the female breast, axillary tail
1748	Malignant neoplasm of the female breast, other specified sites of female breast
1749	Malignant neoplasm of the female breast, unspecified
1750	Malignant neoplasm of the male breast, nipple and areola
1759	Malignant neoplasm of the male breast, other and unspecified sites of male breast
19881	Malignant neoplasm of the breast, secondary
2330	Carcinoma in situ of breast

In addition to the above diagnosis codes, the following additional diagnosis codes are benefits for simple, subcutaneous, radical, and modified radical mastectomies and for all breast reconstruction procedures:

Diagnosis Code	Description
V103	Personal history of malignant neoplasm of breast
V163	Family history of malignant neoplasm of breast
V4571	Acquired absence of breast and nipple
V8401	Genetic susceptibility to malignant neoplasm of breast

Mastectomy and breast reconstruction for the treatment of defects or trauma are benefits when medically necessary and prior authorized.

The physician must maintain documentation of medical necessity in the client's medical record. Services are subject to retrospective review.

Mastectomy and breast reconstruction services for clients who do not meet criteria outlined in this section may be considered for reimbursement through the prior authorization process.

Mastectomy

Mastectomy is a benefit of the CSHCN Services Program for male and female clients who are 18 years of age and older with a diagnosis of breast cancer or for other conditions for which it is medically necessary to remove a breast.

Partial mastectomy (e.g., lumpectomy) is a benefit for male and female clients of all ages.

The following mastectomy procedure codes are benefits of the CSHCN Services Program:

Procedure Code	Client Gender and Ages	Limitations
Partial Mastectomy		
19301	Male and female clients of all ages	
19302	Male and female clients of all ages	
Simple, Subcutaneous, Radical, and Modified Radical Mastectomy		
19303	Male and female clients who are 18 years of age and older	Two procedures per lifetime
19304	Male and female clients who are 18 years of age and older	Two procedures per lifetime
19305	Male and female clients who are 18 years of age and older	Two procedures per lifetime
19306	Male and female clients who are 18 years of age and older	Two procedures per lifetime
19307	Male and female clients who are 18 years of age and older	Two procedures per lifetime

Prophylactic Mastectomy

Prophylactic mastectomy is a benefit of the CSHCN Services Program for clients who are 18 years of age or older and who are at moderate-to-high risk or at high-risk for the development of breast cancer.

Note: *For purposes of this section, "relative" means close blood relative, including first-degree male or female relative (e.g., parent, sibling, child), second-degree relative (e.g., aunt, uncle, grandparent, niece, nephew), or third-degree relative (e.g., first cousin, great-grandparent), all of whom are on the same side of the family as the client.*

High-risk clients are those who meet one or more of the following criteria:

- Two or more first-degree relatives with breast cancer
- One first-degree relative and two or more second- or third-degree relatives with breast cancer
- One first-degree relative diagnosed with breast cancer at 44 years of age or younger and another relative with breast cancer
- One first-degree relative with breast cancer and one or more relatives with ovarian cancer
- Two second- or third-degree relatives with breast cancer and one or more with ovarian cancer
- One second- or third-degree relative with breast cancer and two or more with ovarian cancer
- Three or more second- or third-degree relatives with breast cancer
- One first-degree relative with bilateral breast cancer
- Presence of a breast cancer 1 (BRCA1) or breast cancer 2 (BRCA2) mutation in the client that is consistent with a BRCA1 or BRCA2 mutation in a family member with breast or ovarian cancer

Moderate-to-high-risk clients are those who meet one or more of the following criteria:

- Presence of lesions associated with an increased risk for cancer, such as atypical hyperplasia and lobular carcinoma in situ (LCIS)
- Diagnosis of breast cancer in one breast, with or without additional risk factors

- Extensive mammographic abnormalities such as calcifications, making an adequate biopsy impossible

Documentation that supports medical necessity for the procedure must be maintained in the client's medical record and must indicate the following:

- The client is moderate-to-high risk, as previously defined
- As a candidate for prophylactic mastectomy, the client has undergone counseling from a health professional other than the operating surgeon. The counseling must include assessment of the following:
  - The client's ability to understand the risks and long-term implications of the surgical procedure
  - The client's informed choice to proceed with the surgical procedure

All documentation is subject to retrospective review.

Excision or Destruction of Benign Lesions

Excision or destruction of a benign lesion, cyst, or lipoma is a benefit only when the lesion is:

- Inflamed
- Infected
- Irritated
- Bleeding
- Increasing in size
- Obstructing vision
- Interfering with oral function
- Located in an area which could affect motion or function
- A suspected malignancy

The following procedure codes may be reimbursed for the excision or destruction of a benign lesion, cyst, or lipoma:

Procedure Codes				
11200	11201	11300	11301	11302
11303	11305	11306	11307	11308
11310	11311	11312	11313	11400
11401	11402	11403	11404	11406
11420	11421	11422	11423	11424
11426	11440	11441	11442	11443
11444	11446	11760	11762	15786
15787	17000	17003	17004	17106
17107	17108	17110	17111	17311
17312	17313	17314	21555	21740
21930	21931	22900	22902	22903
23075	24075	25075	26115	27047
27327	27618	28043	28313	40818
54660	67710	67715	67880	67882
67950				

To meet the documentation requirement for actinic keratosis or for excision or destruction of a benign lesion, cyst, or lipoma, modifier KX must be submitted with the appropriate procedure code.

Excision or destruction of multiple lesions, cysts, or lipomas are reimbursed according to the multiple surgery payment guidelines. Initial or follow-up visits billed in addition to a lesion excision and/or destruction for the same diagnosis are subject to global surgery payment criteria.

Refer to: Section 31.2.37.6, "Global Fees," on page 31-110 and Section 31.2.37.7, "Multiple Surgeries," on page 31-113 for additional information about global surgery and multiple surgery fees.

Reduction Mammoplasty

Procedure code 19318 may be reimbursed with prior authorization for reduction mammoplasty.

Reduction mammoplasty (procedure code 19318) requires prior authorization by the Associate Medical Director or designee of the CSHCN Services Program and may be authorized only when documentation supports medical necessity for the requested procedure.

Breast Reconstruction

Breast reconstruction is a benefit for clients who are 18 years of age and older when performed to correct or repair abnormal structures of the breast caused by one or more of the following:

- Tumor or disease (e.g., following a primary mastectomy procedure in order to establish symmetry with a contralateral breast or following bilateral mastectomy)
- Congenital defect
- Developmental abnormality
- Infection
- Trauma to the chest wall

The client must have a documented history of a mastectomy performed while eligible for the CSHCN Services Program.

Breast reconstruction may be performed using one of the following:

- Implants (saline or silicone)
- Tissue transfers (such as TRAM flaps, latissimus dorsi flaps, or gluteal flaps)

The following mastectomy and breast reconstruction procedure codes are benefits of the CSHCN Services Program when submitted with one of the diagnosis codes listed at the beginning of this section:

Procedure Code	Client Gender and Ages	Limitations
19340	Female clients who are 18 years of age or older	
19342	Female clients who are 18 years of age or older	
19350	Male and female clients who are 18 years of age and older.	
19357	Female clients who are 18 years of age or older	
19361	Male and female clients who are 18 years of age and older.	
19364	Male and female clients who are 18 years of age and older.	
19366	Male and female clients who are 18 years of age and older.	
19367	Male and female clients who are 18 years of age and older.	
19368	Male and female clients who are 18 years of age and older.	
19369	Male and female clients who are 18 years of age and older.	
S2068	Male and female clients who are 18 years of age and older.	

The following additional procedure codes may be reimbursed when performed as part of a covered breast reconstruction:

Procedure Code	Client Gender and Ages	Limitations
11920	Male and female clients who are 18 years of age and older	Two procedures per lifetime
11921	Male and female clients who are 18 years of age and older	Two procedures per lifetime
11922	Male and female clients who are 18 years of age and older	Two procedures per lifetime
19316	Female clients who are 18 years of age and older	
19324	Female clients who are 18 years of age and older	
19325	Female clients who are 18 years of age and older	
19355	Male and female clients who are 18 years of age and older	
19396	Female clients who are 18 years of age and older	

Breast reconstruction may be performed as multiple, staged procedures (e.g., tissue expansion followed by implants, nipple or areola reconstruction). Nipple-areola pigmentation, commonly known as medical tattooing, is the final stage of breast reconstruction surgery.

Tattooing to correct color defects of the skin (procedure codes 11920, 11921, and 11922), is limited to clients with a documented history of a breast reconstruction performed while the client was eligible for the CSHCN Services Program. Services for clients without an established history are considered for coverage through the prior authorization process.

Treatment for Complications of Breast Reconstruction

Treatment for complications of breast reconstruction is a benefit of the CSHCN Services Program, regardless of when the initial breast reconstruction occurred.

The following procedure codes are benefits of the CSHCN Services Program for the treatment of complications of breast reconstruction and may be reimbursed for services rendered to clients who are 18 years of age and older:

Procedure Codes				
19328	19330	19370	19371	19380

Procedure codes 19328, 19330, 19370, and 19371 may be reimbursed for services rendered to female clients. Procedure code 19380 may be reimbursed for services rendered to male and female clients.

Regardless of the client's eligibility at the time of the original breast reconstruction, the treatment of complications is considered for reimbursement when medical necessity criteria are met.

Authorization Requirements

Prior authorization is not required for mastectomy and breast reconstruction when all of the following criteria are met:

- The procedure is a mastectomy or breast reconstruction.
- The client is 18 years of age or older.
- The diagnosis is one listed at the beginning of this section.
- The client meets gender criterion for the procedure code billed.

Prior authorization for mastectomy or breast reconstruction is required when one of the following criteria is met:

- The client is 17 years of age or younger.
- The diagnosis is not listed in the table at the beginning of this section.

- The client does not meet the gender criterion for the requested procedure, as required by the CSHCN Services Program.
- The client does not have an established history of related services while CSHCN-eligible.

Exception: *Partial mastectomy procedure codes 19301 or 19302 are eligible for reimbursement regardless of the client's age, and do not require prior authorization.*

Requests that do not contain the required information are considered incomplete and will be denied. Surgeons are required to include the following information in their letter of medical necessity requesting prior authorization:

- Client's name and CSHCN Services Program client number
- Complete history and physical, including height, weight, and breast size
- Description of functional debility caused by the condition
- Preoperative photographs (both front and side views)
- Description of past treatments and outcomes
- Number of grams of tissue to be removed from each side
- Requesting surgeon's provider identifier
- Name and address of facility where services are to be performed and CSHCN Services Program provider identifier

Prior authorization requests must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request Form.

Breast Prosthesis

External breast prostheses are benefits when provided to clients with a history of a medically necessary mastectomy procedure and when provided by a licensed prosthetist or licensed prosthetist/orthotist.

Refer to: Chapter 17, "Durable Medical Equipment (DME)," on page 17-1 for breast prosthesis benefits and limitations.

31.2.37.13 Other Reconstructive Cosmetic Procedures

Only those reconstructive and cosmetic procedures that meet the following criteria are benefits for clients who are eligible for the CSHCN Services Program:

- The reconstructive surgery is performed on structures of the body for the purpose of improving or restoring bodily functions or correcting significant deformity resulting from disease, trauma, previous therapeutic process, or congenital or developmental anomalies.
- The cosmetic surgery is designed to restore appearance when anomalies are due to disease, trauma, previous therapeutic process, or congenital or developmental anomalies.

Acne Surgeries, Dermabrasion, and Chemical Peel Procedures

The following procedure codes will be made benefits for acne surgeries, dermabrasion and chemical peel procedures:

Procedure Code				
10040	15782	15783	15792	15793

Acne surgeries, dermabrasion and chemical peel procedures require prior authorization. One of the following medical necessity criteria must be met and included with the prior authorization request:

- Correction or repair of severe disfigurement due to disease or accidental injury (photographic documentation is required)
- Restoration of physical function resulting from disease or accidental injury (specific function must be detailed in the prior authorization request)

Panniculectomy

Procedure codes 15830 and 15847 are benefits for panniculectomy and abdominoplasty procedures:

Panniculectomy and abdominoplasty procedures require prior authorization. All of the following medical necessity criteria must be met and included with the prior authorization request:

- The panniculus hangs below the level of the pubis (photographic documentation is required).
- The panniculus is the result of weight loss of at least 75 pounds that has been sustained (and not subsequently regained) for longer than one year.
- There is documentation in the medical record that the panniculus directly impairs physical function. Specifically, the panniculus must interfere with ambulation, urination, or other activities of daily living; or the panniculus must cause recurring persistent fungal and bacterial panniculitis that is refractory to good personal hygiene and documented optimal medical management including topical anti-infectives and at least three systemic medication treatments.

Authorization Requirements

Reconstructive or cosmetic procedures that are performed as part of cleft-craniofacial surgery require prior authorization.

Refer to: Section 31.2.37.11, "Cleft/Craniofacial Procedures," on page 31-115 for information about CSHCN Services Program cleft-craniofacial benefits and limitations.

All prior authorization requests for rhytidectomy procedure code 15828 must be reviewed by the CSHCN Services Program Medical Director or designee.

Mastectomy and breast reconstruction services for clients who do not meet criteria outlined in policy are considered for reimbursement through the prior authorization process.

Noncovered Services

The following cosmetic procedures are not a benefit of the CSHCN Services Program:

- Rhytidectomy procedure codes 15824, 15825, 15826, and 15829
- Excisions of excessive skin and subcutaneous tissue (includes lipectomy) (procedure codes 15832, 15833, 15834, 15835, 15836, 15837, and 15839)
- Suction assisted lipectomies (procedure codes 15877, 15878, and 15879)
- Cryotherapy for acne (procedure code 17340)
- Chemical exfoliation (procedure code 17360)
- Electrolysis epilation (procedure code 17380)

The CSHCN Services Program does not reimburse for the alteration of a natural, undamaged, or unimpaired body part, unless otherwise indicated.

31.2.37.14 Rhizotomy

Rhizotomy for clients with spastic cerebral palsy is a benefit of the CSHCN Services Program.

Rhizotomies (procedure codes 63185 and 63190) must be prior authorized.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only Form.

Rhizotomies are a benefit when submitted for reimbursement with one of the following diagnosis codes:

Diagnosis Code	Description
3430	Diplegic infantile cerebral palsy
3431	Hemiplegic infantile cerebral palsy
3432	Quadriplegic infantile cerebral palsy
3433	Monoplegic infantile cerebral palsy
3434	Infantile hemiplegia
3438	Other specified infantile cerebral palsy

Diagnosis Code	Description
3439	Unspecified infantile cerebral palsy
34481	Locked-in state
34489	Other specified paralytic syndrome

Documentation of whether or not the client has spastic cerebral palsy with no athetosis or fluctuations in muscle tone, but does have underlying muscle strength, must be included with the prior authorization request form.

Either electromyography or intraoperative neurophysiology testing is paid, but not both during the same procedure, when performed on the same day.

PT and occupational therapy (OT) are benefits up to three times a week (each) for a period of 1 year postoperatively.

31.2.37.15 Septoplasty

Septoplasty (procedure code 30520) that is not related to the repair or reconstruction of a cleft lip, cleft palate, or craniofacial anomaly may be prior authorized with documentation to support medical necessity.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only.

CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons

31.2.38 Therapeutic Apheresis

Therapeutic apheresis does not require authorization.

Reimbursement for procedure codes 36511, 36512, 36513, 36514, 36515, and 36516 is limited to the following diagnosis codes:

Diagnosis Code	Description
20300	Multiple myeloma, without mention of having achieved remission
20302	Multiple myeloma, in relapse
20310	Plasma cell leukemia, without mention of having achieved remission
20312	Plasma cell leukemia, in relapse
20380	Other immunoproliferative neoplasms, without mention of having achieved remission
20382	Other immunoproliferative neoplasms, in relapse
20400	Acute lymphoid leukemia, without mention of having achieved remission
20402	Acute lymphoid leukemia, in relapse
20410	Chronic lymphoid leukemia, without mention of having achieved remission
20412	Chronic lymphoid leukemia, in relapse
20420	Subacute lymphoid leukemia, without mention of having achieved remission
20422	Subacute lymphoid leukemia, in relapse
20480	Other lymphoid leukemia, without mention of having achieved remission
20482	Other lymphoid leukemia, in relapse
20490	Unspecified lymphoid leukemia, without mention of having achieved remission
20492	Unspecified lymphoid leukemia, in relapse

Diagnosis Code	Description
20500	Acute myeloid leukemia, without mention of having achieved remission
20502	Acute myeloid leukemia, in relapse
20510	Chronic myeloid leukemia, without mention of having achieved remission
20512	Chronic myeloid leukemia, in relapse
20520	Subacute myeloid leukemia, without mention of having achieved remission
20522	Subacute myeloid leukemia, in relapse
20530	Myeloid sarcoma, without mention of remission
20532	Myeloid sarcoma, in relapse
20580	Other myeloid leukemia, without mention of having achieved remission
20582	Other myeloid leukemia, in relapse
20590	Unspecified myeloid leukemia, without mention of having achieved remission
20592	Unspecified myeloid leukemia, in relapse
20600	Acute monocytic leukemia, without mention of having achieved remission
20602	Acute monocytic leukemia, in relapse
20610	Chronic monocytic leukemia, without mention of having achieved remission
20612	Chronic monocytic leukemia, in relapse
20620	Subacute monocytic leukemia, without mention of having achieved remission
20622	Subacute monocytic leukemia, in relapse
20680	Other monocytic leukemia, without mention of having achieved remission
20682	Other monocytic leukemia, in relapse
20690	Unspecified monocytic leukemia, without mention of having achieved remission
20692	Unspecified monocytic leukemia, in relapse
20700	Acute erythremia and erythroleukemia, without mention of having achieved remission
20702	Acute erythremia and erythroleukemia, in relapse
20710	Chronic erythremia, without mention of having achieved remission
20712	Chronic erythremia, in relapse
20720	Megakaryocytic leukemia, without mention of having achieved remission
20722	Megakaryocytic leukemia, in relapse
20780	Other specified leukemia, without mention of having achieved remission
20782	Other specified leukemia, in relapse
20800	Acute leukemia of unspecified cell type, without mention of having achieved remission
20802	Acute leukemia of unspecified cell type, in relapse
20810	Chronic leukemia of unspecified cell type, without mention of having achieved remission
20812	Chronic leukemia of unspecified cell type, in relapse
20820	Subacute leukemia of unspecified cell type, without mention of having achieved remission
20822	Subacute leukemia of unspecified cell type, in relapse

Diagnosis Code	Description
20880	Other leukemia of unspecified cell type, without mention of having achieved remission
20882	Other leukemia of unspecified cell type, in relapse
20890	Unspecified leukemia, without mention of having achieved remission
20892	Unspecified leukemia, in relapse
2384	Neoplasm of uncertain behavior of polycythemia vera
23871	Essential thrombocythemia
2720	Pure Hypercholesterolemia
2730	Polyclonal hypergammaglobulinemia
2731	Monoclonal paraproteinemia
2733	Macroglobulinemia
28260	Sickle-cell disease, unspecified
28261	Hb-SS disease without crisis
28262	Hb-SS disease with crisis
28263	Sickle-cell/Hb-C disease without crisis
28264	Sickle-cell/Hb-C disease with crisis
28268	Other sickle-cell disease without crisis
28269	Other sickle-cell disease with crisis
2828	Other specified hereditary hemolytic anemias
2830	Autoimmune hemolytic anemias
28310	Unspecified non-autoimmune hemolytic anemia
28311	Hemolytic-uremic syndrome
28319	Other non-autoimmune hemolytic anemias
2863	Congenital deficiency of other clotting factors
28652	Acquired hemophilia
2866	Defibrination syndrome
2870	Allergic purpura
2871	Qualitative platelet defects
2872	Other nonthrombocytopenic purpura
28730	Primary thrombocytopenia, unspecified
28731	Immune thrombocytopenic purpura
28732	Evans' syndrome
28733	Congenital and hereditary thrombocytopenic purpura
28739	Other primary thrombocytopenia
2875	Unspecified thrombocytopenia
2878	Other specified hemorrhagic conditions
2879	Unspecified hemorrhagic conditions
2884	Hemophagocytic syndromes
28869	Other elevated white blood cell count
2890	Polycythemia, secondary
2896	Familial polycythemia
2897	Methemoglobinemia

Diagnosis Code	Description
28989	Other specified diseases of blood and blood-forming organs
2899	Unspecified diseases of blood and blood-forming organs
3564	Idiopathic progressive polyneuropathy
3570	Acute infective polyneuritis
3571	Polyneuropathy in collagen vascular disease
3572	Polyneuropathy in diabetes
3573	Polyneuropathy in malignant disease
3574	Polyneuropathy in other diseases classified elsewhere
3575	Alcoholic polyneuropathy
3576	Polyneuropathy due to drugs
3577	Polyneuropathy due to other toxic agents
35781	Chronic inflammatory demyelinating polyneuritus
35782	Critical illness polyneuropathy
35789	Other inflammatory and toxic neuropathy
35800	Myasthenia gravis without (acute) exacerbation
35801	Myasthenia gravis with (acute) exacerbation
35831	Lambert-Eaton syndrome in neoplastic disease
390	Rheumatic fever without mention of heart involvement
3918	Other acute rheumatic heart disease
44620	Unspecified hypersensitivity angiitis
44621	Goodpasture's syndrome
44629	Other specified hypersensitivity angiitis
4466	Thrombotic microangiopathy
4476	Unspecified arteritis
4478	Other specified disorders of arteries and arterioles
570	Acute and subacute necrosis of liver
5718	Other chronic nonalcoholic liver disease
5731	Hepatitis in viral diseases classified elsewhere
5732	Hepatitis in other infectious diseases classified elsewhere
5733	Unspecified hepatitis
57431	Calculus of bile duct with acute cholecystitis and obstruction
57441	Calculus of bile duct with other cholecystitis and obstruction
5800	Acute glomerulonephritis with lesion of proliferative glomerulonephritis
5804	Acute glomerulonephritis with lesion of rapidly progressive glomerulonephritis
5810	Nephrotic syndrome with lesion of proliferative glomerulonephritis
5811	Nephrotic syndrome with lesion of membranous glomerulonephritis
5812	Nephrotic syndrome with lesion of membranoproliferative glomerulonephritis
5813	Nephrotic syndrome with lesion of minimal change glomerulonephritis
58181	Nephrotic syndrome in diseases classified elsewhere
58189	Other nephrotic syndrome with other specified pathological lesion in kidney

Diagnosis Code	Description
5819	Nephrotic syndrome with unspecified pathological lesion in kidney
5820	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis
5821	Chronic glomerulonephritis with lesion of membranous glomerulonephritis
5822	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis
5824	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis
5830	Nephritis and nephropathy, not specified as acute or chronic, with lesion of proliferative glomerulonephritis
5831	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranous glomerulonephritis
5832	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranoproliferative glomerulonephritis
5834	Nephritis and nephropathy, not specified as acute or chronic, with lesion of rapidly progressive glomerulonephritis
5836	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal cortical necrosis
5837	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal medullary necrosis
58381	Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere
58389	Nephritis and nephropathy, not specified as acute or chronic, with other specified pathological lesion in kidney, other
5839	Nephritis and nephropathy, not specified as acute or chronic, with unspecified pathological lesion in kidney
6944	Pemphigus
7010	Circumscribed scleroderma
7100	Systemic lupus erythematosus
7101	Systemic sclerosis
7103	Dermatomyositis
7104	Polymyositis
7140	Rheumatoid arthritis
7141	Felty's syndrome
7142	Other rheumatoid arthritis with visceral or systemic involvement
71430	Polyarticular juvenile rheumatoid arthritis, chronic or unspecified
71431	Polyarticular juvenile rheumatoid arthritis, acute
71432	Pauciarticular juvenile rheumatoid arthritis
71433	Monoarticular juvenile rheumatoid arthritis
99680	Complications of transplanted organ

Other diagnoses may be considered upon appeal with documentation of medical necessity.

Therapeutic apheresis with extracorporeal affinity column adsorption and plasma reinfusion may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis or the protein A immunoadsorption columns.

Claims for apheresis services must be submitted with procedure codes 36511, 36512, 36513, 36514, 36515, and 36516, as appropriate.

Therapeutic apheresis requires direct supervision by a physician.

Procedure codes for therapeutic apheresis may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.39 Transplants

31.2.39.1 Renal (Kidney) Transplant

Renal transplants are a benefit for CSHCN Services Program clients when the projected costs of the transplant and follow-up care are less than the cost of continuing dialysis treatments. The estimated cost of the renal transplant over a 1-year period versus the cost of renal dialysis for 1 year at the requesting facility must be both documented and reviewed.

Clients who have not previously applied for Medicare and Kidney Health Care coverage and are anticipating the need for a renal transplant must apply for Medicare and Kidney Health Care coverage.

Renal transplants may only be considered for reimbursement when performed in a Medicaid-approved, CSHCN Services Program-enrolled transplant center facility, certified by the United Network of Organ Sharing (UNOS).

Refer to: Section 2.1.7, "Transplant Specialty Centers," on page 2-9.

For any client who is 18 years of age or older, the transplant team must also provide a plan of care to be implemented after the client reaches 21 years of age and is no longer eligible for services through the CSHCN Services Program.

Renal transplants must be prior authorized, and approval is subject to the availability of funds. Only an initial and one subsequent renal transplant may be reimbursed for a client as a lifetime benefit.

Documentation supporting the prior authorization request must include the following:

- The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant form
- A recent and complete history and physical
- A statement of the client's status including why a transplant is being recommended at this time
- Documentation of the cost effectiveness of the transplant versus continued dialysis

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant Form and Instructions.

Nationally, hospital stays for renal transplants are 5 to 10 days followed by outpatient follow-up; therefore, no additional hospital days beyond the 60 per year allowed by the CSHCN Services Program may be authorized without an appeal documenting medical necessity.

If the transplant is not prior authorized, services directly related to the transplant within 3 days preoperative and during the 6 weeks postoperative period are denied for the surgeon, assistant surgeon, or facility. The anesthesiologist may be reimbursed.

The following procedure codes must be used to bill for physician services related to the renal transplant:

Surgery and Assistant Surgery Procedure Codes				
50300	50320	50323	50325	50327
50328	50329	50340	50360	50365
50370	50380	50547		

Anesthesia Procedure Code
00868

Radiology Procedure Code
76776

Procedure codes 50323, 50325, 50327, 50328, and 50329 are payable under the organ recipient, and may only be reimbursed when procedure code 50360 or 50365 has been paid for the same date of service.

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

Reimbursement for renal transplants includes the cost of the transplant services and one of the following:

- The cost of procuring a cadaveric organ and services associated with procurement from an organ procurement organization (OPO) designated by the Secretary of Health and Human Services. Documentation validating the organ's source must accompany the claim.
- Donor costs for living donors. Donor costs must be included on the client's inpatient hospital claim and may only be reimbursed if another source of payment is not available. Donor costs for CSHCN Services Program clients who also have Medicaid will not be reimbursed.

A maximum amount of $200,000 per client may be reimbursed for a transplant hospitalization. All hospital charges for patient care (inpatient hospital only) during the time of the hospital stay are applied to the $200,000 limit. Donor costs are included in this $200,000 limit.

Renal transplant recipients are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge.

31.2.39.2 Transplants - Nonsolid Organ

Stem cell transplants and post-transplantation cellular infusions must be performed in 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), UNOS, or the National Marrow Donor Program (NMDP). TMHP maintains a current list of approved centers.

Refer to: Section 2.1.7, "Transplant Specialty Centers," on page 2-9.

The following surgery procedure codes should be used to submit claims for reimbursement of transplantation and post-transplantation cellular infusion procedures:

Procedure Codes				
38205	38206	38230	38232	38240
38241	38242	38243	38999	S2142

Stem cell transplants and post-transplantation cellular infusions must be prior authorized. Prior authorization must be obtained by both the facility and the physician.

Providers may fax prior authorization requests to 1-512-514-4222.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant Form and Instructions.

The CSHCN Services Program does not authorize the following:

- Experimental or investigational services, supplies, or procedures
- Human leukocyte antigen (HLA)-typing of possible donors

The CSHCN Services Program may cover post-transplantation cellular infusions and only autologous and matched related and matched nonrelated allogenic transplants.

The CSHCN Services Program will recognize the following covered indications for allogenic stem cell transplants:

- Bone marrow disorders
- Hemoglobinopathies

- Immunodeficiency disorders
- Inherited metabolic disorders
- Leukemias
- Lymphomas
- Multiple myeloma/plasma cell disorders
- Platelet function disorder

The CSHCN Services Program will recognize the following covered indications for autologous stem cell transplants:

- Brain tumors
- Germ cell tumors
- Leukemias
- Lymphomas
- Multiple myeloma/plasma cell disorders
- Small round blue cell tumors of childhood

Indications for post-transplantation cellular infusions include the following:

- Stem cell infusion for failure to graft (autologous)
- Donor leukocyte infusion for persistent or relapsed malignant disease (allogenic)
- Donor hematopoietic progenitor cell (HPC) boost infusion for relapse and post-transplantation cytopenias (allogenic)

Post-transplantation cellular infusions must be prior authorized separately with evidence of previous stem cell transplantation.

Stem cell transplants and post-transplantation cellular infusions may be considered for other conditions if documentation provides clinical evidence of the efficacy for the condition.

Coverage is limited to an initial transplant and one subsequent transplant, for a total of two transplants per lifetime regardless of payer. Indications for re-transplantation include the following:

- Relapse of disease
- Failure to engraft or poor graft function
- Graft rejection

The subsequent transplant must be prior authorized separately from the initial transplant.

Physician Reimbursement

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

If approved, a letter with the authorization number is sent to the physician (when applicable) and to the hospital where the procedure is to be performed. This authorization number must be placed in Block 23 of the CMS-1500 paper claim form.

Note: *A benefit of up to 60 inpatient days may be granted to a client, to begin the date of an approved stem cell transplant. Any days remaining from the standard 60 inpatient day limit may be added to the 60 days for the transplant if the $200,000 limit for the transplant maximum amount has not been exceeded. Donor costs must be included on the client's inpatient hospital claim for the transplant and are included in the $200,000 limit for the transplant maximum amount. If prior authorization is received for a second stem cell transplant after a client has already received an initial transplant, an additional benefit of up to 60 inpatient days may be reimbursed for an additional maximum amount of $200,000, beginning with the actual first day of the second transplant.*

31.2.40 Wound Care Management

Wound care management includes first- and second-line therapies.

The following services are not a benefit of the CSHCN Services Program:

- Infrared therapy

- Ultraviolet therapy
- Topical hyperbaric oxygen therapy
- Low-energy ultrasound wound cleanser (MIST therapy)
- Services that are submitted as debridement but do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.
- Electrical stimulation and electromagnetic therapy
- Whirlpool therapy for wound care (procedure code 97602)

31.2.40.1 First-Line Wound Care Therapy

First-line wound care therapy includes the following:

- Compression
- Debridement

Compression

Compression therapy is an important component in the standard of care for treatment of venous ulcers. An Unna boot may be used as part of compression therapy to promote healing, control edema, increase blood return to the heart, and reduce infection. Compression performed as part of wound care management may be reimbursed when billed with procedure code 29580.

Debridement

Selective debridement consists of the following:

- Conservative sharp debridement
- High-pressure lavage to selected areas

Non-selective debridement consists of the following:

- Autolytic debridement
- Blunt debridement
- Enzymatic debridement
- Hydrotherapy and wound immersion
- Mechanical debridement

The following procedure codes are a benefit for wound debridement:

Procedure Codes				
11000	11001	11042	11043	11044
16020	16025	16030	97597	97598

The procedure code submitted on the claim must reflect the level of debrided tissue, e.g., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle, and/or bone, and not the extent, depth, or grade of the ulcer or wound.

Wound debridement procedure codes 11042, 11043, and 11044 are not appropriate and will not be approved for the following:

- Washing bacteria or fungal debris from the feet
- Paring or cutting of corns or calluses
- Incision and drainage of an abscess
- Trimming or debridement of nails, or avulsion of nail plates
- Acne surgery
- Destruction of warts
- Burn debridement

31.2.40.2 Second-Line Wound Care Therapy

Second-line wound care therapy includes the following:

- Metabolically active skin equivalents/skin substitutes
- Pulsatile jet irrigation

Metabolically Active Skin Equivalents/Skin Substitutes

Metabolically active skin equivalents/skin substitutes will be a benefit when they are provided in accordance with the material's Food and Drug Administration (FDA)-approved package label and applied according to the manufacturer's instructions for use. Skin substitutes are used for partial- or full-thickness wounds that do not involve tendon, muscle, joint capsule, or exposed bone or sinus tracts and are applied to wounds that have demonstrated failed or insufficient response to conservative wound care measures.

The following procedure codes are a benefit for metabolically active skin equivalents provided in the office setting:

Procedure Codes				
C9250	Q4100	Q4101	Q4102	Q4103
Q4104	Q4105	Q4106	Q4107	Q4108
Q4110	Q4111	Q4112	Q4113	Q4114
Q4115	Q4116	Q4122	Q4123	Q4124
Q4126	Q4127	Q4128	Q4129	Q4130
Q4131	Q4134	Q4135	Q4136	Q4137
Q4138	Q4140	Q4142	Q4143	Q4146
Q4147	Q4148	Q4149		

The client's medical record must include documentation that wound treatments with metabolically active skin equivalents or skins substitutes are accompanied by appropriate adjunctive measures, and must identify the adjunctive therapies being provided to the client as part of the wound treatment regimen.

Prior authorization is required for unspecified skin substitute procedure code Q4100. When requesting prior authorization for procedure code Q4100, providers must submit the CSHCN Services Program Authorization and Prior Authorization Request form and the following information with the request:

- The client's diagnosis
- Characteristics of the wound, including:
  - Location
  - Dimensions (diameter and depth)
  - Drainage (amount and type)
  - Related signs and symptoms (swelling, pain, inflammation)
  - Presence of necrotic tissue/slough
- Medical records that indicate prior treatment for the diagnosis, the medical necessity of the requested skin substitute, and the wound care treatment plan
- A clear, concise description of the skin substitute to be applied and the reason for recommending this particular item
- A CPT or HCPCS procedure code that is comparable to the requested procedure
- Documentation that demonstrates that the requested procedure is not investigational or experimental
- The place of service in which the requested procedure will be performed
- The physician's intended fee for the requested procedure

Pulsatile-Jet Irrigation

Pulsatile-jet irrigation is a benefit for the treatment of Stage III or IV wounds when other forms of treatment have failed. To cleanse a wound bed, pulsatile-jet irrigation uses lavage, which increases impaired circulation and removal of waste from the lymphatic system. Removal of devitalized tissue using pulsatile-jet irrigation may be reimbursed when claims are submitted for procedure code 97597 or 97598.

Professional services for selective wound debridement (procedure codes 97597 and 97598) may also be reimbursed to a licensed physical therapist or physical therapy group when the service is determined to be within the provider's scope of practice and the service is prescribed by a supervising physician or qualified non-physician provider who is enrolled in the CSHCN Services Program.

31.2.40.3 Documentation Requirements

For all wound care management services, documentation that supports the medical necessity of the service must be maintained in the client's medical records, including the following information:

- Accurate diagnostic information that pertains to the underlying diagnosis and condition as well as any other medical diagnoses and conditions, which include the client's overall health status.
- Appropriate medical history related to the current wound, including the following:
  - Wound measurements, which includes length, width, and depth, any tunneling and/or undermining
  - Wound color, drainage (type and amount), and odor, if present
  - The prescribed wound care regimen, which includes frequency, duration, and supplies needed
  - Treatment for infection, if present
  - All previous wound care therapy regimens, if appropriate
  - The client's use of a pressure reducing support surface, mattress, and/or cushion, when appropriate

Documentation maintained in the client's medical record must support the level of debridement service provided.

Fewer than five surgical debridements that involve removal of muscle or bone are typically required for management of most wounds. Documentation that is maintained in the client's medical record must support the number of debridements involving muscle or bone that are performed.

All wound care management services are subject to retrospective review.

31.3 Claims Information

To avoid claim denials, providers billing as a group *must* use the performing provider identifier number on their claims.

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

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

Physicians who submit a claim using the physician's own provider identifier for services provided by an APRN or physician assistant must submit one of the following modifiers on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit:

- SA - Services were provided by an APRN
- U7 - Services were provided by a physician assistant

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

31.3.1 General Medical Record Documentation Requirements

The CSHCN Services Program routinely performs a retrospective review of all providers. This review may include comparing services billed to the client's medical record. The provider must document the following information in the client's medical record:

- Service
- Date the service was rendered
- Any pertinent information about the client's condition that supports the need for the service
- Care provided

Note: *If a provider bills for an office visit, the client's medical record must contain documentation for that date of service about the client's complaint, physician's findings, and any physician orders. If the visit is a follow-up office visit, the client's progress relating to the previous condition must be documented for the date of service billed. If billing for a hospital visit, whether it is a routine hospital visit or other type of hospital visit, documentation of that visit must be part of the client's medical record and must be written in the physician's orders or the client's progress notes.*

The following are general requirements for all providers. Mandatory requirements not present in the client's medical record subject 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 identification number.	Mandatory
Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.	Mandatory
The selection of E/M codes (levels of service) is supported by the client's clinical record documentation. The AMA's CPT descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service.	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

Requirement	Mandatory/Desirable
The services provided are clearly documented in the medical record with all pertinent information about 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 have 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 address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.	Desirable

31.4 Reimbursement

Physicians may be reimbursed for most physician services according to the Texas Medicaid Reimbursement Methodology (TMRM).

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an APRN or physician assistant if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. The 92 percent reimbursement rate will not apply to laboratory services, radiology services, and injections provided by an APRN or physician assistant.

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.*

Refer to: Section 31.2.5, "Anesthesia Services," on page 31-14 for more information about anesthesia services that may be reimbursed according to relative value units (RVUs).

31.4.1 Physician Services in Outpatient Hospital Setting

31.4.1.1 Reimbursement Reduction

Nonemergent and nonurgent services provided by physician providers in an outpatient setting (POS 5) may be reimbursed at 60 percent of the allowed amount. The 40 percent reduction in reimbursement will be based upon the emergency department service that is submitted on the claim.

31.5 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.

Chapter

32

Physician Assistant (PA)

32.1 Enrollment

To enroll in the CSHCN Services Program, a physician assistant (PA) must be actively enrolled in Texas Medicaid, licensed as a physician assistant, and recognized as a PA by the Texas Physician Assistant Board. PAs may enroll as a CSHCN Services Program provider by completing the provider enrollment application available through the TMHP-CSHCN Services Program. Out-of-state PAs must meet all these conditions and be located in the United States within 50 miles of the Texas state border.

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

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

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

Refer to: Section 2.1,"Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program enrollment procedures.

32.2 Benefits, Limitations, and Authorization Requirements

Services provided by PAs are benefits if the services are:

- Within the scope of practice for PAs, as defined by Texas state law.
- Consistent with rules and regulations promulgated by the Texas Medical Boardor other appropriate state licensing authority.
- Benefits of the CSHCN Services Program when provided by a licensed physician (doctor of medicine [MD] or doctor of osteopathy [DO]).
- Reasonable and medically necessary as determined by DSHS or its designee.

PAs who are employed or paid by a physician, hospital, facility, or other provider must not bill the CSHCN Services Program for their services, if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician's own provider identifier for services provided by a PA must submit modifier U7 on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

All limitations applicable to physicians for the same service will also be applied to the PA.

32.2.1 Authorization Requirements

Authorization and prior authorization requirements are listed in individual sections of this manual. Authorization requirements applied to services provided by physicians (MD or DO) also apply to services provided by PAs.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for detailed information about authorization and prior authorization requirements.

Section 31.2.13,"Clinician-Directed Care Coordination Services," on page 31-26 for information and prior authorization requirements for clinician-directed care coordination services.

32.3 Claims Information

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

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

The 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement,"on page 5-1 for general information about claims filing.

Section 5.7.2.4,"CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

32.4 Reimbursement

PAs may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician. Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by a PA if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

Exceptions to the 92 percent reimbursement methodology for PAs and physicians include injections, laboratory services, radiology services, and immunizations.

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.*

32.5 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.

Chapter

33

Radiation Therapy Services

33.1 Enrollment

To enroll and be reimbursed for services in the CSHCN Services Program, radiation therapy 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 radiation therapy services providers must meet all the above conditions and be located in the United States within 50 miles of the Texas state border.

Physicians, hospitals, and free-standing radiation treatment centers are eligible to enroll in Texas Medicaid and to receive reimbursement for CSHCN Services Program radiation therapy services.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

33.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program may reimburse radiation therapy services performed by physicians, radiation treatment centers, and inpatient and outpatient hospitals.

Radiation therapy services include, but are not limited to, the following:

- Clinical brachytherapy
- Clinical treatment planning
- Intensity modulated radiation therapy (IMRT) (prior authorization required)
- Medical radiation physics, dosimetry, and treatment devices
- Proton- or neutron-beam therapy (prior authorization required)
- Radiation treatment management and delivery
- Stereotactic radiosurgery

All drugs given during the course of radiation therapy should be billed separately for appropriate reimbursement.

All inpatient radiation therapy services must be billed with the appropriate procedure code(s) in addition to the revenue code (333).

Note: *Outpatient hospital services include those services performed in the emergency room or clinic setting of a hospital. In instances of sudden illness or injury, the client may receive treatment in the emergency room and be discharged, admitted for observation, or admitted for further care as an inpatient. 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 submitted as ancillary charges.*

Refer to: Chapter 24, "Hospital," on page 24-1 for more information about inpatient, outpatient, ER, and observation services.

Normal follow-up care by the same physician on the same day as any therapeutic radiology service will be denied. Any other E/M office visit will not be reimbursed when billed with the same date of service by the same provider as the radiation treatment or a radiation treatment complication. If complications occur on the same day as a therapeutic radiology service, or if medical visits are necessary for services unrelated to the radiation treatment, additional care may be reimbursed on appeal with documentation of medical necessity.

Providers may use modifier 25 to indicate the additional visit was for a separate, distinct service unrelated to the radiation treatment or radiation treatment complication. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Note: *Each provider is responsible for verifying client eligibility. Any services that are provided outside of the client's eligibility period or beyond the limitations of the CSHCN Services Program are not considered for reimbursement.*

Prior Authorization Requirements

Prior authorization is required for stereotactic radiosurgery, proton- or neutron-beam treatment delivery, and IMRT. Prior authorization is not required for all other radiation therapy services. Prior authorization must be obtained before submitting claims for the services rendered. Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Prior authorization is given only if the client is eligible for CSHCN Services Program benefits when TMHP receives the request.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for more information about authorizations and prior authorizations.

33.2.1 Clinical Brachytherapy

The following surgical procedure codes for brachytherapy may be reimbursed:

Surgery Procedure Codes				
19296	19297	19298	31626	31643
32553*	49327*	49411	49412	55860
55862*	55865*	55875	55876	57156
58346	61770	92974		
*Assistant surgeons also may be reimbursed for procedure codes 32553, 49327, 55862, and 55865.				

The following radiation therapy procedure codes may be reimbursed:

Radiation Therapy Procedure Codes				
77750*	77761*	77762*	77763*	77776*
77777*	77778*	77785	77786	77787
77789	77799			
*Total component only.				

Clinical brachytherapy services include admission to the hospital, daily care, and same-day office visits. Initial and subsequent hospital care and same-day office visits will be denied when billed with the same date of service as clinical brachytherapy services.

33.2.2 Clinical Treatment Planning

The following radiation therapy procedure codes must be used to bill clinical treatment planning services:

Procedure Codes				
77261	77262	77263	77280	77285
77290	77293	77295	77299	

Therapeutic radiology field setting procedure code 77295 is limited to once per day.

An office visit performed on the same day by the same provider as clinical treatment planning is included in the therapeutic radiology procedure.

Clinical treatment planning includes interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment modality, determination of number and size of treatment ports, selection of appropriate treatment devices, and other procedures.

The following procedure codes will not be reimbursed by the CSHCN Services Program:

Procedure Codes				
77321	77331	77336	77370	77470
77600	77605	77610	77615	77620
77790				

33.2.3 Intensity Modulated Radiation Therapy (IMRT)

IMRT (procedure codes 77385 and 77386) must be prior-authorized and may be considered after review of documentation of medical necessity along with a review of current literature supporting the requested use.

33.2.4 Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services

The following procedure codes may be reimbursed for medical radiation physics, dosimetry, treatment devices, and special services:

Procedure Codes				
77300	77301	77306	77307	77316
77317	77318	77332	77333	77334
77338	77399			

33.2.5 Proton-Beam and Neutron-Beam Delivery

The following procedure codes may be used to bill proton-beam and neutron-beam treatment delivery services:

Procedure Codes				
Proton-Beam				
77520	77522	77523	77525	S8030
Neutron-Beam				
77422	77423			

33.2.5.1 Prior Authorization Requirements

Prior authorization requirements for proton-beam and neutron-beam treatment delivery may include, but are not limited to, diagnoses indicating one of the following medical conditions:

Proton-Beam Treatment Delivery

- Melanoma of the uveal tract (iris, choroid, ciliary body)
- Postoperative treatment for chordomas or low grade chondrosarcomas of the skull or cervical spine
- Prostate cancer
- Pituitary neoplasms
- Other central nervous system tumors located near vital structures

Neutron-Beam Treatment Delivery

- Malignant neoplasms of the salivary glands

Other diagnoses may be considered for proton-beam and neutron-beam treatment delivery after a review of medical necessity documentation along with a review of current literature supporting the use of the requested therapy.

Providers must use the CSHCN Services Program Authorization and Prior Authorization Request form to submit requests for prior authorization.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for more information about authorizations and prior authorizations.

33.2.6 Radiation Treatment Management and Delivery

The total radiation therapy component for the following procedure codes may be reimbursed for radiation treatment management services:

Radiation Treatment Management Procedure Codes				
77427	77431	77432	77435	77499

The following procedure codes may be reimbursed for radiation treatment delivery services:

Radiation Treatment Delivery/Port Films				
77385*	77386*	77387	77401**	77417**
77422*	77423*	G6002*	G6003*	G6004*
G6005*	G6006*	G6007*	G6008*	G6009*
G6010*	G6011*	G6012*	G6013*	G6014*
G6015*	G6016*	G6017*		

*Total component only.
**Technical component only.

Radiation treatment delivery/port films procedure codes may be billed in addition to procedure codes 77427 and 77431 when provided in the office setting.

33.2.6.1 Radioisotope Therapy

The CSHCN Services Program may reimburse therapeutic radioisotopes separately.

Diagnostic radioisotopes are considered part of the diagnostic service and will not be reimbursed separately.

33.2.7 Stereotactic Radiosurgery

The surgical component of the following procedure codes may be reimbursed for stereotactic radiosugery services (SRS):

Surgery Procedure Codes				
32701	61781	61782	61783	61796
61797	61798	61799	61800	63620
63621				

The total radiation therapy component of the following procedure codes may be reimbursed for SRS:

Radiation Therapy Procedure Codes				
77371	77372	77373	G0339	G0340
G6002				

The benefit and limitation information listed in the following table applies to the procedure codes indicated:

Procedure Code	Benefits and Limitations
61796	Services will not be reimbursed more than once per course of treatment. Procedure codes 61796 and 61798
61797	Procedure code 61797 must be billed with procedure code 61796 or 61798. Procedure code 61797 will not be reimbursed more than once per lesion. Procedure code 61797 may be reimbursed up to four times for the entire course of treatment regardless of the number of lesions treated.
61798	Procedure code 69718 will be denied if it is billed with procedure code 61796.
61799	Procedure code 61799 must be billed with procedure code 61798. Procedure code 61799 will not be reimbursed more than once per lesion. Procedure code 61799 may be reimbursed up to four times for the entire course of treatment regardless of the number of lesions treated.
61800	Procedure code 61800 must be billed with procedure code 61796 or 61798.
63620	Procedure code 63620 may be reimbursed once per course of treatment. Procedure code 63620 will not be reimbursed for services rendered on the same date of service by the same provider as radiation treatment management procedure code 77435.
63621	Procedure code 63621 must be billed with procedure code 63620. Procedure code 63621 may be reimbursed two times for the entire course of treatment, regardless of the number of lesions treated. Procedure code 63621 will not be reimbursed for services rendered on the same date of service by the same provider as radiation treatment management procedure code 77435.

Prior Authorization Requirements

Prior authorization requirements for SRS procedure codes may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Benign and malignant tumors of the central nervous system
- Vascular malformations
- Soft tissue tumors in the chest, abdomen, and pelvis
- Trigeminal neuralgia refractory to medical management

Other diagnoses may be considered with prior authorization after reviewing the documentation of medical necessity.

Note: *SRS is considered investigational and not a benefit of the CSHCN Services Program for all other indications including, but not limited to, epilepsy and chronic pain.*

Providers must use the CSHCN Services Program Authorization and Prior Authorization Request form to submit requests for prior authorization.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1 for more information about authorizations and prior authorizations.

33.2.8 Strontium-89

Strontium-89 is a benefit of the CSHCN Services Program. Procedure code A9600 may be reimbursed once every 90 days by any provider.

Procedure code A9600 must be submitted with one of the following diagnosis codes to be considered for reimbursement:

Diagnosis Code	Description
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of male breast; nipple and areola
1759	Malignant neoplasm of male breast; other and unspecified sites
185	Malignant neoplasm of prostate
1985	Secondary malignant neoplasm of bone and bone marrow

33.2.9 Technetium TC 99M Tetrofosmin

Procedure codes A9500 and A9502 are limited to a quantity of three each per day when billed by the same provider.

33.3 Claims Information

Claims for radiation therapy services must include the following:

- *The referring provider.* Radiologists are required to identify the referring provider by full name and address or CSHCN Services Program provider identifier in Block 17 of the CMS-1500 paper claim form. Baseline screening or comparison studies are not benefits.
- *Authorization and prior authorization number (as appropriate).* All claims must meet all authorization and prior authorization requirements and claim filing and authorization deadlines. Details are given in the description of the services and in more detail in association with services described in this chapter and in Chapter 4, "Prior Authorizations and Authorizations," on page 4-1.

Radiation therapy services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms or 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 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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Chapter 5, "CMS-1500 Paper Claim Form Instructions," on page 5-26 and "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form," on page 5-31 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Inpatient and outpatient hospitals must use the UB-04 CMS-1450 paper claim form to submit charges for covered services. 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 submitted on the UB-04 CMS-1450 paper claim form as an ancillary charge.

33.4 Reimbursement

Physicians and radiation treatment centers may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Inpatient hospitals may be reimbursed at 80 percent of the All Patient Refund Diagnosis Groups (APR-DRG) payment for CSHCN Services. Outpatient hospital may be reimbursed at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

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.*

33.5 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.

Chapter

34

Renal Dialysis

34.1 Enrollment

To enroll in the CSHCN Services Program, renal dialysis facilities must be licensed by the state of Texas as an end-stage renal disease (ESRD) facility, and be certified by Medicare. Home health agencies must be licensed by the state of Texas as home and community support services agencies designated to provide home dialysis services. The facilities 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 renal dialysis facility providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

34.2 Client Eligibility

Clients needing renal dialysis must also apply for Medicare coverage, unless the referring provider attests that the client is not eligible for Medicare. If the client is not eligible for Medicare coverage, the CSHCN Services Program may reimburse dialysis services as long as the services are needed. CSHCN Services Program coverage of renal dialysis begins with the client's initial date of eligibility or the first dialysis treatment, whichever is later.

34.3 Benefits, Limitations, and Authorization Requirements

The following types of dialysis are a benefit of the CSHCN Services Program in an inpatient or outpatient hospital, renal dialysis facility, or the client's home:

- Hemodialysis
- Continuous ambulatory peritoneal dialysis (CAPD)
- Continuous cycling peritoneal dialysis (CCPD)
- Intermittent peritoneal dialysis (IPD)

Dialysis services may be provided to dialysis clients by one of the following two methods:

- **Method I:** In-facility services and facility-supported home dialysis. The dialysis facility provides all necessary services, equipment, and support to the dialysis client either in the facility or in the client's home.
- **Method II:** Home dialysis by working directly with a dialysis supplier and receiving support services from a dialysis facility. A separate supplier provides services and equipment to the dialysis client in the client's home. The client also receives support services from a dialysis facility with whom the supplier maintains a written agreement to provide backup and support services.

The CSHCN Services Program may reimburse outpatient renal dialysis services for the following diagnosis codes:

Diagnosis Code	Description
5845	Acute kidney failure with lesion of tubular necrosis
5846	Acute kidney failure with lesion of renal cortical necrosis
5847	Acute kidney failure with lesion of renal medullary (papillary) necrosis
5848	Acute kidney failure with other specified pathological lesion in kidney
5849	Acute kidney failure, unspecified
5851	Chronic kidney disease, Stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified V

The following additional services related to renal dialysis are benefits of the CSHCN Services Program:

- Ultrafiltration
- Dialysis training not to exceed 18 days of hemodialysis or peritoneal (IPD, CAPD, or CCPD) training

Note: *The facility charge for dialysis services is denied as part of the dialysis training when billed with the same date of service as the dialysis training.*

- Related physician services
- Dialysis support services

The installation and repair of home hemodialysis machines is not a benefit.

34.3.1 In-Facility Services and Method I Home Dialysis Services

Outpatient dialysis is furnished on an outpatient basis at a renal dialysis center or facility.

Allowable outpatient dialysis services include:

- Staff-assisted dialysis performed by the center's or facility's staff.
- Self-dialysis performed by a client with little or no professional assistance, provided that the client has completed an appropriate course of training.
- In-home dialysis performed by an appropriately trained client or an appropriately trained caregiver.
- Dialysis services provided in an approved renal dialysis facility on an outpatient basis.

The facility's composite rate is a comprehensive daily payment for all in-facility and Method I home dialysis. The cost of an item or service is included under this rate unless specifically excluded, such as physician's professional services, lab work that is designated as separately billable, and drugs designated as separately billable. Providers should bill the following revenue codes for Method I services performed on a daily basis:

Revenue Code	Description
821	Hemodialysis (outpatient/home) - composite or other rate
831	Peritoneal dialysis (outpatient/home) - composite or other rate
841	CAPD (outpatient/home) - composite or other rate
851	CCPD (outpatient/home) - composite or other rate

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. The composite rate will be denied as part of dialysis training (revenue code 829, 839, 849, or 859) when billed for the same date of service.

Refer to: Section 34.5, "Reimbursement," on page 34-11 for additional information about the Method I composite rate.

Examples of services that are not separately payable include, but are not limited to:

- Dialysate (procedure codes A4720, A4721, A4722, A4723, A4724, A4725, A4726, and A4765)
- Cardiac monitoring (procedure codes 93040 and 93041)
- Catheter changes (procedure codes 36000 and 49421)
- Suture removal or dressing changes
- Crash cart usage for cardiac arrest
- Declotting of shunt performed by facility staff for hemodialysis (procedure code 36593)
- Oxygen (procedure codes E0424, E0431, E0434, E0435, E0439, E0440, E0441, E0442, E0443, and E0444)
- Staff time to administer blood, separately billable drugs, and blood collection for laboratory tests (procedure codes 36430 and 36591)
- Routine laboratory services for dialysis (listed in the table below) are included in the composite rate and not billed separately
- When additional in-facility laboratory testing is medically necessary beyond the routine frequencies identified below, providers must bill using Current Procedural Terminology (CPT) modifier 91. Documentation supporting medical necessity must be maintained in the client's medical record by the client's physician and the renal dialysis center.

Modifier 91 is used to indicate that a test was performed more than once on the same day, for the same client, only when it is necessary to obtain multiple results in the course of the treatment. This modifier may not be used when tests are re-run to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal one-time, reportable result is all that is required. This modifier may not be used when there are standard Healthcare Common Procedure Coding System (HCPCS) codes available that describe the series of results (e.g., glucose tolerance tests, evocative/suppression. testing, etc.). This modifier may only be used for laboratory tests paid under the clinical diagnostic laboratory fee schedule.

Refer to: The CMS website at www.cms.gov/CLIA/10 Categorization of Tests.asp for information about procedure codes and modifier QW requirements. The CSHCN Services program follows the Medicare categorization of tests for CLIA certificate-holders.

Procedure Codes	Limitation
80069	Every 6 months
81050	Every 6 months
82040	Monthly
82310	Monthly
82374	Monthly
82435	Monthly
82565	Weekly
83615	Monthly
84075	Monthly
84100	Monthly
84132	Monthly
84155	Monthly
84295	Monthly for CAPD
84450	Monthly

Procedure Codes	Limitation
84520	Weekly
85004	Every 3 months
85014	Once per dialysis
85018	Once per dialysis
85025	Monthly
85027	Monthly
85041	Every 3 months
85049	Every 3 months
85345	Per treatment
85347	Per treatment
85610	Weekly

In addition to the services listed above, certain drugs such as those to elevate or decrease blood pressure, antiarrythmics, blood thinners or expanders, antihistamines, or antibiotics to treat catheter site infections or peritonitis, are included in the composite rate. Examples include, but are not limited to:

- Dextrose (procedure codes J7042, J7060, and J7070)
- Digoxin (procedure code J1160)
- Diphenhydramine (procedure code J1200)
- Dopamine (procedure code J1265)
- Glucose
- Heparin (procedure codes J1642 and J1644)
- Hydralazine (*Apresoline*, procedure code J0360)
- Hydrocortisone sodium succinate (procedure code J1720)
- Insulin
- Lidocaine, bupivacaine (procedure code J2001)
- Mannitol (procedure code J2150)
- Norepinephrine bitartrate (*Levophed*)
- Procaine
- Propranolol (procedure code J1800)
- Protamine (procedure code J2720)
- Saline (procedure codes A4216, A4217, A4218, J7030, J7040, and J7042)
- Verapamil

Other drugs that are not included in the composite rate, but that may be medically necessary, are separately payable when furnished by and administered in the dialysis facility by the facility staff. However, staff time and supplies used to administer the drugs are included in the composite rate. Examples include, but are not limited to:

- Antibiotics, except when prescribed for clients to treat infections or peritonitis related to peritoneal dialysis
- Hematinics
- Anabolics
- Muscle relaxants
- Analgesics
- Sedatives
- Tranquilizers

- Thrombolytics used to declot central venous catheters
- Erythropoietin
- Intravenous levocarnitine, for ESRD clients who have been on dialysis for a minimum of 3 months for one of the following indications:
  - Carnitine deficiency, defined as a plasma-free carnitine level less than 40 micromoles per liter.
  - Signs and symptoms of erthropoietin-resistant anemia that has not responded to standard erythropoietin with iron replacement, and for which other causes have been investigated and adequately treated.
  - Hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g., fluid management). Such episodes of hypotension must have occurred during at least 2 dialysis treatments in a 30-day period.
  - All other indications for levocarnitine are noncovered.

Note: *Continued use of levocarnite is not a benefit if improvement has not been demonstrated within 6 months of initiation of treatment. The ordering physician must maintain documentation supporting medical necessity in the client's medical record. Procedure code J1955 is not age restricted.*

34.3.2 Method II Home Dialysis (Dealing Direct)

If the client is working directly with a single supplier to obtain supplies and equipment for home dialysis, the supplier must submit the appropriate procedure codes for the equipment and supplies provided to the client for the home dialysis. The selected supplier cannot be a dialysis facility but must maintain a written agreement with a support dialysis facility to provide backup and support services.

The support facility must bill for services using the following revenue codes:

Revenue Code	Description	Limitation*
845	CAPD (outpatient/home) - support services	Monthly
855	CCPD (outpatient/home) - support services	Monthly
* Medically necessary support services denied as exceeding the limitation may be appealed with documentation of medical necessity.		

Examples of dialysis support services covered in the reimbursement for revenue code 845 and 855 include, but are not limited to:

- Changing the connecting tube (administration set).
- Observing the client or caregiver performing dialysis and validating that they are correctly performing the procedure.
- Documenting past or present peritonitis events requiring hospitalization or physician intervention.
- Inspecting the catheter site for infection and patency.
- Emergency home visits by ESRD facility staff as needed.
- ESRD-related laboratory tests that are included in the composite rate.
- Assuring that the water supply is of the appropriate quality.
- Testing and appropriate treatment of water used in dialysis.
- Monitoring the functioning of dialysis equipment.

The routine laboratory services listed in the table in Section 34.3.1, "In-Facility Services and Method I Home Dialysis Services" on page 34-4 are included in the Method II support services and are not considered separately for reimbursement. When one of these laboratory tests is required more frequently than the limitation indicated in the table, renal dialysis facility providers should bill the appropriate procedure code with modifier 91 for separate reimbursement as outlined in Section 34.3.1.

The supply company must bill the appropriate procedure code(s) for the dialysis supplies. The following supplies may be reimbursed:

Procedure Codes					
36000	36430	36591	36593	49421	93040
93041	A4651	A4652	A4653	A4657	A4660
A4663	A4670	A4671	A4672	A4673	A4674
A4680	A4690	A4706	A4707	A4708	A4709
A4714	A4719	A4720	A4721	A4722	A4723
A4724	A4725	A4726	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4772	A4773	A4774	A4802	A4860	A4911
A4913	A4918	A4927	A4928	A4929	A4930
A4931	A4932	E0424	E0431	E0434	E0435
E0439	E0440	E0441	E0442	E0443	E0444
E1510	E1520	E1530	E1540	E1550	E1560
E1570	E1580	E1590	E1592	E1594	E1600
E1620	E1632	E1635	E1630	E1634	E1637
E1639	E1699	J1955	Q4081		

Supplies, equipment, and support services for clients working with a single supplier to obtain supplies and equipment for home dialysis may be reimbursed separately up to the total monthly allowable amount.

If more than one claim for support services is received per month, the additional claims are denied. The denied claims may be appealed with documentation of medical necessity.

34.3.3 Maintenance Hemodialysis

If a client is admitted for hospitalization only to receive maintenance renal dialysis, the dialysis services are considered outpatient services.

Refer to: Section 34.3.1, "In-Facility Services and Method I Home Dialysis Services," on page 34-3 for more information about outpatient dialysis services.

34.3.4 Dialysis Training

Dialysis training is a benefit for CSHCN Services Program clients or their caregivers using the following revenue codes:

Revenue Code	Description
829	Hemodialysis training
839	Peritoneal dialysis training
849	CAPD training
859	CCPD training

These revenue codes include the following:

- Personnel services
- Parenteral items routinely used in dialysis

- Training manuals and materials
- Routine laboratory tests listed in the table in Section 34.3.1, "In-Facility Services and Method I Home Dialysis Services" on page 34-4 (The frequency of routine laboratory tests during training are not limited, as these tests are commonly given during each day of training. These laboratory tests are not to be billed separately and may only be billed once a day.)

A maximum of 18 days of training may be provided to the client or their caregiver(s). If additional days of training are medically necessary, the denied claims for the additional days may be appealed for consideration of reimbursement. Documentation of medical necessity supporting the need for additional training sessions must be attached to the appealed claim for reimbursement to be considered.

Refer to: Section 7.1, "Appeals," on page 7-2 for information about appealing a claim.

Dialysis training provided in an inpatient setting may be reimbursed the same rate as the facility's outpatient training rate.

Revenue codes 821, 831, 841, and 851 are denied if billed with the same date of service as dialysis training (revenue codes 829, 839, 849, and 859).

34.3.5 Unscheduled or Emergency Dialysis in a Non-Certified ESRD Facility

The CSHCN Services Program will reimburse an unscheduled or emergency dialysis treatment furnished to ESRD clients in the outpatient department of a hospital that does not have a certified ESRD facility.

Reimbursement for procedure code G0257 is limited to the same services included in the Method 1 composite. Providers will not be reimbursed for individual services related to dialysis. (Refer to Appendix for list of bundled services).

Reimbursement of other outpatient hospital services are only reimbursed when medically necessary and when they are not related to an unscheduled or emergency dialysis services. Providers must submit documentation of unrelated services.

Repeated billing of this service by the same provider for the same clients may indicate routine dialysis treatments are being performed and providers will be subject to recoupment upon medical record review.

Procedure code G0257 is limited to one service a day, any provider.

Procedure code G0257 must be billed with revenue code 880 on the same claim. If procedure code G0257 is not on the same claim as revenue code 880, it will be denied.

Erythropoietin (procedure code Q4081) may be billed separately and must be billed with revenue code 634 or 635 on the same claim.

34.3.6 Ultrafiltration

Ultrafiltration of the client's blood is part of a hemodialysis treatment and is included in the reimbursement for the hemodialysis treatment. Ultrafiltration is not a substitute for dialysis.

Medical complications may occur if the client retains excess fluid following a regular dialysis treatment. When an additional treatment is required to remove the excess fluid, the facility must provide documentation indicating the medical necessity of this additional treatment and must submit the claim for the ultrafiltration procedure using revenue code 881.

34.3.7 Evaluation and Management

Physician evaluation procedure codes 90935, 90937, 90945, and 90947 are a benefit in an inpatient setting for ERSD or non-ERSD services only when provided by a physician. The physician must be physically present and involved during the course of the dialysis.

Procedure codes 90935, 90937, 90945, and 90947 are also a benefit in an office or outpatient setting for non-ESRD services that are provided by a physician, physician assistant, or advanced practice registered nurse (APRN).

Only one evaluation procedure code may be reimbursed per day for any provider, regardless of setting. Hospital visits cannot be billed for the same date of service as an evaluation code.

If the physician only sees the patient when they are not dialyzing, the physician should bill the appropriate hospital visit procedure code. The inpatient dialysis procedure code should not be submitted for payment.

Outpatient dialysis services for non-ESRD clients may be reimbursed with procedure codes 90935, 90937, 90945, and 90947.

Reimbursement for physician supervision of outpatient ESRD dialysis includes services provided by the attending physician in the course of office visits where any of the following occur:

- The routine monitoring of dialysis
- The treatment or follow-up of complications of dialysis, including:
  - The evaluation of related diagnostic tests and procedures
  - Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts

The following procedure codes may be reimbursed for physician supervision of ESRD dialysis services:

Procedure Codes				
90951	90952	90953	90954	90955
90956	90957	90958	90959	90960
90961	90962	90963	90964	90965
90966	90967	90969	90970	

In circumstances where the client is not on home dialysis, has had a complete assessment visit during the calendar month, and a full month of ESRD-related services are provided, one of the following procedure codes must be used:

Procedure Codes				
90951	90952	90953	90954	90955
90956	90957	90958	90959	90960
90961	90962			

The procedure code will be determined by the number of face-to-face visits the physician has had with the client during the month and by the client's age.

When a full calendar month of ESRD-related services are reported for clients on home dialysis, procedure code 90963, 90964, 90965, or 90966 must be used. The appropriate procedure code will be determined by the client's age.

Procedure codes 90967, 90968, 90969, or 90970 should be billed per day when ESRD-related services are provided for less than a full month under the following conditions:

- Partial month during which the client, not on home dialysis, received one or more face-to-face visits but did not receive a complete assessment
- Client on home dialysis received less than a full month of services
- Transient client
- Client was hospitalized during a month of services before a complete assessment could be performed
- Dialysis was stopped due to recovery or death of client
- Client received a kidney transplant

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing these procedure codes, the dates of service must indicate each day that supervision was provided.

Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed during the same calendar month by any provider as the procedure codes in the following table. Only one of the procedure codes in the following table will be reimbursed per calendar month to any provider:

Procedure Codes				
90951	90952	90953	90954	90955
90956	90957	90958	90959	90960
90961	90962	90963	90964	90965
90966				

Physician services beyond those that are related to the treatment of the client's renal condition that cause the number of physician-client contacts to increase are considered nonroutine, and may be separately reimbursed. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

34.3.8 Renal Transplants

Renal transplants are a benefit of the CSHCN Services Program with documentation of end-stage renal disease (ESRD).

Refer to: Section 24.3.1.3 and Section 31.2.39.1 for detailed information about renal transplants.

34.3.9 Prior Authorization Requirements

Prior authorization is required for renal dialysis. Providers must submit the CSHCN Services Program Prior Authorization Request for Renal Dialysis Treatment form to the CSHCN Services Program or its designee.

An initial prior authorization of 3 months is given to clients seeking eligibility with Medicare. An additional 3 months may be prior authorized on a case-by-case basis if clients have applied for, but have not yet received, a determination from Medicare at the end of the initial prior authorization.

If a denial for Medicare is received or if the referring provider attests that the client is ineligible for Medicare, an open-ended prior authorization may be granted.

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

34.4 Claims Information

Renal dialysis facilities must submit claims to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Claims for separately billable drugs and laboratory fees must be submitted to TMHP in an approved electronic format or on the appropriate paper claim form. Hospitals and renal dialysis facilities must use the UB-04 CMS-1450 paper claim form and may include these separately billable items on the same UB-04 CMS-1450 form as the dialysis services. Physicians must use the CMS-1500 paper claim form. Providers may purchase both claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing claim forms, 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.

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

The HCPCS/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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 and Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form," on page 5-31 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

34.5 Reimbursement

The CSHCN Services Program may reimburse dialysis services using one of the following methods as defined by CMS:

- **Method I:** *Composite Rate*. The composite rate is paid to the dialysis facility as a comprehensive payment for all in-facility and Method I home dialysis. The cost of an item or service is included in this rate unless specifically excluded as separately billable. Separately billable services would include the physician's professional services, lab work that is designated as separately billable, and drugs that are designated as separately billable. The reimbursement rates associated with revenue codes (composite rates) are available in the Static Fee Schedules, Renal Dialysis Facility Insert, on the TMHP website at www.tmhp.com. CSHCN providers are reimbursed at the same rate as Medicaid providers.

Refer to: Section 34.3.1, "In-Facility Services and Method I Home Dialysis Services," on page 34-3 for benefits and limitations concerning Method I billing.

- **Method II:** *Direct Dealing*. With direct dealing, the client works with a single supplier such as a durable medical equipment (DME) or other medical supplier (not a dialysis facility) to obtain supplies and equipment to dialyze at home. The supplier will bill the CSHCN Services Program for the services provided. Reimbursement for supplies and services is limited to a maximum amount of $1,974.45 per client, per calendar year.

Refer to: Section 34.3.2, "Method II Home Dialysis (Dealing Direct)," on page 34-6 for benefits and limitations concerning Method II billing.

Physicians, laboratories, and medical suppliers may be reimbursed for renal dialysis services the lower of the billed amount or the amount allowed by Texas Medicaid.

Outpatient hospitals may be reimbursed for renal dialysis services at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

Advanced practice registered nurses (APRNs) and physician assistants may be reimbursed for renal dialysis services the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician.

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.*

34.6 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.

Chapter

35

Respiratory Equipment and Supplies

35.1 Enrollment

Durable medical equipment (DME) 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 laws and requirements. Out-of-state respiratory equipment providers must meet all of these conditions and be located in the United States, within 50 miles of the Texas state border, and approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

35.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program may reimburse the rental or purchase of medically necessary and appropriate respiratory equipment. The item must be prescribed by a licensed physician and be a benefit of the CSHCN Services Program.

Equipment may be rented or purchased depending on the cost-effectiveness of the action requested. In general, equipment is purchased if it is needed for more than 6 months. The CSHCN Services Program purchases only new, unused equipment. The reimbursement of rented equipment includes all supplies, accessories, adjustments, repairs, and replacement parts needed during the rental period.

Exception: *Ventilators, oxygen concentrators, and cough stimulating devices are rented, not purchased, because of high maintenance costs and the frequency of required repairs.*

Repairs are considered if the item was purchased by the CSHCN Services Program or is an item on the CSHCN Services Program-approved list that was obtained from another source. The repair must be more cost-effective than the cost of replacement. Repairs may be reimbursed at the list price of parts plus labor time. Providers must use procedure code E1340 when requesting authorization and submitting claims for repairs.

The CSHCN Services Program considers requests for coverage of the following types of respiratory equipment:

Rental or purchase of:

- Suction equipment
- Electric percussors for chest physiotherapy
- High frequency chest wall compression systems (HFCWCS)
- Medical grade or "heavy duty" air compressors

- Continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP) machines (BiPAP machines will only be provided to clients who have documented treatment failure of CPAP)
- Immersion heaters
- Nebulizers
- Pulse oximeters
- Ventilators and supplies (ventilators may be a benefit for lease only)
- Controlled dose inhalation drug delivery system
- Cardiorespiratory (apnea) monitors (only nonrecording apnea monitors will be authorized for ventilator dependent clients)

Rental of:

- Stationary gaseous oxygen cylinders or liquid oxygen systems
- Portable gaseous oxygen system

Note: *Stands, carts, regulators, oxygen conservers, and carrying cases are included in the rental reimbursement for stationary gaseous oxygen cylinders, liquid oxygen systems, and portable gaseous oxygen systems.*

- Oxygen concentrators (a back up cylinder of gaseous oxygen is included in the rental reimbursement)
- Cough stimulating devices (Cofflator)

Purchase of:

- Liquid or gaseous oxygen contents or refills for client-owned equipment
- Oxygen humidification devices (e.g., Cascade device)
- Ambu bag
- Tracheostomy tubes and supplies
- Incentive spirometer
- Mucus clearance valve

Note: *Rental of substitute equipment is not covered when a purchased item that is under warranty is being repaired.*

The CSHCN Services Program will cover only one of the following per client:

- A cough stimulating device
- An HFCWCS

The CSHCN Services Program will consider the following two situations with documentation of medical necessity:

- Requests for the rental or purchase of duplicate items that will be used in two different locations. The CSHCN Services Program will not pay for the rental or purchase of items when the provision of the items are the legal responsibility of a school district or the Texas Department of Assistive and Rehabilitative Services (DARS).
- Requests to replace items purchased within the last 2 years.

The CSHCN Services Program may cover items under the Family Support Services (FSS) benefit within annual coverage limits. Type of items include, but are not limited to:

- Room air vaporizers or humidifiers
- Air filtering systems
- Specialized vacuum cleaners
- Heaters
- Air conditioners
- Dehumidifiers

Contact the CSHCN Services Program at 1-800-252-8023 for additional information about the FSS benefit.

The following equipment is not a benefit of the CSHCN Services Program:

- Intrapulmonary percussive ventilation (IPV)
- Vaporizers
- Intermittent pressure breathing (IPPB) machines
- Disposal tracheostomy inner cannulas

Providers must have the client or the client's representative complete the CSHCN Services Program Documentation of Receipt form when DME is delivered to the client. The date of delivery on the documentation of receipt form is the date of service that should appear on the claim. The provider should retain this form; do not submit it with the claim.

The documentation of receipt form is available in both English and Spanish.

The following table is a list of respiratory equipment and supplies and their limitations.

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
A4481	31 per month	A4483	31 per month	A4605	10 per month
A4606	4 per month	A4611	1 per 5 years	A4612	1 per 5 years
A4613	1 per 5 years	A4614	1 per 6 months	A4615	2 per month
A4616	4 per year	A4617	2 per month	A4618	4 per month
A4619	2 per month	A4620	2 per month	A4623	1 per month
A4624	90 per month	A4627	1 per 6 months	A4628	2 per month
A4629	31 per month	A7000	4 per month	A7002	8 per month
A7003	2 per month	A7004	1 per month	A7005	1 per 6 months
A7006	1 per month	A7007	2 per month	A7009	4 per month
A7010	1 per 2 months	A7011	1 per calendar year	A7012	2 per month
A7013	2 per month	A7014	1 per 3 months	A7015	1 per month
A7016	2 per month	A7017	1 per 3 years	A7018	4 per month
A7026	1 per 6 months	A7027	1 per 3 months	A7028	1 per month
A7029	2 per month	A7030	1 per 3 months	A7031	1 per month
A7032	2 per month	A7033	2 per month	A7034	4 per year
A7035	1 per 6 months	A7037	1 per month	A7038	2 per month
A7039	1 per 6 months	A7520	1 per month	A7521	1 per month
A7522	4 per year	A9284	1 per 6 months	A9900	1 per month
E0424	4 rentals per lifetime	E0431	4 rentals per lifetime	E0433	1 per month
E0434	4 rentals per lifetime	E0439	4 rentals per lifetime	E0441	4 rentals per lifetime

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
E0442	4 rentals per lifetime	E0443	1 per month	E0444	1 per month
E0445	1 purchase per 5 years; 1 rental per month	E0450	1 per month	E0457	1 purchase per 3 years; 1 rental per month
E0459	1 purchase per lifetime; 1 rental per month	E0460	1 per month	E0463	1 per month
E0464	1 per month	E0470	1 purchase per 5 years; 1 rental per month	E0471	1 purchase per 3 years; 1 rental per month
E0472	1 purchase per 3 years; 1 rental per month	E0480	1 purchase per 3 years; 1 rental per month	E0482	1 per month
E0483	1 purchase per lifetime; 1 rental per month	E0500	4 rentals per lifetime	E0561	1 purchase per 5 years; 1 rental per month
E0562	1 purchase per 3 years; 1 rental per month	E0565	1 purchase per 3 years; 1 rental per month	E0570	1 per 3 years
E0575	1 per 3 years	E0580	1 per 3 years	E0600	1 per 3 years
E0601	1 purchase per 3 years; 4 rentals per lifetime	E0605	1 per 3 years	E0618	1 per month
E0619	4 rentals per lifetime	E1353	1 per year	E1355	1 per 3 years
E1372	1 per 3 years	E1399	Limited by policy	S8101	1 per 180 days
S8185	1 per 5 years	S8189	Limited by policy	S8999	1 per year

35.2.1 General Authorization Requirements

Requirements for authorization and prior authorization vary with the type of equipment requested. Refer to the types of equipment listed below for authorization and prior authorization requirements. Authorization and prior authorization request forms must be submitted in writing and must include documentation of medical necessity.

Refer to: Chapter 4, "Prior Authorizations and Authorizations," on page 4-1.

CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

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

35.2.2 Cardiorespiratory (Apnea) Monitors

Prior authorization with documentation of medical necessity is required for diagnoses other than those listed below for infants 4 months of age or younger.

Prior authorization with documentation of medical necessity is required for infants older than 4 months of age.

The rental of procedure code E0619 must be used when billing for recording apnea monitors with the following diagnosis codes:

Diagnosis Code	Description
33700	Idiopathic peripheral autonomic neuropathy, unspecified
33709	Other idiopathic peripheral autonomic neuropathy
4260	Atrioventricular block, complete
42610	Unspecified atrioventricular block
42611	First degree atrioventricular block
42612	Mobitz (type) II atrioventricular block
42613	Other second degree atrioventricular block
4270	Paroxysmal supraventricular tachycardia
4272	Unspecified paroxysmal tachycardia
42789	Other specified cardiac dysrhythmias
53011	Reflux esophagitis
53081	Esophageal reflux
74686	Congenital heart block
7707	Chronic respiratory disease arising in the perinatal period
77081	Primary apnea of newborn
77082	Other apnea of newborn
77083	Cyanotic attacks of newborn
77084	Respiratory failure of newborn
77089	Other respiratory problems after birth
77981	Neonatal bradycardia
77982	Neonatal tachycardia
7850	Tachycardia, unspecified
78603	Apnea
V198	Family history of other conditions

Prior authorization may be given for nonrecording apnea monitors (procedure code E0618) used by ventilator dependent clients.

Documentation must be submitted to the claims contractor. Documentation should include information that supports medical necessity. The documentation must include interpretation of previous apnea monitor downloads, be signed and dated by the physician who interpreted the download when the infant had previous monitoring, and document that the apnea monitor to be rented is capable of recording and storing data. Providers must use the CSHCN Services Program Prior Authorization Request for Apnea Monitor Rental.

Electrodes and lead wires (procedure codes A4556 and A4557) that are used with an apnea monitor owned by a client must be authorized. The CSHCN Services Program requires that a physician statement declaring that the client owns the monitor be submitted with the claim.

Electrodes and lead wires for the apnea monitor may be reimbursed separately only if the client owns the monitor.

35.2.3 Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (BiPAP) Systems

A CPAP system is used primarily for the treatment of obstructive sleep apnea. Other conditions may be considered based on medical necessity.

Providers must use procedure code E0601 for the CPAP system and procedure code E0470, E0471, or E0472 for the BiPAP system.

CPAP and BiPAP systems require authorization. Providers may submit evidence of medical necessity with the first claim to the CSHCN Services Program claims contractor. The rental of BiPAP machines will only be provided to clients who have a documented failure with a CPAP device.

The CPAP system may be prior authorized for rental or purchase based on the physician's predicted length of treatment.

The CPAP system may be approved for an initial 3-month rental period based on documentation that supports the medical necessity and appropriateness of the system.

CPAP may be approved for an initial 3-month period for adults if one of the following conditions is met:

- The Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) is greater than or equal to 15 per hour
- The Sleep Study RDI or AHI is greater than 5 per hour and at least one of the following is true:
  - Excessive daytime sleepiness (documented by either an Epworth greater than ten or a Multiple Sleep Latency Test less than six)
  - Documented symptoms of impaired cognition, mood disorders, or insomnia
  - Documented hypertension (systolic blood pressure greater than 140 mm Hg and/or diastolic blood pressure greater than 90 mm Hg)
  - Documented ischemic heart disease
  - Documented history of stroke
  - Greater than 20 episodes of oxygen desaturation less than 85 percent during a full night sleep study
  - Any one episode of oxygen desaturation less than 70 percent

One of the following AHI or oxygen saturation levels may be used for children:

- Polysomnography documentation of an AHI greater than 1
- An oxygen saturation of less than 92 percent, taken upon exertion and breathing room air.

Headgear, tubing, and filters used with client-owned positive airway pressure systems do not require prior authorization. Headgear, tubing, and filters are considered part of the rental and will not be reimbursed separately.

Humidifiers may be prior authorized when used with a CPAP system and with documentation of medical necessity.

Note: *Supplies are limited to the amounts that an average client would use. If a client has an unusual need or situation, prior authorization for overages may be obtained with documentation of medical necessity.*

35.2.4 Controlled Dose Inhalation Drug Delivery System

A controlled dose inhalation drug delivery system (procedure code K0730) may be reimbursed when submitted with diagnosis code 4168.

35.2.5 Cough Stimulating Devices

Prior authorization is required for cough stimulating devices (procedure code E0482). Cough stimulating devices may be rented for 3 months. Documentation of medical necessity must include the following:

- Why other modes of chest physiotherapy have not been effective for the client (include information about other modes used with the client)
- Results of pulmonary function tests (PFTs) done in the last 6 months
- Hospitalizations or infections that required IV antibiotics in the last 6 months
- Work or school absences during the last 6 months because of problems related to a respiratory condition
- Whether the client has discontinued sports or other extracurricular activities because of fatigue related to the respiratory condition

Rental beyond the initial 3-month period will be considered with the following:

- PFT results from the final month of rental
- Evidence of clinical improvement, other than PFTs, including improved work or school attendance or the ability to participate in extracurricular activities

Providers must document the information on the CSHCN Services Program Prior Authorization Request for Chest Physiotherapy Devices Form.

35.2.6 High Frequency Chest Wall Compression System (HFCWCS)

Providers must use procedure code E0483 when billing for HFCWCS.

Prior authorization is required for HFCWCS. A completed CSHCN Services Program Prior Authorization Request for Chest Physiotherapy Devices Form must be submitted with documentation of medical necessity.

Prior authorization for the purchase of HFCWCS may be considered with the following diagnosis codes. Other diagnoses will be considered with documentation of medical necessity.

Diagnosis Code	Description
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
33510	Unspecified spinal muscular atrophy
33511	Kugelberg-Welander disease
33519	Other spinal muscular atrophy
3430	Diplegic infantile cerebral palsy
3431	Hemiplegic infantile cerebral palsy
3432	Quadriplegic infantile cerebral palsy
3433	Monoplegic infantile cerebral palsy
3434	Infantile hemiplegia
3438	Other specified infantile cerebral palsy
3439	Unspecified infantile cerebral palsy
3591	Hereditary progressive muscular dystrophy (Duchenne's only)

Documentation of medical necessity must include:

- An explanation of why other modes of chest physiotherapy have not been effective for the client. Include information about other modes used with the client.
- Results of PFTs done in the last 6 months.
- Hospitalizations or infections in the last 6 months that required intravenous (IV) antibiotics.
- Work or school absences in the last 6 months because of problems related to the respiratory condition.
- Whether the client has discontinued sports or other extracurricular activities because of fatigue related to a respiratory condition.

If documentation supports the need for an HFCWCS, a 3-month rental trial may be approved. If the HFCWCS is documented to be effective at the end of the initial 3-month rental period, purchase of the system may be authorized. If at the end of the initial 3-month rental period a determination of purchase cannot be made, an additional 3-month rental may be given.

At the end of the 3-month trial, the following information should be sent with the request to purchase the generator for the client:

- PFT results from the final month of rental
- Evidence of clinical improvement, other than PFTs, including improved work or school attendance or the ability to participate in extracurricular activities
- The frequency and compliance graphs that were generated by the compressor for the 6-month period and that indicate compliance with the physician's prescription

Providers must document the information on the CSHCN Services Program Prior Authorization Request for Chest Physiotherapy Devices Form.

The rental fees for these systems are applied to the purchase price of the compressor; therefore, a new compressor is provided at the onset of the rental period.

An HFCWCS is a once-in-a-lifetime purchase because the manufacturer provides a lifetime warranty.

An exception may be considered for replacement of the HFCWCS vest if documentation indicates that the client has outgrown the vest.

An HFCWCS is not purchased or rented if the CSHCN Services Program is currently renting a cough stimulating device for the client.

35.2.7 Mucus Clearance Valve

Providers must use procedure code S8185 for the purchase of a mucus clearance valve. The mucus clearance valve does not require authorization.

35.2.8 Nebulizers

A nebulizer may be rented or purchased for clients when:

- The equipment is prescribed by a physician for an approved diagnosis.
- The documentation submitted with the claim, the authorization, or prior authorization request supports medical necessity and appropriateness.

The purchase of nebulizers may be reimbursed with the anticipation that the equipment will last a minimum of 2 years with continuous use and up to 5 years with intermittent use.

The following procedure codes may be reimbursed for nebulizers and supplies:

Procedure Codes					
Small Volume Nebulizer and Supplies					
A7003	A7004	A7005	A7006	E0565	E0572
Large Volume Nebulizer and Supplies					
A7007	A7008	E0585			

Procedure Codes		
Filtered Volume Nebulizer and Supplies		
A7006	E0565	E0572
Ultrasonic Volume Nebulizer and Supplies		
E0574	E0575	

Authorization is not required for nebulizers if an approved diagnosis, listed in the table above, is submitted:

Small volume nebulizer with related compressor

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV)
1363	Pneumocystosis
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
46611	Acute bronchiolitis due to respiratory syncytial virus (RSV)
46619	Acute bronchiolitis due to other infectious organisms
4800	Pneumonia due to adenovirus
4801	Pneumonia due to respiratory syncytial virus
4802	Pneumonia due to parainfluenza virus
4803	Pneumonia due to SARS-associated coronavirus
4808	Pneumonia due to other virus not elsewhere classified
4809	Unspecified viral pneumonia
481	Pneumococcal pneumonia (streptococcis pneumoniae pneumonia)
4820	Pneumonia due to Klebsiella pneumoniae
4821	Pneumonia due to Pseudomonas
4822	Pneumonia due to Hemoplilus influenzae (H. influenzae)
48230	Pneumonia due to unspecified Streptococcus
48231	Pneumonia due to Streptococcus, group A
48232	Pneumonia due to Streptococcus, group B
48239	Pneumonia due to other Streptococcus
48240	Pneumonia due to Staphylococcus, unspecified
48241	Methicillin susceptible Staphylococcus aureus
48242	Methicillin resistant pneumonia due to Staphylococcus aureus
48249	Other Staphylococcus pneumonia
48281	Pneumonia due to anaerobes
48282	Pneumonia due to Escherichia coli (E. coli)
48283	Pneumonia due to other gram-negative bacteria
48284	Legionnaires' disease
48289	Pneumonia due to other specified bacteria
4829	Unspecified bacterial pneumonia

Diagnosis Code	Description
4830	Pneumonia due to Mycoplasma pneumoniae
4831	Pneumonia due to Chlamydia
4838	Pneumonia due to other specified organism
4841	Pneumonia in cytomegalic inclusion disease
4843	Pneumonia in whooping cough
4845	Pneumonia in anthrax
4846	Pneumonia in aspergillosis
4847	Pneumonia in other systemic mycoses
4848	Pneumonia in other infectious diseases classified elsewhere
485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
48801	Influenza due to identified Avian influenza virus with pneumonia
48802	Influenza due to identified Avian influenza virus with other respiratory manifestations
48811	Influenza due to identified 2009 H1N1 influenza virus with pneumonia
48812	Influenza due to identified 2009 H1N1 influenza virus with other respiratory manifestations
48881	Influenza due to identified novel influenza A virus with pneumonia
48882	Influenza due to identified novel influenza A virus with other respiratory manifestations
49300	Extrinsic asthma, unspecified
49301	Extrinsic asthma with status asthmaticus
49302	Extrinsic asthma with (acute) exacerbation
49310	Intrinsic asthma, unspecified
49311	Intrinsic asthma with status asthmaticus
49312	Intrinsic asthma with (acute) exacerbation
49320	Chronic obstructive asthma, unspecified
49321	Chronic obstructive asthma with status asthmaticus
49322	Chronic obstructive asthma with (acute) exacerbation
49381	Exercise induced bronchospasm
49382	Cough variant asthma
49390	Asthma, unspecified
49391	Asthma, unspecified, with status asthmaticus
49392	Asthma, unspecified with (acute) exacerbation
5070	Pneumonitis due to inhalation of food or vomitus
5071	Pneumonitis due to inhalation of oils and essences
74861	Congenital bronchiectasis
99680	Complications of transplanted organ, unspecified site
99681	Complications of transplanted kidney
99682	Complications of transplanted liver
99683	Complications of transplanted heart
99684	Complications of transplanted lung

Diagnosis Code	Description
99685	Complications of transplanted bone marrow
99686	Complications of transplanted pancreas
99687	Complications of transplanted organ, intestine
99689	Complications of other transplanted organ

Large Volume Nebulizer with Compressor

Diagnosis Code	Description
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
4940	Bronchiectasis without acute exacerbation
4941	Bronchiectasis with acute exacerbation
51919	Other diseases of trachea and bronchus
V440	Tracheostomy status
V550	Attention to tracheostomy

Filtered Nebulizer or Related Compressor

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV)
99680	Complications of organ transplants, unspecified site

Prior authorization requests must be submitted in writing to the CSHCN Services Program and must document the medical necessity of a nebulizer for any diagnosis not listed above or to justify the purchase of more than one nebulizer.

The purchase of ultrasonic nebulizers (procedure codes E0574 and E0575) may be considered for prior authorization with documentation of the failure of standard therapy.

35.2.9 Pulse Oximeters

Pulse oximeters require prior authorization. A completed CSHCN Services Program Prior Authorization Request for Pulse Oximeter Devices form, must be submitted with documentation of medical necessity.

The rental of pulse oximeters includes the probes.

Oximeters may be reimbursed for a rental period of up to 6 months. Extensions will be considered with documentation of medical necessity. Purchase may be considered with documentation of medical necessity. Pulse oximeters should be billed using procedure code E0445.

Pulse oximeters may be prior authorized for clients who meet one of the following criteria:

- Client is oxygen or ventilator dependent, or
- Client is clinically stable and is weaning off the oxygen or ventilator, or
- Client has another condition that requires monitoring of oxygen saturation.
- Client needs continuous monitoring or monitoring during sleep, or
- Client needs continuous monitoring to maintain optimal oxygen saturation levels, and
- Client is clinically unstable or just returned home from a hospital stay.

There must be a caregiver identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.

35.2.10 Tracheostomy Tubes

Standard tracheostomy tubes do not require prior authorization. Tracheostomy tubes billed with modifiers TF or TG must be prior authorized. Documentation of medical necessity and the manufacturer's suggested retail price (MSRP) must accompany the prior authorization request form.

One standard tracheostomy tube and/or one inner cannula is a benefit per month. If a client has a custom tracheostomy tube, no inner cannulas will be authorized. Disposable tracheostomy inner cannulas are not a benefit.

Providers must use procedure code A7520, A7521, or A7522 when billing tracheostomy tubes. Providers must add modifier TF when billing a tracheostomy with specialized functions and modifier TG when billing a custom-made tracheostomy.

35.2.11 Other Equipment

All other respiratory equipment must be authorized. Documentation of medical necessity for the item must accompany the claim.

35.3 Claims Information

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

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

Modifier RR must be used for DME rental equipment, and modifier NU must be used for the purchase of new DME equipment.

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

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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing and may be left blank.

35.4 Reimbursement

Respiratory equipment may be reimbursed the lower of either the billed amount or the amount allowed by Texas Medicaid.

Reimbursement of rented equipment includes all of the supplies, accessories, adjustments, repairs, and replacement parts needed during the rental period.

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.*

35.5 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.

Chapter

36

Speech-Language Pathology (SLP) Services

36.1 Enrollment

To enroll in the CSHCN Services Program, speech-language pathology (SLP) providers must be actively enrolled in Texas Medicaid, have completed the CSHCN Services Program enrollment process, have a valid Provider Agreement with the CSHCN Services Program, and comply with all applicable state laws and requirements. Out-of-state SLP providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and be approved 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 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

36.2 Benefits, Limitations, and Authorization Requirements

Speech language-pathology (SLP) services are benefits of the Children with Special Health Care Needs (CSHCN) Services Program for clients with acute or chronic medical conditions when documentation from the prescribing physician and the treating therapist shows there is or will be progress made towards goals.

Note: *An advanced practice registered nurse (APRN) or physician assistant (PA) may sign and date all documentation related to the provision of speech therapy (ST) services on behalf of the client's physician when the physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number are required.*

Therapy goals for acute or chronic medical conditions include, but are not limited to:

- Improving function
- Maintaining function
- Slowing the deterioration of function

Speech therapy evaluations and treatments must be ordered or prescribed by the client's physician, APRN, or PA and based on medical necessity.

A client may receive any combination of physical, occupational, or speech therapy in the office, home, or outpatient setting, up to one hour per day for each type of therapy.

Therapy evaluations are a benefit once per 180 rolling days, any provider. Therapy re-evaluations are a benefit when documentation supports one of the following:

- A change in the client's status
- A request for extension of services
- A change of provider

Additional therapy evaluations or re-evaluations that exceed these limits may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter that is signed and dated by the client, parent, or guardian that documents all of the following:
- The date that the client ended therapy (effective date of change) with the previous provider
- The names of the previous and new providers
- An explanation of why providers were changed

An evaluation or re-evaluation will be denied when billed by any provider on the same date of service as therapy treatment from the same discipline.

All documentation, including the medical necessity and comprehensive treatment plan related to the therapy services prior authorized and provided, must be maintained in the client's medical record and made available upon request. For each therapy discipline provided, the documentation maintained in the client's medical record must identify the therapy provider's name and must include all of the following:

- Date of service
- Start time of the therapy
- Stop time of the therapy
- Total minutes of the therapy
- Specific therapy performed
- Client's response to therapy

Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

36.2.1 Speech Therapy Limitations

Treatment procedure codes are limited to one hour of speech therapy on the same day, any provider with the GN modifier.

Speech therapy evaluations (procedure codes 92521, 92522, 92523 and 92524) and oral and pharyngeal swallowing function evaluations (procedure code 92610) are payable once in 180 rolling days to any provider.

Speech therapy re-evaluations (procedure code S9152) will be considered when documentation supports a change in the client's status or with a request for extension of services, or with a change of provider.

Additional speech therapy or swallowing function evaluations or re-evaluations exceeding these limits may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter signed and dated by the client, parent, or guardian documenting all of the following:
- The date the client ended therapy with the previous provider (effective date of change)
- The names of the previous and new providers
- An explanation of why providers were changed

Providers should use the following procedure codes for speech therapy services:

Procedure Codes			
92507	92521	92522	92523
92524	92526	92610	97535
S9152			

Speech therapy procedure codes should be billed with the GN modifier.

SLP evaluations and re-evaluations (procedure codes 92521, 92522, 92523, 92524, 92610, and S9152) do not require a modifier.

If a therapy evaluation or re-evaluation procedure code and therapy treatment procedure code(s) from the same discipline are billed for the same date of service by any provider, the evaluation or re-evaluation will be denied.

Speech therapy evaluations or speech therapy re-evaluations and swallowing function evaluations or re-evaluations may be considered for separate reimbursement on the same date of service.

36.2.2 Authorization Requirements

Speech therapy evaluations and re-evaluations do not require prior authorization.

All other speech therapy services require prior authorization. These services may be prior authorized in 15-minute unit increments and will be limited to a combined maximum of four units (1 hour) per day, per therapy type. Additional services to exceed the four units (1 hour) per day limit may be considered with documentation of medical necessity supporting the rationale for exceeding the limitation.

Note: *If medically necessary services are provided after hours or on a recognized holiday or weekend, services may be authorized when the request is submitted on the next business day.*

The following documentation must be submitted for consideration for authorization:

- A CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1) form or CSHCN Services Program Authorization Request for Extension of Outpatient Therapy (TP2) form must be received within the deadlines listed above for prior authorization to be considered. Extensions to these deadlines are not given by the CSHCN Services Program for a provider to correct incomplete prior authorization requests.

Note: *An APRN or PA may sign and date all documentation related to the provision of speech therapy (ST) services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

Prior authorization for therapy services will be considered when all of the following are met:

- The client has acute or chronic medical conditions resulting in a significant decrease in functional ability that will benefit from therapy services in an office or outpatient setting
- Documentation must support treatment goals and outcomes for the specific therapy disciplines requested
- Services do not duplicate those provided concurrently by any other therapy
- Services are provided within the provider’s scope of practice as defined by state law

36.2.2.1 Paper and Electronic Prior Authorization Documentation

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization request and required documentation through fax or mail.

Faxed authorizations must include a working fax number to receive faxed responses or correspondence from TMHP and the last four digits of the client's Medicaid or CSHCN Services Program Identification number on the fax coversheet.

A copy of the prior authorization request and all submitted documentation must be maintained in the client's medical record at the therapy provider's place of business.

Note: *All prior authorization requests must be submitted with the provider's signature.*

To complete the prior authorization process electronically, the provider must complete and submit the prior authorization request and required documentation through any approved method, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To avoid unnecessary denials, the physician, APRN or PA must provide correct and complete information, including documentation of medical necessity for the service(s) requested. The ordering practitioner must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

36.2.2.2 Initial Prior Authorization Request for Therapy Services

The initial request for prior authorization must be received prior to the initiation of therapy treatment services. Requests received after therapy initiation will be denied for dates of service that occurred before the date the request was received.

Initial prior authorization may be given for a service period not to exceed 180 days. Subsequent prior authorizations may be granted for up to 180 days for chronic conditions with documentation. Prior authorizations may be approved for a time period less than the established maximum.

Supporting Documentation

Supporting documentation must be submitted for an initial request and must include all of the following:

- A completed CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1) Form. The request form must be signed and dated by the ordering physician, APRN, or PA.

Note: *A request received without the ordering practitioner's signature will not be processed and will be returned to the provider.*

- A current therapy evaluation documenting the client's age at the time of the evaluation.
  - A therapy evaluation is current when performed within 60 rolling days before the initiation of therapy services.
- A client-specific comprehensive treatment plan established by the ordering physician, APRN, or PA or therapist to be followed during treatment in the therapy setting must include all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Treatment goals for the therapy discipline and associated disciplines requested related to the client's individual needs
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Requested dates of service

36.2.2.3 Subsequent Prior Authorization Requests for Therapy Services

A prior authorization request for subsequent services must be received no more than 30 days prior to the expiration of the current prior authorization period. Requests for subsequent services received after the current prior authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

Prior authorization requests for subsequent services may be considered for increments up to 180 days for each request. Providers are required to submit a new CSHCN Services Program Authorization Request for Extension of Outpatient Therapy (TP2) form. The request form must be signed and dated by the ordering physician, APRN or PA.

Note: *A request received without the ordering practitioner's signature will not be processed and will be returned to the provider.*

Supporting Documentation

Documentation that supports medical necessity of the subsequent services must also include:

- A current therapy evaluation or re-evaluation documenting the client's age at the time of the evaluation or re-evaluation

  - A therapy evaluation or re-evaluation is current when performed within 30 rolling days before the request for subsequent services
- An updated client-specific comprehensive treatment plan established by the ordering physician, APRN, PA or therapist to be followed during treatment which must include all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Updated treatment goals for the therapy discipline and associated disciplines related to the client's individual needs
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - A brief summary of the outcomes of the previous treatment relative to the client's debilitating condition
  - Requested dates of service

Revising an Existing Prior Authorization

Requests for revisions of prior authorization must be received by the next business day after the date the revised therapy treatments are initiated. Requests for revisions received more than one day after the initiation of the revised services will be denied for dates of service that occurred before the date the request was received. A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Discontinuation of Therapy or Change of Provider

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider the new provider must submit all of the following:

- A new therapy request form that is signed by the ordering practitioner
- A new evaluation with required documentation of medical necessity
- A change of provider letter signed and dated by the client, parent, or guardian documenting the date the client ended therapy with the previous provider (effective date of change), the names of the previous and new providers, and an explanation of why providers were changed.

A change of provider during an existing authorization period will not extend the original authorization period approved to the previous provider. Regardless of the number of provider changes, clients may not receive therapy services beyond limitations.

Refer to: Section 4.2, "Authorizations," on page 4-3 for detailed information about authorization requirements.

Chapter 10, "Augmentative Communication Devices (ACDs)." on page 10-1.

CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1)

CSHCN Services Program Authorization Request for Extension of Outpatient Therapy (TP2)

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

Note: *A physician's prescription is considered current when it is signed and dated within 60 days before the start of therapy. A prescription is valid for 6 months.*

36.2.3 Rehabilitation Postcochlear Implant

Refer to: Chapter 20.3.2.2, "Auditory Rehabilitation." on page 20-14 for information about aural rehabilitation after the implantation of a cochlear device.

36.2.4 Services That Are Not a Benefit

The following speech therapy services are not a benefit of the CSHCN Services Program:

- Group therapy for SLP services (procedure code 92508)

- Unattended electrical stimulation (procedure code 97014)
- Separate reimbursement for VitalStim therapy for dysphagia
- Treatment solely for the instruction of other agency or professional personnel in the client's physical, occupational or speech therapy program
- Training in nonessential tasks, such as homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling, or teaching a second language
- Emotional support, adjustment to extended hospitalization or disability and behavioral readjustment
- Services and procedures that are investigational or experimental

36.3 Coordination with the Public School System

Clients may receive therapy services from both the CSHCN Services Program and school districts only when the therapy provided by the CSHCN Services Program addresses different client needs. If the client is of school age, therapy provided through the CSHCN Services Program is not intended to duplicate, replace, or supplement services that are the legal responsibility of other entities or institutions.

The CSHCN Services Program encourages the private therapist to coordinate with other therapy providers to avoid treatment plans that might compromise the client's ability to progress.

36.4 Claims Information

Claims for SLP services must include modifier GN. Evaluation and reevaluation procedure codes do not require the modifiers. Outpatient therapy services provided by outpatient facilities and SLP providers must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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.

Note: *NCCI guidelines do not apply to therapy procedure codes if a valid prior authorization number is submitted on the claim.*

Refer to: Chapter 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

36.4.1 Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units

Procedure codes 92507, 92526, and 97535 must be billed in 15-minute increments. All claims for reimbursement of these procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit=15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service.

If the total billable minutes are not divisible by 15 and are greater than seven, the minutes are converted to one (1) unit of service. If the total billable minutes are not divisible by 15 and are seven minutes or fewer, the minutes are converted to zero (0) units.

Example: 68 total billable minutes/15 = four units + eight minutes. Since eight minutes are more than seven minutes, those eight minutes are converted to one unit. Therefore, 68 total billable minutes equals five units of service.

Time intervals for one through eight units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 units	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

Time-based speech therapy treatment procedure codes that may be billed in multiple quantities of 15 minutes each are limited to one hour per date of service.

36.5 Reimbursement

The CSHCN Services Program may reimburse SLP providers at the lesser of the billed amount or the amount allowed by Texas Medicaid. Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

Outpatient hospital facilities are reimbursed at 80 percent of the rate allowed by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which is equivalent to the hospital's interim rate.

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.*

36.6 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.

Chapter

37

Telecommunication Services

37.1 Enrollment

To enroll in the CSHCN Services Program, telecommunication 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 laws and requirements. Out-of-state providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

Home health agency and hospital providers who wish to provide telemonitoring services must notify TMHP as follows:

- Current providers must use the Provider Information Management System (PIMS) to indicate that they provide telemonitoring services.
- Newly enrolling or re-enrolling home health agency or outpatient hospital providers will indicate whether they provide telemonitoring services during the enrollment process.

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

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

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

37.2 Benefits, Limitations, and Authorization Requirements

Authorization is not required for telemedicine or telehealth services, however prior authorization may be required for the individual procedure codes billed.

Telemedicine and telehealth services must be provided in compliance with standards established by the respective licensing or certifying board of the professional providing the services.

Only those services that involve direct face-to-face interactive video communication between the client and the distant-site provider constitute a telemedicine or telehealth service. No separate reimbursement will be made for the cost of telemedicine and telehealth hardware or equipment, electronic documentation, and transmissions. Telephone conversations, chart reviews, electronic mail messages, and fax transmissions alone do not constitute a telemedicine or telehealth interactive video service and will not be reimbursed as telemedicine or telehealth services.

Emergency room care, critical care, home care, preventive care, newborn care, and care provided in a nursing home, skilled nursing facility, or client's home, are not approved telemedicine or telehealth services. Consultative, but not routine, inpatient care, is included as a telemedicine or telehealth service.

Documentation for a service provided via telemedicine or telehealth must be the same as for a comparable in-person service.

The audio and visual fidelity and clarity, and field of view of the telemedicine or telehealth service must be functionally equivalent to an evaluation performed on a client when the provider and client are both at the same physical location or the client is at an established medical site.

More than one medically necessary telemedicine or telehealth service may be reimbursed for the same date and same place of service if the services are billed by providers of different specialties.

37.2.1 Telemedicine Services

Telemedicine is defined as a health-care service that is either initiated by a physician who is licensed to practice medicine in Texas or provided by a health professional who is acting under physician delegation and supervision. Telemedicine is provided for the purpose of the following:

- Client assessment by a health professional
- Diagnosis, consultation, or treatment by a physician
- Transfer of medical data that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health-care services or medical specialty expertise.

37.2.1.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site benefits include services that are performed by the following providers, who must be enrolled as a CSHCN Services Program provider:

- Physician
- Advanced Practice Registered Nurse (APRN)
- Physician assistant (PA)

The following procedure codes, when billed with the GT modifier, are a benefit for distant-site providers:

Procedure Codes					
90791	90792	90832	90833	90834	90836
90837	90838	90951	90952	90954	90955
90957	90958	90960	90961	99201	99202
99203	99204	99205	99211	99212	99213
99214	99215	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255
99354	99355	G0406*	G0407*	G0408*	G0425
G0426	G0427				

*Procedure codes are limited to one service per day.

Note: Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Chapter 29, "Outpatient Behavioral Health." Procedure codes 90833, 90836, and 90838 are add-on codes and must be billed with a primary E/M procedure code in order to be reimbursed.

Electronic documentation of the telemedicine consultation must be kept on file at the distant site location and must be available for review upon request by DSHS or its designee.

37.2.1.2 Patient Site

A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- *Established medical site* - A location where clients will present to seek medical care. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the client's presenting complaint. A defined physician-client relationship is required. A client's private home is not considered an established medical site.
- *Established health site* - A location where clients will present to seek a health service. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation or assessment, as appropriate for the client's presenting complaint. A defined health provider-client relationship is required. A client's private home is not considered an established health site.

Patient-site providers enrolled in the CSHCN Services Program may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to advanced practice registered nurses, physician assistants, and physicians in the office and outpatient hospital settings and to hospitals in the outpatient hospital setting. Charges for other services that are performed at the patient site may be submitted separately.

All patient sites must maintain documentation for each service, including:

- The date of the service.
- The name of the client.
- The name of the distant-site provider.
- The name of the patient-site presenter.

A patient-site presenter must introduce the client to the distant-site provider for examination and must perform any tasks and activities that are delegated by the distant-site provider. A patient-site provider must be one of the following:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual's licensure or certification
- A qualified mental health professional-community services (QMHP-CS) as defined in Title 25 *Texas Administrative Code* (TAC) 412.303

The patient-site presenter must maintain the records created at the distant site unless the distant site provider maintains the records in an electronic-health-record format.

37.2.2 Telehealth Services

Telehealth is defined as health services, other than telemedicine, that:

- Are delivered by licensed or certified health professionals who are acting within the scope of their license or certification.
- Require the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health care services or medical specialty expertise.

Before receiving a telehealth service, the client must receive an in-person evaluation for the same diagnosis or condition. An in-person evaluation is a client evaluation that is conducted by a provider who is at the same physical location as the client.

Exception: *Clients who have a mental health diagnosis or condition may receive a telehealth service without an in-person evaluation if the purpose of the initial telehealth appointment is to screen and refer the client for additional services. The referral must be documented in the medical record.*

To continue receiving telehealth services, the client must have had an in-person evaluation by a person who is qualified to determine a need for services at least once in the 12 months before the telehealth service.

Written policies and procedures must be maintained and evaluated at least annually by both the distant-site provider and the patient-site presenter and must address all of the following:

- Client privacy, to assure confidentiality and integrity of client telehealth services
- Archival and retrieval of client service records
- Quality oversight mechanisms

37.2.2.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site benefits include services that are performed by the following providers, who must be enrolled as a CSHCN Services Program provider:

- Licensed professional counselor
- Licensed marriage and family therapist
- Licensed clinical social worker
- Psychologist
- Licensed dietician

The following procedure codes, when billed with the GT modifier, are a benefit for distant-site providers:

Procedure Codes					
90791	90832	90834	90837	97802	97803
97804	S9470				

*Procedure codes are limited to one service per day.

Note: Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Chapter 29, "Outpatient Behavioral Health." Procedure codes 90833, 90836, and 90838 are add-on codes and must be billed with a primary E/M procedure code in order to be reimbursed.

Electronic documentation of the telehealth consultation must be kept on file at the distant site location and must be available for review upon request by DSHS or its designee.

37.2.2.2 Patient Site

A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- *Established medical site* - A location where clients will present to seek medical care. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the client's presenting complaint. A defined physician-client relationship is required. A client's private home is not considered an established medical site.
- *Established health site* - A location where clients will present to seek a health service. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation or assessment, as appropriate for the client's presenting complaint. A defined health provider-client relationship is required. A client's private home is not considered an established health site.

The facility fee (procedure code Q3014) is not a benefit for telehealth services. Charges for other services that are performed at the patient site may be submitted separately.

All patient sites must maintain documentation for each service, including:

- The date of the service.
- The name of the client.
- The name of the distant-site provider.

- The name of the patient-site presenter.

A patient-site presenter must introduce the client to the distant-site provider for examination and must perform any tasks and activities that are delegated by the distant-site provider. A patient-site provider must be one of the following:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual's licensure or certification
- A qualified mental health professional-community services (QMHP-CS) as defined in Title 25 *Texas Administrative Code* (TAC) 412.303

For telehealth services, the patient-site presenter must be readily available.

Note: *Readily available means in the same room or (at the discretion of the licensed or certified professional that is providing the service) not in the same room as the client but within a proximity determined by the licensed or certified professional who is providing the telehealth service.*

If the telehealth services relate only to mental health, a patient-site presenter does not have to be readily available unless the client is a danger to the client or to others.

The patient-site presenter must maintain the records created at the distant site unless the distant site provider maintains the records in an electronic-health-record format.

37.2.3 Telemonitoring Services

Home telemonitoring services are a benefit of the CSHCN Services Program.

Home telemonitoring is a health service that requires scheduled remote monitoring of data related to a client's health, and transmission of the data from the client's home to a licensed home health agency or a hospital. The data transmission must comply with standards set by the Health Insurance Portability and Accountability Act (HIPAA).

Data parameters are established as ordered by a physician's plan of care. Data must be reviewed by a registered nurse (RN), APRN, or PA, who is responsible for reporting data to the prescribing physician in the event of a measurement outside the established parameters.

Online evaluation for home telemonitoring services (procedure code 99444) is a benefit in the office or outpatient hospital setting when services are provided by an APRN, PA, or physician provider. Procedure code 99444 is limited to once per seven days and will be denied if submitted within the postoperative period of a previously completed procedure or within seven days of a related evaluation and management service by the same provider.

Scheduled periodic transmission of the client data to the physician is required, even when there have been no readings outside the parameters established in the physician's orders. Telemonitoring providers must be available 24 hours a day, 7 days a week. Although transmissions are generally at scheduled times, they can occur any time of the day or day of the week, according to the client's plan of care.

The physician who orders home telemonitoring services has a responsibility to ensure that the client has the right to discontinue home telemonitoring services at any time.

Although the CSHCN Services Program supports the use of home telemonitoring, clients are not required to use this service.

37.2.3.1 Facility Services

The provision and maintenance of home telemonitoring equipment is the responsibility of the home health agency or the hospital. The initial setup and installation (procedure code 99090) of the equipment in the client's home is a benefit when services are provided by a home health agency or an outpatient hospital. Hospital providers must submit revenue code 780 or 789 with procedure code 99090.

Procedure code 99090 is limited to once per episode of care even if monitoring parameters are added after initial setup and installation. A claim for a subsequent set up and installation will not be reimbursed unless there is a documented new episode of care.

Daily home monitoring (procedure code 99090 with modifier GQ) is a benefit when services are provided by a home health agency or an outpatient hospital. The home health agency or hospital may submit a claim for the daily rate each day the telemonitoring equipment is used to monitor and manage the client's care. Hospital providers must submit revenue code 780 or 789 with the procedure code for daily home monitoring.

Procedure code 99090 with modifier GQ is limited to once per day, regardless of the number of transmissions, for the length of the prior authorization period.

37.2.3.2 Prior Authorization Guidelines

Procedure codes 99090 and 99090 with modifier GQ require prior authorization. Home telemonitoring services may be approved for up to 60 days per prior authorization request. If additional home telemonitoring services are needed, the home health agency or hospital must request prior authorization before the current prior authorization period ends.

Home telemonitoring services are a benefit only for clients who are diagnosed with diabetes or hypertension. Clients must exhibit two or more of the following risk factors:

- Two or more hospitalizations in the previous 12-month period
- Frequent or recurrent emergency department visits
- A documented history of poor adherence to ordered medication regimens
- Documented history of falls in the previous six-month period
- Limited or absent informal support systems
- Living alone or being home alone for extended periods of time
- A documented history of care access challenges

Documentation that supports the prior authorization request must be maintained in the client's medical record.

A completed Home Telemonitoring Services Prior Authorization Request form must be submitted to request home telemonitoring services. The request must include all of the following:

- An order for telemonitoring services, signed and dated by the prescribing physician who is familiar with the client
- A plan of care, signed and dated by the prescribing physician, that includes home telemonitoring transmission frequency
- The client's diagnoses and risk factors that qualify the client for home telemonitoring services

Providers can also request prior authorization online through the secure TMHP provider portal.

The home health agency or hospital must attest to all of the following on the prior authorization request:

- The telemonitoring equipment meets all the following requirements:
  - Capable of monitoring any data parameters included in the plan of care
  - Food and Drug Administration Class II hospital-grade medical device
  - Capable of measuring and transmitting client blood glucose or blood pressure data
- The provider's staff is qualified to install the needed telemonitoring equipment and to monitor the client data transmitted according to the client's care plan.
- Clinical data will be provided to the prescribing physician or his/her designee.
- Services are not duplicated under the disease management programs described in Texas Human Resources Code, Section 32.057.
- Monitoring of the client's clinical data is not duplicated by any other provider.
- Written protocols, policies and procedures on the provision of home telemonitoring services are available to the Department of State Health Services (DSHS) or its designee upon request. Written protocols must address all of the following:
  - Authentication and authorization of users
  - Authentication of the origin of client data transmitted

- Prevention of unauthorized access to the system or information
- System security, including the integrity of information that is collected, program integrity, and system integrity
- Maintenance of documentation about system and information usage
- Information storage, maintenance, and transmission
- Synchronization and verification of patient profile data

The client's prescribing physician must attest to all of the following on the prior authorization request:

- The client is sufficiently cognitively intact and able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data. (Not required if the equipment does not require active participation from the recipient.)
- The client is not currently receiving duplicate services via disease management services.
- Monitoring of the client's clinical data is not duplicated by any other provider.

Refer to: Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information about prior authorization requirements.

Home Telemonitoring Services Prior Authorization Request Form

37.3 Claims Information

Telecommunication services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms or 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 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 at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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: Section 40, "TMHP Electronic Data Interchange (EDI)," on page 40-1 for information about electronic claims submissions.

Section 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 and Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form," on page 5-31 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

37.4 Reimbursement

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

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.*

37.5 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.

Chapter

38

Transportation of Deceased Clients

38.1 Enrollment

Funeral home providers are not required to be actively enrolled in Texas Medicaid or the CSHCN Services Program.

38.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program provides coverage for the costs of transporting a deceased client who expires in a CSHCN Services Program-approved facility (including non-billing facilities such as MD Anderson, Shriner's Hospital, Scottish Rite) while receiving CSHCN Services Program health-care benefits, if client was is not in the family's city of residence.

The program may also pay the transportation cost of a parent or other person accompanying the remains from the facility to the place of burial in Texas that is designated by the parent or other person legally responsible for interment.

If the program prior authorized a treatment out-of-state and the client expires, the program may pay the costs of transporting the client's remains, and the transportation cost of a parent or other person accompanying the remains from the facility to the place of burial in Texas that is designated by the parent or other person legally responsible for interment.

The CSHCN Services Program considers the following services for reimbursement:

- *First Call Charge*. This includes the removal of the body by the funeral home from the facility in which the client expired.
- *Air Transportation*. Transportation costs of moving the deceased from the funeral home to the airport, cost of an air tray provided by the funeral home, and cost of airline transportation for the body and an accompanying parent or other responsible person may all be paid.
- *Land Transportation*. If the body is transported over land, one-way mileage is paid based on the State Mileage Guide. Funeral homes or mortuary services use standard air-conditioned vehicles to transport bodies. It is common for the body to be transported on a cot; however, the CSHCN Services Program may pay for a container or coffin (not a casket) if one is used. It is legal in Texas for the family to transport the body themselves. If the family chooses to do this, the CSHCN Services Program may reimburse the family or a third party on the family's behalf at the standard CSHCN Services Program mileage rate for a one-way trip.
- *Rail Transportation*. If the body is transported by rail, the CSHCN Services Program may pay the cost of transportation of moving the deceased from the funeral home to the station and the cost of a container provided by the funeral home. The cost of rail transportation for the body and an accompanying parent or other responsible person may also be paid.
- *Bus Transportation*. It is not common practice for bodies to be transported by bus.
- *Embalming*. State law requires that a body be refrigerated between 34º to 40ºF, or the body must be embalmed within 24 hours after death. Airlines and rail systems require embalming. Depending on the distance, a body may be transported over land without being embalmed.

Note: *The CSHCN Services Program does not pay for cremation or transporting the ashes of a deceased client.*

38.2.1 Authorization Requirements

Authorization is not required for the transportation of deceased clients.

38.3 Claims Information

Claims for the transportation of a deceased client must be submitted to TMHP on the approved CSHCN Services Program Reimbursement Request for Transportation of the Remains of Deceased Clients form.

38.4 Reimbursement

Costs associated with the transportation of the remains of a deceased client are reimbursed the lower of the amount billed or the amount listed:

Service	Reimbursement
First call	$150
Embalming	$100
Container	$150
Mileage billed by funeral home	$1.00 per mile
Air Freight	Billed amount

38.5 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.

Chapter

39

Vision Services

39.1 Enrollment

To enroll in the CSHCN Services Program, ophthalmologists, optometrists, and opticians are required to be actively enrolled in Texas Medicaid. They must have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Optometrists, ophthalmologists, and opticians may enroll either as an individual or as a group with performing providers. Opticians may also enroll as a facility. Out-of-state ophthalmologist, optometrists, and optician providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

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

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 25 Texas Administrative Code (TAC) 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.

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

Refer to: Section 2.1, "Provider Enrollment," on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

39.2 Benefits, Limitations, and Authorization Requirements

Vision related services are a benefit of the CSHCN Services Program. The CSHCN Services Program may consider the following services for reimbursement:

- Vision eye exams with refraction
- Other eye exams for medical reasons
- Medical eye treatments
- Frames
- Lenses
- Contact lenses
- High-power lenses
- Scleral lenses
- Repair and replacement of frames and lenses
- Other vision services

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

- Eyeglasses that do not significantly improve visual acuity or that do not impede the progression of visual problems
- Plano sunglasses
- Optional eyeglass features that are requested by the client but that do not increase visual acuity, such as tinting, decorative accessories or lettering, or eyeglass cases
- Prisms that are ground into the lenses

- Ultraviolet (UV) lenses (procedure code V2755)
- Contact lenses that correct color vision deficiency (procedure code V2503)
- Low vision aids

Note: *Clients in need of low vision aids may be referred to the Texas Department of Assistive and Rehabilitative Services (DARS) Division for Blind Services (DBS) for consideration of coverage.*

Vision services are a benefit when provided by ophthalmologists, optometrists, and opticians practicing according to standards established by their licensing boards and the state laws of Texas.

39.2.1 Frames, Lenses, and Contact Lenses

39.2.1.1 Frames

Providers must offer frames that meet the following criteria:

- A choice of at least three styles that are appropriate to the client's age or gender
- Frames in sizes that are appropriate to the client's needs
- A choice of at least three colors

Frames must be composed of all zylonite components, meet statutory quality standards, and be made of new materials. Clients or families may only choose frames that are metal or a combination of zylonite and metal if they are willing to pay the difference between the CSHCN Services Program's reimbursement for frames and the cost of metal or metal and zylonite frames.

Ophthalmologists, optometrists, and opticians may submit procedure codes V2020 and V2025 for the reimbursement of frames.

39.2.1.2 Eyeglass Lenses

Lenses must meet the American National Standards Institute (ANSI) specifications (see www.ansi.org) for first quality prescription ophthalmic lenses, including, but not limited to, the following:

- Lenses must be made of clear glass or plastic.
- Lenses must be composed of new materials.
- Bifocals must be flat-tops or an equivalent style with a near segment of at least 25 mm width.
- Trifocals must be flat-tops or an equivalent style with an intermediate segment of at least 7 X 25 mm.

Ophthalmologists, optometrists, and opticians may submit the following procedure codes for the reimbursement of eyeglass lenses. Providers must bill with a quantity of two for a pair of lenses.

Single Vision Lenses Procedure Codes				
V2100	V2101	V2103	V2104	V2107
V2108	V2115	V2118	V2121	

Bifocal Lenses Procedure Codes				
V2200	V2201	V2203	V2204	V2207
V2208	V2215	V2218	V2219	V2220
V2221				

Trifocal Lenses Procedure Codes				
V2300	V2301	V2303	V2304	V2307
V2308	V2315	V2318	V2319	V2320
V2321				

39.2.1.3 Special Eyeglass Lenses

Special lenses, such as high-index, polycarbonate, and high-powered lenses, are a benefit of the CSHCN Services Program if they are ordered by the treating physician because they are medically necessary and not solely because of a client's preference.

- High-power lenses have a sphere equal to or greater than plus or minus 7 diopters or a cylinder of plus or minus 4 diopters.
- High-index lenses allow lighter-weight lenses for clients who have unusually heavy lenses.
- Polycarbonate lenses are considered the standard for children's eyewear because polycarbonate provides extra strength, flexibility, and inherent UV protection.

Ophthalmologists, optometrists, and opticians may submit the following procedure codes for the reimbursement of special eyeglass lenses:

High-Power Lenses Procedure Codes				
V2102	V2105	V2106	V2109	V2110
V2111	V2112	V2113	V2114	V2202
V2205	V2206	V2209	V2210	V2211
V2212	V2213	V2214	V2302	V2305
V2306	V2309	V2310	V2311	V2312
V2313	V2314			

Special Lenses Procedure Codes			
V2410	V2430	V2762	V2784

The polarization of lenses (procedure code V2762) prevents damage to the eye from UV rays. The polarization of lenses is a benefit of the CSHCN Services Program for the following diagnosis codes of aphakia:

Diagnosis Codes				
37931	37832	37933	37934	74335
V431				

Polycarbonate lens (procedure code V2784) is considered an add-on code and must be billed in conjunction with the primary lens code with the same date of service by the same provider.

Polycarbonate lenses provide inherent protection against UV rays; therefore, the polarization of a polycarbonate lens will be denied.

39.2.1.4 Contact Lenses

Contact lenses that are made of hydrophilic and rigid materials are a benefit of the CSHCN Services Program.

- Hydrophilic contact lenses that have been reviewed by the U.S. Food and Drug Administration (FDA) and released for sale in the U.S. will be considered for reimbursement only for those uses for which they have been reviewed.
- Hard and gas permeable lenses must conform to the ANSI requirements for first quality contact lenses.

Examinations for contact lens prescriptions and fittings include:

- The specific optical and physical characteristics of the contact lens including power, size, curvature, flexibility, and gas-permeability.
- Medically necessary tests including multiple ophthalmometry, measurement of tear flow, measurement of ocular adnexa, and initial tolerance evaluation.
- The instruction and training of the client and incidental revision during the training period.
- Follow-up care for a period of six months.

Ophthalmologists and optometrists may submit the following procedure codes for the fitting of contact lenses:

Contact Lens Fitting Exam Procedure Codes				
92071	92072	92310	92311	92312
92313	92314	92315	92316	92317
92325	92326			

Procedure codes 92071 and 92072 will be denied if they are billed by the same provider with the same date of service as procedure codes 92018 and 92019.

Ophthalmologists, optometrists, and opticians may submit the following procedure codes for the reimbursement of contact lenses:

Contact Lens Procedure Codes				
V2500	V2501	V2502	V2510	V2511
V2512	V2513	V2520	V2521	V2522
V2523	V2530	V2531	V2599	

Contact lenses and their prescription and fitting are limited to the following diagnosis codes:

Diagnosis Code	Description
36220	Retinopathy of prematurity, unspecified
36221	Retrolental fibroplasia
36225	Retinopathy of prematurity, stage 3
36226	Retinopathy of prematurity, stage 4
36227	Retinopathy of prematurity, stage 5
3670	Hypermetropia
3671	Myopia
36720	Unspecified astigmatism
36721	Regular astigmatism
36722	Irregular astigmatism
36731	Anisometropia
36732	Aniseikonia
3674	Presbyopia
36800	Unspecified amblyopia
36801	Strabismic amblyopia
36802	Deprivation amblyopia
36803	Refractive amblyopia
37160	Unspecified keratoconus
37161	Keratoconus, stable condition
37162	Keratoconus, acute hydrops
37931	Aphakia
37932	Subluxation of lens
37933	Anterior dislocation of lens
37934	Posterior dislocation of lens
74335	Congenital aphakia
74341	Congenital anomaly of corneal size and shape
V431	Lens replaced by other means

Contact lenses are sometimes used as corneal bandages to prevent blindness in an eye that is affected by a disease process. Ophthalmologists and optometrists should bill for the fitting of contact lenses for the treatment of disease (procedures code 92071 and 92072) in the following way:

- The provider must document in the medical record that a contact lens used as a corneal bandage was required to treat an acute medical condition.
- The applicable LT (left eye) or RT (right eye) modifier must be submitted with the claim to indicate which eye was treated.

Scleral lenses that are prescribed as a liquid bandage must be billed using procedure code S0515. Scleral lenses that are used therapeutically in other ways should be billed using procedure code V2530 or V2531. Reimbursement for scleral lenses requires authorization.

Opticians may bill for the replacement of contact lenses using procedure code 92326.

If disposable contact lenses are deemed medically necessary and are prior-authorized, procedure code V2599 must be used to bill for their reimbursement.

39.2.1.5 Eye Wear

The CSHCN Services Program will consider one form of eyewear for reimbursement per calendar year.

If a client wants frames or lenses that exceed the benefit limitations, the client must pay the difference between the amount allowed by the CSHCN Services Program and the actual cost. CSHCN Services Program clients or their parents or guardians must acknowledge that their choice exceeds the program requirements by signing the CSHCN Services Program Vision Care Eyeglass Client Certification Form. A copy of this form is available in both English and Spanish. Providers must maintain a copy of this signed form in the client's medical record. The provider may withhold the noncovered eyewear until the client pays the difference. If the client fails to pay for the noncovered items within three months, the provider may return any reusable items to stock. Any payment made by the CSHCN Services Program must be refunded to the CSHCN Services Program.

More than one pair of eyeglasses may be authorized if there is a change in lens power that is generally equal to or greater than 0.5 diopters in either eye (e.g., progressive myopia, cataract development).

Providers may be reimbursed for custom-made eyewear based on the services that were performed and the materials that were used until the time the provider received a notice of cancellation for the eyewear (because the client has died or because the prescription changed before the eyewear was completed and delivered). This applies only to custom items. Items not made to order for a specific client will be denied.

One pair of contact lenses and one contact lens prescription and fitting may be covered in a calendar year for a payable diagnosis listed in the table above in Section 39.2.1.4, "Contact Lenses," on page 39-4. Additional contact lenses and contact lens prescriptions and fittings within the same calendar year may be prior authorized with proof of medical necessity.

Contact lenses may require more frequent replacement than one new pair per calendar year, depending on the style and the prescribed use. More frequent replacement must be medically necessary and prior authorization must be obtained.

Modification of contact lenses as a separate procedure (procedure code 92325) will be denied as part of another procedure if it is billed with the same date of service by the same provider as contact lens fittings and replacement (procedure codes 92311, 92312, 92313, 92315, 92316, 92317, and 92326).

The prescription and fitting of contact lenses for aphakia for both eyes (procedure code 92312) will be denied if it is billed with the same date of service as the prescription and fitting of contact lenses for aphakia for one eye (procedure code 92311).

The prescription and fitting of contact lenses for aphakia, the prescription and fitting of corneo-scleral lenses, and the modification of contact lenses (procedure codes 92311, 92312, 92313, and 92325) will be denied if they are billed with the same date of service as the replacement of a contact lens (procedure code 92326).

The prescription and fitting of contact lenses for aphakia for one eye (procedure code 92311) will be denied if billed with the same date of service as the prescription and fitting of corneoscleral lenses (procedure code 92313).

39.2.1.6 Services Requiring Authorization

Authorization is required for medically necessary contact lenses and their prescriptions and fittings for diagnoses that are not listed in the diagnosis table above in Section 39.2.1.4, "Contact Lenses" on page 39-5. Requests for authorization must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form with documentation of the following:

- The medical diagnosis of the cause of the disorder of refraction
- For an established patient, current and new prescriptions that show a change of 0.5d or more in the sphere, cylinder, or prism measurements from a previous exam
- For a new patient, the new prescription including prescriptive measurements
- Which eyes are being treated: left, right, or both
- The specific procedure codes for which the authorization is being requested
- The medical necessity of contact lenses for the correction of the client's vision or for the treatment of the client's medical condition, and why eyeglasses are inappropriate or contraindicated in this case

Authorization is required for scleral lenses (procedure codes V2530 and V2531) and scleral lenses used as liquid bandage devices (procedure code S0515). Providers must submit the CSHCN Services Program Authorization and Prior Authorization Request form. Claims must be submitted with documentation of all of the following:

- The client has a condition that requires a scleral lens or a liquid bandage and is refractive to conservative treatment.
- The client has a condition that indicates a severe ocular surface disease, including, but not limited to, the following conditions:
  - Corneal ectasia such as keratoconus, pellucid marginal degeneration, keratoglobus (The use of scleral lenses does not achieve precise vision correction for high-order aberrations related to these diagnoses.)
  - Post keratoplasty astigmatism (Scleral lenses generally provide excellent visual acuity for the treatment of this condition and should be considered in lieu of wedge resections, relaxing incisions, and laser ablations.)
  - Terriens marginal degeneration
  - Corneal surface irregularities that are due to ocular surface disease, anterior corneal dystrophies, scars, and other causes
  - Aphakia, high myopia or astigmatism
  - Corneal stem cell deficiencies that are a result of Stevens-Johnson syndrome and toxic epidermal necrosis (TEN), chemical and thermal injuries, ocular pemphigoid, aniridia, and other causes
  - Keratitis sicca that is a result of disorders of the lacrimal gland such as Sjogren's syndrome, graft vs. host disease, irradiation, surgery, and meibomian gland deficiency
  - Neurotrophic corneas resulting from herpes simplex or zoster keratitis, congenital corneal anesthesia (dysautonomia), diabetes, acoustic neuroma surgery, trigeminal ganglionectomy, trigeminal rhyzotomy, and other causes
  - Persistent noninfectious corneal ulcers and epithelial defects that are associated with stem cell-deficient and neurotrophic corneas

Authorization is not required for the following:

- One annual vision exam with refraction
- One medically necessary pair of prescription eyewear per calendar year

- Eye exams and eye treatments for medical reasons (Medical eye exams and treatments may also include special vision services and ocular viewing and diagnostic procedures.)

Refer to: Section 4.2, "Authorizations," on page 4-3 for detailed information on prior authorization requirements.

39.2.1.7 Services Requiring Prior Authorization

A separate prior authorization request must be submitted for all contact lens replacements and for additional prescriptions and fittings of contact lenses within the calendar year. Requests must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form with documentation of the following:

- The medical diagnosis of the cause of the disorder of refraction
- Which eyes are being treated: left, right, or both
- The procedure codes for which the prior authorization is being requested
- The medical necessity of either the replacement of the contact lenses or of an additional contact lens prescription and fitting within the calendar year

If a pattern of contact lens replacement is requested, the medical necessity of the pattern of replacement (e.g., monthly, every three months, or any other frequency) for the correction of a client's vision or for the treatment of a client's medical condition must be established. If the request for replacement is because of a change in prescription during the calendar year, the provider must include current and new prescriptions that show a change of 0.5 diopters or more in any corresponding meridian, or a cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters, or a cylinder axis change of at least 15 degree for a cylinder power of 0.75-0.87 diopters, or a cylinder axis change of at least 10 degree for a cylinder power of 1.00-1.87 diopters, or a cylinder axis change of at least 5 degrees for a cylinder power of 2.00-0.87 diopters.

Note: *A cylinder power of 0.12-0.37 diopters with a change in axis does not warrant replacement glasses.*

Providers must submit an invoice that shows the manufacturer's suggested retail price (MSRP) of the prescribed contact lenses with the prior authorization request.

Procedure code 76999 requires prior authorization. The provider must submit the following documentation with their request:

- The client's diagnosis
- A clear, concise description of the ophthalmic ultrasound being performed
- A CPT or HCPCS procedure code which is comparable to the ophthalmic ultrasound being requested
- The physician's intended fee for this procedure
- Reason for recommending this particular procedure

Note: *Services and procedures that are investigational or experimental are not a benefit of the CSHCN Services Program.*

Refer to: Section 4.3, "Prior Authorizations," on page 4-5 for detailed information on prior authorization requirements.

39.2.1.8 Eye Prostheses

Eye prostheses may be authorized when prescribed by the treating physician and when there is documentation of medical necessity and appropriateness.

There are no specific time limitations on replacement of eye prostheses. A child's eye socket may change size at variable times because of differences in bone growth rate and soft tissue change.

39.2.2 Eye and Vision Examinations

Vision services that are medically necessary for the treatment of a client include, but are not limited to, the following:

- Eye examinations and the treatment of the eye for medical reasons (i.e., aphakia diagnoses, diseases of the eye, or as a result of eye surgery or an injury to the eye). Eye examinations that are performed for medical reasons may be reimbursed as medically necessary.
- One vision examination with refraction per calendar year to obtain a prescription for eyewear for disorders of refraction and accommodation. More frequent vision exams may be reimbursed if they are recommended by a school nurse, teacher, or parent.
- One pair of nonprosthetic eyewear per calendar year.

A client who experiences vision-related difficulty with activities of daily living (ADLs) or with employment may be referred to DARS DBS for evaluation and appropriate resources.

39.2.2.1 Vision Examinations with Refraction

Vision examinations with refraction to obtain a prescription for eyewear (procedure code S0620 or S0621) may be reimbursed once per calendar year when billed with one of the following diagnosis codes:

Diagnosis Code	Description
3669	Unspecified cataract
3670	Hypermetropia
3671	Myopia
36720	Unspecified astigmatism
36721	Regular astigmatism
36722	Irregular astigmatism
36731	Anisometropia
36732	Aniseikonia
3674	Presbyopia
36751	Paresis of accommodation
36752	Total or complete internal ophthalmoplegia
36753	Spasm of accomodation
36781	Transient refractive change
36789	Other disorder refraction and accommodation
3679	Unspecified disorder of refraction and accommodation
37182	Corneal disorder due to contact lens
V720	Examination of eyes and vision

39.2.2.2 Medical Eye Examinations

Medical eye examinations performed for medical reasons may be reimbursed to ophthalmologists and optometrists using procedure codes 92002, 92004, 92012, 92014, and 92015. These examinations may be reimbursed as medically necessary with a valid 3- to 5-digit diagnosis code that describes the medical reason for the eye examination.

Medical eye examinations may also be reimbursed to ophthalmologists and optometrists using procedure codes 92020, 92060, 92065, and 92100.

A new patient is one who has not received any professional services within the past three years from the provider or another provider of the same specialty who belongs to the same group practice. Providers must use procedure codes 92002, 92004, or S0620 to bill for new patient ophthalmological eye exams provided in the office, or in an outpatient or other ambulatory facility.

An established patient is one who has received professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years. Providers must use procedure codes 92012, 92014, or S0621 to bill for established patient ophthalmological eye exams that were provided in the office, or in an outpatient or other ambulatory facility.

Sensorimotor exams (procedure code 92060) are limited to two per calendar year.

Orthoptic and pleoptic training (procedure code 92065) is limited to 3 services per week over a 12-week period.

Routine vision examinations, with refraction (procedure codes S0620 and S0621) will be denied as part of another service if they are billed with the same date of service as an ophthalmological medical exam (procedure codes 92002, 92004, 92012, 92014, and 92015).

Comprehensive new and established patient ophthalmological medical examinations (procedure codes 92004 and 92014) will be denied as part of another service if they are billed with the same date of service as intermediate ophthalmological new and established medical examinations (procedure codes 92002 and 92012).

An intermediate new patient ophthalmological medical examination (procedure code 92002) will be denied as part of another service if it is billed with the same date of service as a comprehensive ophthalmological medical examination (procedure code 92012).

A comprehensive new patient ophthalmological medical examination (procedure code 92004) will be denied as part of another service if it is billed with the same date of service as a comprehensive established patient ophthalmological medical examination (procedure code 92014).

Ophthalmological medical exams (procedure codes 92002, 92004, 92012, 92014, and 92015) will be denied if they are billed with the same date of service by the same provider as physician evaluation and management (E/M) visits.

39.2.2.3 Services Requiring Authorization

Authorization is required if a school nurse, teacher, or parent recommends an additional eye examination with refraction within a calendar year. If a new pair of eyeglasses is required as a result of the exam, an authorization is required. Requests for either authorization must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form with documentation of the following:

- The medical diagnosis of the cause of the disorder of refraction
- The new prescription that shows at least one of the following:
  - A change of 0.50 diopters or more in any corresponding meridian
  - A cylinder axis change of at least 20 degree for a cylinder power of 0.50-0.62 diopters
  - A cylinder axis change of at least 15 degree for a cylinder power of 0.75-0.87 diopters
  - A cylinder axis change of at least 10 degree for a cylinder power of 1.00-1.87 diopters

- A cylinder axis change of at least 5 degree for a cylinder power of 2.00 diopters or greater.

Note: *A cylinder power of 0.12-0.37 diopters with a change in axis does not warrant replacement glasses.*

- The specific procedure codes for which the authorization is being requested

Authorization is not required for the following:

- One annual vision exam with refraction
- One medically necessary pair of prescription eyewear per calendar year
- Eye exams and eye treatments for medical reasons (Medical eye exams and treatments may also include special vision services and ocular viewing and diagnostic procedures.)

Refer to: Section 4.2, "Authorizations," on page 4-3 for detailed information on authorization requirements.

39.2.3 Special Vision Services

Special vision services may be reimbursed to ophthalmologists and optometrists using the following procedure codes, in addition to simple refraction (procedure code 92015):

Procedure Codes				
92025	92081	92082	92083	92132
92133	92134	92140		

Ophthalmologists and optometrists may also bill procedure codes 92018 and 92019 for special vision services.

Visual field examinations (procedure codes 92081, 92082, and 92083) are limited to two services per calendar year and require prior authorization. The following documentation must be submitted with the prior authorization request:

- Diagnosis being treated
- How the results of the repeated exam will affect the client's treatment plan

Computerized corneal topography (procedure code 92025) is limited to once, per day and is limited to the following diagnosis codes:

Diagnosis Code	Description
36720	Astigmatism, unspecified
36722	Irregular Astigmatism
37000	Corneal ulcer, unspecified
37001	Marginal corneal ulcer
37002	Ring corneal ulcer
37003	Central corneal ulcer
37004	Hypopyon ulcer
37005	Mycotic corneal ulcer
37006	Perforated corneal ulcer
37007	Mooren's ulcer
37020	Superficial keratitis, unspecified
37021	Punctate keratitis
37022	Macular keratitis
37023	Filamentary keratitis
37024	Photokeratitis
37031	Phlyctennular keratoconjunctivitis
37032	Limbar and corneal involvement in vernal conjunctivitis

Diagnosis Code	Description
37033	Keratoconjunctivitis sicca, not specified as Sjogren's
37034	Exposure keratoconjunctivitis
37035	Neurotrophic keratoconjunctivitis
37040	Keratoconjunctivitis, unspecified
37044	Keratitis or keratoconjunctivitis in exanthema
37049	Other and unspecified keratoconjunctivitis, other
37050	Interstitial keratitis, unspecified
37052	Diffuse interstitial keratitis
37054	Sclerosing keratitis
37055	Corneal abscess
37059	Interstitial and deep keratitis, other
37060	Corneal neovascularization, unspecified
37061	Localized vascularization of cornea
37062	Pannus (corneal)
37063	Deep vascularization of cornea
37064	Ghost vessels (corneal)
3708	Other forms of keratitis
3709	Unspecified keratitis
37100	Corneal opacity, unspecified
37101	Minor opacity of cornea
37102	Peripheral opacity of cornea
37103	Central opacity of cornea
37104	Adherent leucoma
37120	Corneal edema, unspecified
37121	Idiopathic corneal edema
37122	Secondary corneal edema
37123	Bullous keratopathy
37140	Corneal degeneration, unspecified
37142	Recurrent erosion of cornea
37146	Nodular degeneration of cornea
37148	Peripheral degenerations of cornea
37149	Corneal degenerations, other
37150	Corneal dystrophy, unspecified
37151	Juvenile epithelial corneal dystrophy
37152	Other anterior corneal dystrophy
37153	Granular corneal dystrophy
37154	Lattice corneal dystrophy
37155	Macular corneal dystrophy
37156	Other stromal corneal dystrophies
37157	Endothelial corneal dystrophy
37158	Other posterior corneal dystrophies

Diagnosis Code	Description
37160	Keratoconus, unspecified
37161	Keratoconus, stable condition
37162	Keratoconus, acute hydrops
37170	Corneal deformity, unspecified
37171	Corneal ectasia
37172	Descemetocele
37173	Corneal staphyloma
37206	Acute chemical conjunctivitis
37234	Pingueculitis
37240	Pterygium, unspecified
37241	Peripheral pterygium, stationary
37242	Peripheral pterygium, progressive
37243	Central pterygium
37244	Double pterygium
37245	Recurrent pterygium
37289	Other disorders of conjunctiva
69513	Stevens-Johnson syndrome
69514	Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome
69515	Toxic epidermal necrolysis
74341	Anomalies of corneal size and shape
8710	Ocular laceration without prolapse of intraocular tissue
8711	Ocular laceration with prolapse or exposure of intraocular tissue
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
9404	Other burn of cornea and conjunctival
99651	Mechanical complication of other specified device, implant, and graft due to corneal graft
V425	Organ tissue replaced by transplant, cornea
V4561	Cataract extraction status
V4569	Other states following surgery of eye and adnexa

Ophthalmological exams that are performed under general anesthesia (procedure codes 92018 and 92019) will be denied if they are billed with the same date of service as a new patient intermediate ophthalmological medical examination (procedure code 92002).

A comprehensive ophthalmological exam that is performed under general anesthesia (procedure code 92018) will be denied if it is billed with the same date of service as established-patient ophthalmological medical examinations (procedure codes 92012 and 92014).

A comprehensive new patient ophthalmological medical examination (procedure code 92004) will be denied as part of another service if it is billed with the same date of service as ophthalmological exams that are performed under general anesthesia (procedure codes 92018 and 92019).

Gonioscopy (procedure code 92020) will be denied as part of another service if it is billed with the same date of service as ophthalmological exams under general anesthesia (procedure code 92018 and 92019) or external ocular photography (procedure code 92285).

Limited ophthalmological exams under general anesthesia (procedure code 92019), the fitting of contact lenses for treatment of disease, and ophthalmodynamometry (procedure code 92260) will be denied as part of another service if they are billed with the same date of service as complete ophthalmological exams performed under general anesthesia (procedure code 92018).

Serial tonography (procedure code 92100) will be denied when it is billed with the same date of service as provocative tests for glaucoma without tonography (procedure code 92140).

Computerized corneal topography (procedure code 92025) will be denied as part of another service if it is billed within the global surgical preoperative and postoperative care days of an ophthalmological surgical procedure.

An intermediate visual field examination (procedure code 92082) will be denied if it is billed with the same date of service as a limited visual field examination (procedure code 92081).

An extended visual field examination (procedure code 92083) will be denied if it is billed with the same date of service as a limited or an intermediate visual field examination (procedure codes 92081 and 92082).

39.2.3.1 Authorization Requirements

Authorization is not required for special vision services.

39.2.4 Ocular Viewing and Diagnostic Testing Procedures

Ophthalmologists and optometrists may submit the following procedure codes for the reimbursement of ocular viewing and diagnostic testing:

Ocular Viewing and Diagnostic Testing Procedure Codes				
76510	76511	76512	76513	76516
76519	76529	76999	92225	92226
92230	92235	92240	92250	92260
92265	92270	92275	92285	92286
92287				

Procedure code 76999 requires prior authorization. Procedure codes 76516, 76519, and 92285 are limited to once per day when billed by any provider.

Refer to: Section 39.2.1.7, "Services Requiring Prior Authorization," on page 39-8 for prior authorization requirements for procedure code 76999.

Providers must bill ophthalmoscopies with retinal drawing (procedure codes 92225 and 92226), fluorescein angioscopies (procedure codes 92230 and 92235), and indocyanin-green angiography (procedure code 92240) with the appropriate LT or RT modifier to indicate on which eye the procedure was performed. If the procedure was bilateral, modifier 50 must be submitted. Bilateral services may be reimbursed fully for the first procedure and at half the reimbursement rate for the second procedure.

Fundal photography (procedure code 92250) will be denied if it is billed with the same date of service as scanning computerized diagnostic ophthalmic imaging (procedure codes 92132, 92133, and 92134) and indocyanin-green angiography (procedure code 92240).

Fluorescein angioscopy (procedure code 92230) will be denied if it is billed with the same date of service by the same provider as fluorescein angioscopy with multiframe imaging (procedure code 92235) and indocyanin-green angiography (procedure code 92240).

Procedure code 76519 may be reimbursed as follows:

- The professional interpretation component must be billed with modifier LT or RT to identify the eye on which the service was performed.
- The technical component may be reimbursed once when one or both eyes are scanned on the same date of service by the any provider.
- The total component may be reimbursed with an additional professional service when both eyes are scanned on the same date of service by the any provider.

39.3 Claims Information

The repair or replacement of lost or destroyed eyeglass frames, eyeglass lenses, or contact lenses outside of their normal replacement schedule will be allowed only if the RB modifier is submitted with the appropriate procedure codes.

Eyewear for a diagnosis of aphakia must be billed with modifier VP.

The MSRP must be submitted for the consideration of the purchase of high-powered and aphakic lenses with the appropriate procedure codes.

Opticians enrolled as a facility must submit claims with their provider identifier in both the billing provider field (Block 33 on a paper claim or the electronic equivalent) *and* in the performing provider field (Block 24J on a paper claim or the electronic equivalent.)

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

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

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html 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 40, "TMHP Electronic Data Interchange (EDI)" on page 40-1 for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" on page 5-1 for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions," on page 5-26 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

39.4 Reimbursement

Contact lenses, frames, and eyeglass lenses, except for high-power and aphakic lenses, may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. High-powered lenses and lenses for aphakia are manually priced. Manually-priced items are reimbursed at the retail price minus a discount as determined by the CSHCN Services Program rule. An invoice that shows the actual MSRP must be filed with every claim of this type.

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.*

39.5 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.

Chapter

40

TMHP Electronic Data Interchange (EDI)

40.1 TMHP EDI Overview

Providers can submit claims and other requests using paper forms or faster electronic methods. Providers are encouraged to submit claims and other requests electronically. Providers can participate in the most efficient and effective method of submitting requests to TMHP by submitting through the TMHP EDI Gateway. TMHP uses the *Health Insurance Portability and Accountability Act* (HIPAA)-compliant American National Standards Institute or ANSI X12 5010 (if provider has passed 5010 testing) file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security. Providers can access TMHP's electronic services through the TMHP website.

40.2 Advantages of Electronic Services

It's fast. No more waiting by the mailbox or making telephone inquiries; know what's happening to claims in less than 24 hours and receive reimbursement for approved claims within a week. TexMedConnect users can submit individual requests interactively and receive a response immediately.

It's free. All electronic services offered by TMHP are free, including TexMedConnect and its technical support and training.

It's easy. TMHP offers computer-based training (CBT) for TexMedConnect, CSHCN Services Program, and many other topics, as well as a large library of reference materials and manuals on the TMHP website at www.tmhp.com.

It's safe. TMHP EDI services use VPN and SSL connections, just like the U.S. government, banks, and other financial institutions, for maximum security.

It's accurate. TexMedConnect and most third-party vendor software have features that let providers know when they've made a mistake, which means fewer rejected and denied claims. Rejected claims are returned with messages that explain what's wrong, so the claim can be corrected and resubmitted right away. Denied claims appear on the provider's Remittance and Status (R&S) Report along with paid and pending claims.

It's there when it's needed. Electronic services are available day and night; from home, the office, or anywhere in the world.

It makes record keeping and research easy. Not only can TexMedConnect be used to send and receive claims, it can retrieve Electronic Remittance and Status (ER&S) reports, perform claim status inquiries, verify client eligibility, and archive claims. TexMedConnect can generate and print reports on everything it sends, receives, and archives.

40.2.1 Getting Help

Contact the TMHP EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time, or visit the TMHP website at www.tmhp.com for more information about EDI services.

The TMHP EDI Help Desk does not provide training or help with billing questions. Providers should contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 for billing and training questions. Information about provider education opportunities is available on the TMHP website at www.tmhp.com/Pages/Education/Ed_Home.aspx.

40.2.2 Electronic Services Available

The services available through EDI are:

- Eligibility verification (EV)
- Claims submission
- Claim status inquiry (CSI)
- ER&S reports
- Appeals (also known as correction and resubmission)

40.3 Electronic Billing

Providers that want to transition from paper billing to electronic billing should decide how they will submit their claims to TMHP. Providers can use TexMedConnect or vendor software to submit files directly to TMHP or they may use a billing agent (i.e., billing companies or clearinghouses) that submits files on the provider's behalf.

The previously announced dual strategy for EDI claims submissions is now in effect.

Trading partners that have passed ANSI X12 version 5010 testing may submit ANSI X12 version 5010 files.

TMHP no longer accepts ANSI X12 version 4010 files. Effective April 1, 2012, electronic claims that are submitted by providers that are not both compliant and certified will not be accepted by TMHP, and, as a result, will not be adjudicated or paid by the CSHCN Services Program.

It is the responsibility of providers to ensure that their method of submitting electronic claims is both EDI compliant and certified by TMHP.

Note: *All CSHCN Services Program electronic claims must include the appropriate benefit code as follows:*

- DM3 for CSHCN Services Program home health durable medical equipment (DME) services
- CSN for all other CSHCN Services Program services

TexMedConnect provides a drop-down box that allows the submitter to choose the appropriate combination of provider numbers and benefit code. For CSHCN Services Program submissions, providers must choose the appropriate combination that includes either the CSN or DM3 benefit code.

Providers that use other vendor software must add the appropriate CSHCN Services Program benefit code (i.e., CSN or DM3) in the appropriate field as designated by the software.

40.3.1 Step 1—Choose How Claims Are Submitted

40.3.1.1 TexMedConnect

TexMedConnect is a free, web-based, claims submission application provided by TMHP. Technical support and training for TexMedConnect are also available free from TMHP. Providers can submit claims, eligibility requests, claim status inquiries, appeals, and download ER&S reports (in either PDF or ANSI 835 formats) using TexMedConnect. TexMedConnect can interactively submit individual claims that are processed in seconds. To use TexMedConnect, providers must have Internet access and one of the following Internet browsers:

- Microsoft® Internet Explorer®
- Netscape Navigator®

Although TexMedConnect will work with Microsoft Internet Explorer 7.0 and Netscape Navigator, TMHP only offers technical support for TexMedConnect when it is used with Microsoft Internet Explorer 6.0. A broadband connection is recommended but not required. Providers that use TexMedConnect can find the online instruction manual on the homepage and on the EDI page of the TMHP website at www.tmhp.com.

40.3.1.2 Vendor Software

Providers that do not use TexMedConnect must use vendor software to create, submit, and retrieve data files. Providers can use software from any vendor listed in the Completed Testing link, which is located on the EDI page of the TMHP website at www.tmhp.com. There are hundreds of software vendors with a wide assortment of services that have been approved to submit electronic files to TMHP. Providers that plan to access TMHP's electronic services with vendor software should contact the vendor for the details of their software requirements. TMHP does not make vendor recommendations or provide any assistance for vendor software. Not all vendor software offers

the same features or levels of support. Providers are encouraged to research their software thoroughly to make certain that it meets their needs and that it has completed testing and have been certified by TMHP.

Note: *Software vendors should refer to Section 40.6, "Third-Party Vendor Implementation," on page 40-5.*

40.3.1.3 Third-Party Billing Agents

Billing agents are companies or individuals that submit electronic files to TMHP on behalf of the provider. Generally, this means that the provider uses a product that sends billing or other information to the billing agent that processes it and then transmits it to TMHP and other institutions. TMHP has no information on the software or other requirements of billing agents. Providers should contact the billing agent to obtain information about their products and processes. A complete list of billing agents that have completed the testing process and been certified by TMHP can be found on the Completed Testing link, which is located on the EDI page of the TMHP website at www.tmhp.com. TMHP does not make billing agent recommendations or provide any assistance for billing agent's software or services.

40.3.1.4 Automated Maintenance Process for All Electronic Submitters

All electronic submitters are responsible for the maintenance of their submitter folders. Folders are limited to 7,500 files and cannot contain files older than 30 days. Files that exceed these limits are systematically archived on a daily basis. Providers should review, retrieve, and backup their electronic response files regularly.

Providers must pay a fee for transmission reports that are produced after the 30-day period or as a result of the systematic archive of files over the 7,500 limit. File submitted using EDI version 5010 are limited to a maximum 5,000 transactions per file. Files that have more than 5,000 files will be rejected.

Refer to: Section 40.4, "Request for Electronic Transmission Reports," on page 40-5.

40.3.2 Step 2—Gaining Access

Providers must setup their software or billing agent services to access the TMHP EDI Gateway. Providers that use billing agents or software vendors should contact those organizations for information on installation, settings, maintenance, and their processes and procedures for exchanging electronic data.

Providers that download the ANSI 835 file through TexMedConnect and providers that use vendor software must request a submitter ID. A submitter ID is necessary for vendor software to access TMHP's electronic services. It serves as an electronic mailbox for the provider and TMHP to exchange data files. To order a submitter ID, providers must call the EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time. Providers that use a billing agent do not need a submitter ID. Providers that use TexMedConnect can access the online instruction manual on the EDI webpage of the TMHP website at www.tmhp.com.

40.3.3 Step 3—Training

Providers should contact the TMHP-CSHCN Contact Center at 1-800-568-2413 for assistance with resolving billing issues. Information about training opportunities is available on the TMHP website at www.tmhp.com/Pages/Education/Ed_Home.aspx. Providers may also use the many reference materials available on the website in the reference materials section.

Refer to: Section 1.2.1, "Publications," on page 1-5.

The TMHP EDI Help Desk provides technical assistance, but does not provide training.

40.4 Request for Electronic Transmission Reports

Providers are required to retain all claim and electronic file transmission records. Providers must verify that all claims submitted to the CSHCN Services Program or its agent are received and accepted. Providers must also track claims submissions against their claims payments to detect and correct all claim errors.

Refer to: Section 2.3, "Provider Responsibilities," on page 2-11 for more information about provider responsibilities and electronic submissions.

When an electronic file transmission record is missing, providers can request copies of the transmission report by contacting the TMHP EDI Help Desk at 1-888-863-3638 and requesting that the electronic transmission report file be reset. The TMHP EDI Help Desk will then reset the file for the production submitter ID provided. Requests for transmission reports that were produced in the previous 30 days are provided at no cost to providers. Requests for transmission reports that were produced more than 30 days before the request cost $500 plus the 8.25 percent sales tax of $41.25, which is a total of $541.25. Providers that hold a tax-exempt certificate are not assessed sales tax. This cost is per transmission report.

40.5 Provider Check Amounts Available Online

Acute care providers can search, view, and print all payment amounts that were issued during the previous year by going to the TMHP website at www.tmhp.com.

The features of the online check amount include:

- The ability to search information up to 1 year before the date of the search.
- All results are displayed on a single screen.
- All results can be printed on a single report.

The 52 weeks of reimbursement payment information includes the:

- Payment date
- Payee name
- Payment amount
- Program for which payment was issued
- Hold amount
- Payment status

Providers must have or must create a Provider Administrator account to view their payment amounts online. Providers can then grant "View Payment Amounts" security permission to the office staff of their choice. Providers can access their check amounts by clicking **My Account** and then **View Payment Amounts**.

Provider check amounts will continue to be available through the Automated Inquiry System (AIS) telephone line and on Electronic Remittance and Status (ER&S) Reports.

40.6 Third-Party Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before granting access to the production server. Vendors that wish to begin testing may either call the EDI Help Desk at 1-888-863-3638 or visit the EDIFECS testing site at https://editesting.tmhp.com and use the *TMHP Support* link. An EDIFECS account is created for the vendor to begin testing EDI formats. After the successful completion of EDIFECS testing and the submission of a Trading Partner Agreement, vendors must complete end-to-end testing on the TMHP test server. Software vendors and billing agents must be partnered with at least one Texas provider before a test submitter ID can be issued. When end-to-end testing has been completed, the billing organization or agent is added to the EDI Submitter List. Providers and billing agents may then order production submitter IDs for use with the vendor software.

40.6.1 EDI Version 5010 Claims Response and Electronic Remittance & Status (R&S) Files

Batch ID Included in Filename for 227CA Claims Response File

The Batch ID (BID) is located in the file name of the returned 227CA response. The 227CA claims response file does not include the batch ID within the file.

Note: *When calling the EDI helpdesk for assistance, providers should have the 227CA filename available so the EDI Helpdesk can provide assistance.*

Setting up the 835 File (ER&S)

After completing the EDI 5010 testing and certification process, providers need to submit a request to establish their ER&S report for their new submitter ID. Acute care providers must submit the Electronic Remittance and Status (ER&S) Agreement , which is available on the TMHP website at tmhp.com.

Providers should fax the completed forms to (512) 506-7808. The process for setting up the ER&S report for EDI 5010 depends upon the designated recipient.

Trading Partners Who Submit 837 Files and Receive 835 Files

The trading partner must complete the appropriate 835 form and submit it to TMHP.

The 835 form must contain the trading partner's EDI 5010 submitter ID and Texas Provider Identifier (TPI).

Trading Partners Who Have a Clearinghouse or Third Party Submit Their Claims but Receive Their Own 835 Files

Each provider that uses a clearinghouse or third-party biller to submit claims must submit their own updated 835 form. A clearinghouse or third-party biller may not submit 835 forms on behalf of the trading partners for which it submits claims.

To be able to receive 835 files directly, providers must first request an EDI 5010 submitter ID to be used for accessing their 835 files. After the EDI 5010 submitter ID is received, providers must complete the appropriate 835 form and submit it to TMHP.

The 835 form must contain the provider's EDI 5010 submitter ID and TPI.

Clearinghouses or Third-Party Billers That Submit Transactions and Receive the 835 Files on Behalf of Trading Partners

Each provider that uses a clearinghouse or third-party biller to submit claims must submit their own updated 835 form. Even if a clearinghouse or third-party biller receives 835 files for its trading partners, it may not submit 835 forms on behalf of the trading partner for which it submits claims.

The 835 form must contain the clearinghouse or third-party biller's EDI 5010 submitter ID and the provider's TPI.

Providers should direct all questions and support requests to the EDI Version 5010 Implementation e-mail address at EDI5010Support@tmhp.com.

40.7 Supported File Types

TMHP EDI supports the following electronic HIPAA-compliant ANSI ASC X12 5010 transaction types:

Electronic Transaction Types	
270	Eligibility request
271	Eligibility response
276	Claim status inquiry
277	Claim status inquiry response
835	ER&S report
837D	Dental claims

Electronic Transaction Types	
837I	Institutional claims
837P	Professional claims

40.8 Forms

The following forms are available on the TMHP website:

- Claim Status Inquiry (CSI) Authorization
- Electronic Funds Transfer (EFT) Notification

Note: *Photocopy these forms and retain the originals for reuse. Forms are also available at www.tmhp.com.*

Refer to: Section 5.8, "Reimbursement," on page 5-47.

40.9 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.

Acronyms and Initialisms Dictionary

Term	Definition
A/R	Accounts Receivable
AAP	American Academy of Pediatrics
ACA	Affordable Care Act of 2010
ACD	Augmentative Communication Device
ACIP	Advisory Committee on Immunization Practices
ACSW	Academy of Certified Social Workers
AFP	Abdominal Flat Plates
AIDS	Acquired Immunodeficiency Syndrome
AIS	Automated Inquiry System
ALL	Acute Lymphoblastic Leukemia
AMA	American Medical Association
ANSI	American National Standards Institute
APN	Advanced Practice Nurse (former name for APRN)
APRN	Advanced Practice Registered Nurse
ASA	American Society of Anesthesiologists
ASBMT	American Society for Blood and Marrow Transplantation
ASC	Ambulatory Surgical Center
ATP	Assistive Technology Professional
AWP	Average Wholesale Price
BCBS	Blue Cross Blue Shield
BCG	Bacille Calmette-Guérin
BiPAP	Bi-level Positive Airway Pressure
BON	(Texas) Board of Nursing
BSSW	Bachelor of Science in Social Work
CAPD	Continuous Ambulatory Peritoneal Dialysis
CBC	Complete Blood Count
C/C	Cleft/Craniofacial
CCP	Comprehensive Care Program
CCPD	Continuous Cycling Peritoneal Dialysis
CDT	Current Dental Terminology
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services—now called TriCare
CHIP	Children's Health Insurance Program
CLIA	*Clinical Laboratory Improvement Amendments*
CML	Chronic Myelogenous Leukemia
CMS	Centers for Medicare & Medicaid Services (formerly HCFA)

Term	Definition
CNS	Clinical Nurse Specialist
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CRCP	Certified Respiratory Care Practitioner
CRNA	Certified Registered Nurse Anesthetist
CSHCN	Children with Special Health Care Needs
CSI	Claim Status Inquiry
CT	Computed Tomography
CVA	Cerebrovascular Accident
DARS	Department of Assistive and Rehabilitative Services
DDS	Doctor of Dental Surgery
DEFRA	*Deficit Reduction Act* of 1984
DMD	Doctor of Dental Medicine
DME	Durable Medical Equipment
DO	Doctor of Osteopathy
DOB	Date of Birth
DOS	Date of Service
DPM	Doctor of Podiatric Medicine
DRG	Diagnosis-Related Group
DSHS	Department of State Health Services
DSM-IV-TR	*Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision
E/M	Evaluation and Management (Services)
ECG	Electrocardiogram
EDI	Electronic Data Interchange
EEG	Electroencephalogram
EFT	Electronic Funds Transfer
EMG	Electromyography
EMTALA	*Emergency Medical Treatment and Labor Act*
EOB	Explanation of Benefits
EOG	Electro-oculogram
EOPS	Explanation of Pending Status
EPO	Erythropoietin Alfa
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ER&S	Electronic Remittance and Status report
ESWL	Extracorporeal Shock Wave Lithotripsy
EV	Eligibility Verification
fMRI	Functional Magnetic Resonance Imaging
FNP	Family Nurse Practitioner
FQHC	Federally Qualified Health Center
FSS	Family Support Services

Term	Definition
FYE	Fiscal Year End
HASC	Hospital-based Ambulatory Surgical Center
HBOT	Hyperbaric Oxygen Therapy
HCPCS	Healthcare Common Procedure Coding System
HCSSA	Home and Community Services Support Agency
HFCWCS	High Frequency Chest Wall Compression Systems
HHA	Home Health Agency
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIPAA	*Health Insurance Portability and Accountability Act*
HIV	Human Immunodeficiency Virus
HKAFO	Hip-Knee-Ankle-Foot Orthotics
HLA	Human Leukocyte Antigen
HMO	Health Maintenance Organization
HO	Hip Orthotics
ICD-9-CM	*International Classification of Diseases, Ninth Revision, Clinical Modification*
ICF	Intermediate Care Facility *(*refer to *also SNF)*
ICF-MR	Intermediate Care Facility for Persons with Mental Retardation
ICN	Internal Control Number (as in, *24-digit ICN*) assigned to a specific claim
ID	Intradermal
IM	Intramuscular
iMRI	Intraoperative Magnetic Resonance Imaging
IOL	Intraocular Lens
IPD	Intermittent Peritoneal Dialysis
IPPA	Insurance Premium Payment Assistance
IPPB	Intermittent Positive Pressure Breathing
IPV	Intrapulmonary Percussive Ventilation
IRS	Internal Revenue Service
IV	Intravenous
JRA	Juvenile Rheumatoid Arthritis
KAFO	Knee-Ankle-Foot Orthotics
KO	Knee Orthotics
KUB	Kidneys, Ureters, and Bladder
LBSW	Licensed Baccalaureate Social Worker
LCSW	Licensed Clinical Social Worker
LDL	Low Density Lipoprotein
LMFT	Licensed Marriage and Family Therapist
LMSW	Licensed Master Social Worker
LMSW-AP	Licensed Master Social Worker-Advanced Practitioner
LPC	Licensed Professional Counselor
LVN	Licensed Vocational Nurse

Term	Definition
MD	Doctor of Medicine
MMIS	Medicaid Management Information System
MNC	Medically Needy Clearinghouse
MNP	Medically Needy Program
MPH	Master of Public Health
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MSRP	Manufacturers Suggested Retail Price
MSSW	Master of Science in Social Work
MSUD	Maple Syrup Urine Disease (also called branched-chain ketoaciduria)
MSW	Master of Social Work
MTP	Medical Transportation Program
NCCI	National Correct Coding Initiative
NDC	National Drug Code
NOS	Not Otherwise Specified
NP	Nurse Practitioner
NPI	National Provider Identifier
OI	Other Insurance
OMT	Osteopathic Manipulation Treatment
OT	Occupational Therapy, Occupational Therapist
PACT	Program for Amplification for Children of Texas (Hearing Aids/Services)
PAF	Physician/Dentist Assessment Form
PAN	Prior Authorization Number
PCN	Patient Control Number
PDA	Personal Digital Assistant
PDF	Portable Document Format
PET	Positron Emission Tomography (PET scan)
PKU	Phenylketonuria
PNP	Pediatric Nurse Practitioner
POC	Plan of Care
POS	Place of Service
PPMP	Physician-Performed Microscopy Procedures
PPO	Preferred Provider Organization
PT	Physical Therapy, Physical Therapist
RAST	Radioallergosorbent Test
RBRVS	Resource-Based Relative Value Scale
RESNA	Rehabilitation Engineering and Assistive Technology Society of North America
RGO	Reciprocating Gait Orthosis
RHC	Rural Health Clinic
RN	Registered Nurse
RSV	Respiratory Syncytial Virus

Term	Definition
RVU	Relative Value Unit
SC	Subcutaneous
SID	Surface Identification
SLP	Speech-Language Pathology/Speech-Language Pathologist
SNF	Skilled Nursing Facility *(*refer to *also ICF)*
SO	Spinal Orthotics
SSL	Secure Socket Layer
TAC	*Texas Administrative Code*
TANF	Temporary Assistance to Needy Families (formerly AFDC)
TEFRA	*Tax Equity and Fiscal Responsibility Act* of 1982
TENS	Transcutaneous Electric Nerve Stimulator
THKAO	Thoracic-Hip-Knee-Ankle Orthotics
THSteps	Texas Health Steps (Texas name for EPSDT)
THSteps-CCP	Texas Health Steps Comprehensive Care Program (Texas name for EPSDT-CCP) (now called CCP)
TMHP	Texas Medicaid & Healthcare Partnership
TMRM	Texas Medicaid Reimbursement Methodology
TOB	Type of Bill
TOS	Type of Service
TPI	Texas Provider Identifier
TPN	Total Parenteral Nutrition (i.e., Hyperalimentation)
TPR	Third-Party Resource
TSBDE	Texas State Board of Dental Examiners
TVFC	Texas Vaccines for Children
UB-04	Uniform Bill 04 CMS-1450
UCB	University of California at Berkeley
VDP	Vendor Drug Program
VIPS	Voice Inquiry Processing System
VPN	Virtual Private Networking